Vicarious Resilience, Vicarious Trauma, and Awareness of Equity in Trauma Work

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Abstract
This qualitative study examines the coexistence of vicarious resilience and vicarious trauma and explores the inclusion of intersectional identities in trauma work with torture survivors in specialized programs across the United States. A constructionist framework and a method of constant comparison discovered themes that speak about the effects of witnessing how clients cope constructively with adversity, and intersectional identities in social context. The data suggest that trauma therapists can be potentially transformed by their clients' resilience in positive, but not painless, ways. Choosing to work in the trauma field with survivors of torture and politically motivated violence involves immersion in profound ongoing experiences of intertwined pain, joy, and hope, and expanding the boundaries of self—personally and professionally.

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Previous research (Engstrom, Hernandez, & Gangsei, 2008) explored vicarious resilience as a construct that helps us understand the ways in which mental health professionals can be positively influenced by exposure to the resilience displayed by their clients, and demonstrated its relevance in trauma therapy training, supervision, and self-care (Hernández, Gangsei, & Engstrom, 2007). The present study deepens our understanding of vicarious resilience by including an exploration of vicarious trauma and vicarious resilience, discerning differences between other forms of positive and negative impact, and the inclusion of intersectional identities and accompanying power and privilege in trauma work with torture survivors in specialized programs across the United States.

The Movement for the Rehabilitation of Torture Survivors

According to Quiroga and Jaranson (2005), the torture treatment movement began in Latin America in the late 1970s and spread to North America and Europe in the early 1980s. Today, about 250 centers or programs operate throughout the world, and 143 of them are member organizations of the International Rehabilitation Council of Torture Victims (IRCT), the largest membership-based civil society organization supporting the prevention of torture and the rehabilitation of torture survivors worldwide. In the United States, the National Consortium of Torture Treatment Programs has 30 full member programs from around the country. Collectively, these centers serve thousands of torture survivors each year from all parts of the globe. Most torture survivor centers in the United States sprang from grass roots movements and were founded and operated by volunteers in their early phases. Although programs differ, centers usually provide some combination of the following services: health and mental health care (medical services, counseling, psychotherapy, and psychiatry), psychosocial or case management (direct services and referrals to meet basic survival needs, such as food, housing, transportation, and financial assistance, legal assistance (coordination with pro bono attorneys, paralegal assistance, documentation of the medical and psychological effects of torture for immigration proceedings and advocacy), and interpreters and cultural brokers (Quiroga & Jaranson, 2005).

Torture is still practiced by at least 111 governments around the world, including the United States (Amnesty International, 2010). While the United Nations Convention Against Torture and Other Cruel or Degrading Treatment or Punishment (1995) characterizes torture in individual terms, torture is also a weapon directed against entire communities. Writing about the function of torture, Bustos (1990) stated, "Torture is used to obtain information, to punish, and to physically and psychologically annihilate. Opposition in the rest

of society is intimidated, terrorized, and paralyzed" (p. 143). Therefore, challenging torture involves both individual reparation and making perpetrators accountable by bringing them to justice. One irony is that while health care workers have an ethical and professional obligation to contribute at both levels via direct treatment, evaluation, and judicial hearings, physicians, medical personnel, and psychologists are actively involved in devising torture methods and assessing their efficient practice (Costanzo, Gerrity, & Likes, 2007).

The survivors whom trauma therapists serve at specialized centers in the United States have suffered severe physical, psychological, and/or sexual torture and have fled their home countries to protect their lives and well-being. In addition to the mental and physical consequences of torture, they have suffered severe and pervasive losses—of family, health, economic status and resources, culture, home and country—as a result of forced migration. They face extreme hardship as they resettle in the United States, their country of refuge. Some are held in immigration detention facilities for months or years while their applications for asylum are adjudicated. Those living in the community are often ineligible for work permits while seeking asylum and face economic, social, cultural, and language challenges as they struggle to acculturate and rebuild their lives (Engstrom & Okamura, 2004). According to the Office of Immigration Statistics (2011), 73,293 persons were admitted as refugees during 2010, with most coming from Iraq, Burma, Bhutan, Somalia, and Cuba. Likewise, 21,113 individuals were granted asylum, with most arriving from China, Ethiopia, Haiti, Venezuela, Nepal, Colombia, Russia, Egypt, Iran, and Guatemala.

Inequity and Trauma Work: An Intersectional Framework

Brown (2008) and Mattar (2011) asserted that the trauma field has historically been compartmentalized in a way that excluded a meaningful integration of social, historical, and diversity dimensions in trauma work. Thus, the ways in which class, gender, race, sexual orientation, (dis)ability, and religious identity shape access and opportunity to recovery, and the meaning therapists, clients, professional communities and societies make out traumatic experiences and paths for resilience, has been for most of its history, absent in the field. As Brown notes, these issues have been reserved for those who work with special populations and for those who work internationally. Identities constructed on the basis of social location on gender, ethnicity, ability, and sexual orientation (among other axes of power) are socially significant, context-specific and useful as markers for historical and social location (Martín-Alcoff, Hames-García, Mohanty, & Moya, 2006). These identities are especially relevant when considering how they

intersect in a particular social context, thereby making visible the structural privileges (i.e. access and opportunity), or lack thereof, that people possess simply by virtue of their location (e.g. lesbian, lower class, fully able-bodied woman of color; heterosexual, upper middle class, visually impaired woman of color). Collins (1998) explains that looking at intersecting identities "highlights how social groups are positioned within unjust power relations, but it does so in a way that introduces added complexity to formerly race-, class-, and gender-only approaches to social phenomena" (p. 205). For example, two female torture survivors from Latin America will likely experience differences in safety, employment, and ability to partner depending on their sexual orientation, ability, ethnicity, and class. Whoever happens to be White, heterosexual, able-bodied, and upper middle class would likely enjoy more potential opportunities and access than whosoever happens to be dark, lesbian, disabled, and working class. Thus, their experience of racism in the United States and in their own countries of origin must also be understood within the context of these intersections, so as to address issues of privilege and accountability in a manner that does justice to their complex intersectional identities. In the therapeutic context, Brown (2008) explains that central to trauma therapy is the therapist's ability "to recognize her/his own multiple identities and the interaction of these identities with clients in therapy" (p. 4). In her view, "a lack of examination of areas in which therapists' hold unearned privileges by virtue of these dimensions hinders their ability to truly appreciate their clients' change processes and how they can learn from them."

Vicarious Trauma and Vicarious Resilience

Trauma therapists are intimately exposed to the suffering of torture survivors due to the empathic bond that is developed in the therapeutic relationship. They are witnesses to testimonies so unique and incomparable as to render them incomprehensible to those who were not there. Empathy involves the capacity to be aware of, understand, and vicariously experience the world and perspective of another, and to feel their distress (Wilson & Brwynn, 2004). The therapist's capacity to maintain an empathetic stance and stay in tune with these clients may become strained as the details and immense pain of their traumatic experiences are related in therapy. Thus, vicarious traumatization may occur and can potentially transform professionals' sense of self and negatively impact their psychological well-being. Related concepts such as empathic strain, compassion fatigue, and secondary traumatic stress are used to describe the negative impact of trauma work and confirm that indirect exposure to trauma may involve significant emotional, cognitive, and

behavioral consequences for therapists (Adams, Boscarino, & Figley, 2006; Bride, Radey, & Figley, 2007; Killian, 2008). In this article, we will use the concept of vicarious trauma to anchor our data analysis.

Vicarious trauma (VT) refers to the cumulative effect of working with traumatized clients, involving interference with the therapist's feelings, cognitive schemas and worldview, memories, self-efficacy, and/or sense of safety. A unique and common consequence of trauma work, VT does not reflect psychopathology in either the therapist or the survivor client, but instead is the transmission of traumatic stress by bearing witness to disturbing clinical material (Figley, 1998; Saakvitne & Pearlman, 1996). However, Wilson and Brwynn (2004) suggest that therapists who experience vicarious traumatization may have stronger countertransference reactions, may be less aware of these reactions, and therefore may make more clinical errors, impeding the progress of treatment.

At the same time, therapists may experience personal and professional growth by being witness to and inspired by their clients' processes of resilience. In vicarious resilience (VR), trauma therapists learn about overcoming adversity from witnessing and participating in trauma survivors' own recovery processes. We hypothesized that vicarious resilience is also a unique and common consequence of trauma work that may coexist with vicarious trauma (Hernández et al., 2007). We wanted to account for the positive transformation and empowerment that some trauma therapists experience through their empathy for and interaction with clients grounded in a strengths-based approach. We are not assuming that VT and VR are parallel processes, or that they can be conceptually explained on the basis of similar theoretical foundations. While the concept of VT is based on constructivist self-development theory (Saakvitne, Gamble, Pearlman, & Lev, 2000) and can be measured by the Trauma Symptom Inventory (TSI) Belief Scale, vicarious resilience emerged from observation, was built on grounded theory, and has been articulated through resilience and vicarious learning theory (Bandura, 1986; Luthar, 2003, 2006; Walsh, 2006).

Relevant to this discussion are the concepts of compassion satisfaction and vicarious post-traumatic growth. In her professional quality of life model for caregivers, Stamm (2009, 2010) explained that professional quality of life addresses the quality that a helper feels in relation to her work and is influenced by both the positive and negative aspects of the work. These aspects include compassion satisfaction, compassion fatigue, and burnout. Compassion satisfaction refers to the pleasure and satisfaction derived from working in a helping profession and may be related to the particular helping practice, the system of care in which one works, beliefs about the self, altruism, and professional environment. Compassion fatigue describes the

cognitive, emotional, and behavioral changes that therapists experience from exposure to trauma survivors and is characterized affectively by fear and anxiety. Burnout refers to the emotional exhaustion, disconnectedness, and hopelessness that develop over time in connection with a high workload and an unsupportive work environment (Killian, 2008). It is hypothesized that empathic engagement is the primary conduit for the transmission of traumatic stress from client to therapist (Figley, 2002a, 2002b). Stamm's model uses this concept to describe the negative aspects of the system of care in which one works. While the professional quality of life model accounts for the negative and positive impacts of caregiving jobs, VR deals specifically with the dynamic nature of the relationship between trauma therapist and survivor client.

Arnold, Calhoun, Tedeschi and Cann (2005) advanced the concept of vicarious posttraumatic growth based on Tedeschi and Calhoun's work on posttraumatic growth (PTG). These authors defined PTG as "positive psychological change experienced as a result of the struggle with highly challenging life circumstances" (Tedeschi & Calhoun, 2004, p. 1). Research shows that there is potential for growth after trauma in the following domains: positive reevaluation of self-worth, greater appreciation of interpersonal relationships, and changed life values and beliefs (Helgeson, Reynolds, & Tomich, 2006; Joseph & Linley, 2008; Prati & Pietrantoni, 2009; Tedeschi & Calhoun, 1996, 2004). According to a review by Linley and Joseph (2004), positive change has been reported in around 30% to 70% of survivors of traumatic events, including transportation accidents, natural disasters and medical problems (cancer, heart attack, brain injury, spinal cord injury), and other experienced adversities such as relationship breakdown, parental divorce, bereavement, and immigration. A recent Israeli study focused on nurses and social workers confirmed that posttraumatic growth and vicarious trauma are not mutually exclusive. Lev-Wiesel, Goldblatt, Eisikovits and Admi (2009) assessed posttraumatic stress symptoms and VT versus vicarious posttraumatic growth and found that nurses had higher posttraumatic growth compared with social workers, and that the emotional detachment activated during or immediately after a traumatic event contributed to both posttraumatic growth and vicarious trauma in social workers. Similarly, in a study of health care providers working with victims of politically motivated violence, Shiri, Wexler, Alkalay, Meiner, and Kreitler (2008) found that the providers reported both positive and negative psychological impact, with more traumatized individuals being more likely to experience posttraumatic growth. However, findings related to trauma in contexts of terrorism are mixed (Hobfoll, Palmieri, Johnson, Canetti-Nisim, & Hall, 2009). Hobfoll et al. (2009) found

that even sustained attempts to find meaning and draw benefit from terrorism and war are counterproductive for people's well-being. We believe that such attempts may falsely raise positive expectations that are never realized when war and terrorism are chronic. (p. 139)

Two qualitative studies exploring vicarious posttraumatic growth in wives of Vietnam veterans (McCormack, Hagger & Joseph, 2011) and in interpreters assisting therapists working with refugees in mental health settings (Splevins, Cohen, Joseph, Murray, & Bowley, 2010) found that veterans' wives and interpreters experienced negative and positive impact. They learned about empathy, finding ways to deal with issues, love, humility, and gratitude. Arnold et al. (2005) explored therapists' perceptions of the ways in which they have been affected by their work with trauma survivors, with a particular focus on changes in memory systems and schemas about self and the world. Of a sample of 21 therapists who did not work exclusively with trauma survivors, 16 therapists "spontaneously mentioned some sort of positive consequence in their responses to the interviewer's neutral, open-ended lead question about how they had been affected by their work with trauma survivors" (Arnold et al., 2005, p. 256). They also identified the following themes: the experience of observing and encouraging clients' growth, a deepening in their spirituality, and an appreciation for the resilience of the human spirit.

Like vicarious posttraumatic growth, VR addresses the observational positive impact of exposure to someone's positive psychological change resulting from struggling with traumatic experiences. However, VR focuses on the unique and positive effects that transform therapists in response to client trauma survivors' own resiliency. It is a term for the positive meaning-making, growth, and transformations in the therapist's experience resulting from exposure to clients' resilience in the course of therapeutic processes addressing trauma recovery (Hernández et al., 2007). In addition, its foundation stands on addressing resilience as "the potential for personal and relational transformation and growth that can be forged out of adversity" (Walsh, 2002, p.130) within evolving systems that encounter transformation and growth from an ecological perspective that captures how systems evolve, adapt, and cope individually and collectively. Vicarious resilience is founded on the assumption that client and therapist influence each other in the therapeutic relationship. Therapists and clients exist in the context of a relationship in which they mutually influence each other and construct meaning in the therapeutic relationship (Anderson, 2007). Obviously, this relationship is framed within layers of contexts (organizational, familial, communal, and social) and includes dimensions of power inherent in the therapeutic relationship and structured by virtue of the parties' social locations.

Method

We locate our work within a critical research paradigm that considers the research process, researcher values, and goals for social change as integral to the study (Denzin & Lincoln, 2005). This qualitative, exploratory study was based on a modified grounded theory approach rooted in feminist principles (Charmaz, 2006).

Sample

Our sample consisted of 1 male and 12 female mental health providers working at torture treatment centers in the West, East and Midwest of the United States. The programs they represent are members of the National Consortium of Torture Treatment Programs, which has 30 member programs in the United States. Collectively, these programs serve thousands of torture survivors from all parts of the globe each year. Twelve participants were of European descent, one was of South Asian descent. Four were immigrants and all had been involved in working with trauma victims outside of the United States, or lived for a substantial number of years outside the United States. Participants ranged in professional experience between 4 and 30 years. The selection criteria required participants to have worked directly with torture survivors and to have appropriate credentials (e.g., psychologists, social workers, and marriage and family therapists).

Data Collection and Analysis

The investigators revised the semistructured interview schedule (see the appendix) used in prior vicarious resilience studies. All interviews were conducted in person at a place determined by the participants and audiotaped with the permission of participants, and professionally transcribed. The analysis involved a constant comparison of data with emerging categories using a consensus process. The interviews were transcribed and coded for analysis. Transcripts were coded for each individual interview into domains that were agreed upon by consensus. The consensus process involved individual review of each other's analyses, face to face meetings and conference calls to discuss how all researchers identified domains. A matrix of themes was developed to identify consensus-based domains. The following guidelines for trustworthiness in qualitative research were followed: researcher and data analysis triangulation, dependability (researchers accounted for their personal influences and biases using debriefing), and data analysis saturation (Lincoln & Guba, 1985).

Table 1. Summary of Themes: Vicarious Resilience and Vicarious Trauma.

Vicarious resilience	Vicarious trauma
Changes in goals or priorities	Sleep disruption
Increased hopefulness and client-based inspiration	Nightmares
Change/impact on spiritual beliefs and practices vis-à-vis the therapeutic process	Fearfulness
Increase in self-care practices	Irritability
Increased resilience and perspective taking on one's own challenges	Fatigue
Increased racial, cultural, and structural consciousness, and awareness of relative privilege, marginalization, and oppression	Flashbacks, intrusive thoughts
	Disassociation
	Hyperarousal
	Negative affect and numbing

Findings

Vicarious resilience can and does coexist with vicarious trauma and other forms of positive and negative impact resulting from trauma recovery work with torture survivors (see Table 1). They coexist in the therapists' experience in the same manner as the experience of resilience in a survivor of torture does not prevent that person from simultaneously suffering symptoms of traumatic stress. In this study, 10 participants reported having experienced VT at one or various points in their work with survivors of torture in the past and discussed specific cases and symptoms involving sleep difficulty, fear, intrusive thoughts, irritability, tiredness, avoidance, anxiety, and depression. Some of these experiences occurred earlier in their careers and became the foundation for carefully attending to self-care and deriving solutions beyond problem solving to establish a source of resilience. For example, participants spoke about meditation, mind–body practices, and personal therapy as practices that have sustained them in doing this work.

A participant who stated that she had "a hard time listening to horror stories" and acknowledged having "less capacity to listen" also alluded to the ways in which client trauma material sometimes triggers memories of her own trauma experiences. It is possible that vicarious trauma was experienced at the time of the interview in addition to burn out. A third of the participants discussed cases involving treating perpetrators of violence and perpetrators who also had experiences of victimization in setting such as refugee camps.

These cases highlighted professional, personal, and ethical challenges that therapists had to confront.

> I've found that, as a clinician and as a person, there's a big struggle within me, and in a sense that speaks a bit to some vicarious trauma of the impact of working at times with perpetrators who also have experienced violence and at the same time, one of the things that was hardest for me is working with survivors from the very same community. And so how do I keep that straight, and in some of those resource core environments where I had the most training of anyone, believe it or not, I didn't have the luxury in a sense of choosing if I would work with them. It was very hard because it challenged me to—and I feel like ultimately I was able to do a fairly decent job of this but not without some challenge—accept the person, to treat them still with dignity and trying to find some empathy for them, to understand the struggles and the pain in their lives that even some of this perpetration experience had caused for them, including people who had made suicide attempts because of the guilt, the shame, and their going against some of their spiritual beliefs, and all that.

While this participant referred to VT, she also discussed what she learned and incorporated from these experiences thereby illustrating a process of VR as well:

> In one context I was involved in a community reconciliation process (. . .) Survivors don't want to continue to perpetuate that cycle [of violence]; they want to be part of a solution and that's when they tend to reconnect with their passion and what they've been fighting for a long time, which is a more peaceful, just world. What effect does it have on me? It really causes me to understand that I don't have nearly as severe circumstances in my own life, and to have more confidence that I can make choices to be involved with people in my life, whether it's difficult clients or perpetrators or difficult things in my personal life, and to come to some peace with that and to be engaged in a more positive way.

The stressful witnessing experience involved in the empathic bond of trauma work has potential negative and positive impacts on therapists at the same time. In this case, the community reconciliation process served to challenge hopelessness, confusion, and other negative emotions and cognitions, and to provide a model for an alternative that shifted her attitude.

Consistent with previous findings, developing the capacity to put into perspective one's own adversities and broadening an understanding of social context in relation to human rights appeared as common themes across the participants. They discussed how over time they were able to identify and bounce back faster from the negative impact of this work and their own personal challenges.

At a larger context level, broadening a perspective on human rights and considering how other countries and clients see the politics and actions of the United States internationally and nationally influenced therapists' own sense of self and purpose in their lives.

> I get some European newspapers because I want to get a different perspective about what they think of America. And also I hear my clients talk about the environment, the world, and all these issues. Somebody dying in Iraq and somebody dying in our family or whatever—when a family member dies here in a nursing home, the pain is pain and it's existential. Existentially we are all human. This work has broadened that and deepened that philosophy.

Trauma work is a source of both stress and joy, involving a developing perspective of how one approaches personal challenges and one's views about larger social issues, and also the stress from dealing with some attorneys and the court system, protective services, and needs that significantly exceed resources. Twelve participants spoke about how these sources of stress are an endemic problem and place additional stress on staff working within the organizations, most of all on those with both clinical and administrative responsibilities.

Therapists who discussed specific forms of negative impact involving empathic stress and/or vicarious trauma symptoms talked about them being connected with specific clients and situations and identified specific issues and how they handled them. For example, a therapist discussed how she addressed a fear triggered by a client's symptoms and story. In therapy, she was able to identify her own trauma issues and what was triggered by the client's story. We found that 12 out of 13 participants identified sources of negative impact within and outside the therapeutic relationship, and that while dealing with it in the therapeutic relationship was challenging, the major source of cumulative stress originated in systems outside of this relationship. Stressors related to the growing of administrative tasks, paper work, competitiveness for resources, dealing with other professionals who may not value their work, and external demands for structure, compartmentalization and homogenization of the trauma work were identified as the most debilitating.

On the other hand, the clinical aspects, supervision, training, collegiality, and positive outcomes for asylum seekers of trauma work continued to be a source of positive impact and VR. Consistent with prior findings (Hernández et al., 2007), almost all participants identified that witnessing their clients overcome adversity affected their perception of self, general outcome in life, trauma work, how they related to other clients, becoming better able to tolerate frustration, and their views on oppression. Half of the participants

identified an impact in their ways of taking care of themselves. Less common responses involved fulfilling a sense of duty, having a familial connection with experiences of migration and immigration, and tapping into their own resilience to do this work. At a professional level, therapists discussed their interest in differentiating concepts like survival, coping, resistance, and resilience mean and how they look in practice, and the meaning of boundaries and therapy within contexts including other countries and settings that offer holistic approaches to recovery. In regards to an increased sophistication regarding resilience as a process in their clients, they said that resilience may not be readily apparent in the beginning of the therapeutic process or even later, and that contextual factors, such as housing, education, employment, the ability to eat properly, and obtaining asylum, may increase or decrease a person's well-being and play a role in clients' development of resilience over time.

Intersectional Identities and Trauma Work

The nature, and context, of trauma work with torture survivors is international. Trauma therapists working in this specialized setting (ideally) are knowledgeable of the history, politics, cultures, religions, and mores of a variety of countries. In addition, many have lived and/or served in other countries, and others are immigrants. Thus, we chose not to focus on how much or what kind of cultural competence or diversity training and skills they had, but rather on exploring to what extent participants thought of the ways in which ethnicity, class, sexual orientation, religion, or other dimensions played a role in the therapeutic relationship, and in the clients' ability to overcome adversity. However, exploring diversity from the perspective of intersectional identities, privilege and marginalization was challenging. We found ourselves struggling for clarity and simplicity, and sometimes we had to explain our questions while not providing illustrations that would influence the participants' answers. While eight participants discussed how these factors are an integral part of their work, five participants did not mention them during the interview and/or did not relate to a specific question we posed addressing this topic. A participant's view illustrating the meaning of privilege and lack of privilege vis-à-vis these dimensions expressed:

> When I came in to this country, I already spoke some English, and had a bachelor's degree. I am white. I had so many advantages right there. I was already accepted in graduate school. I had enough money to rent an apartment. I had all of that going for me. I had a hard time obtaining a visa, I experienced interrogations at the airport and I was sent home. I had lots of those experiences, but still . . . I'm white, and that gets me through the door. I don't think, especially

in this country, you can ignore the fact that there are skin color differences—it's a racist place. So you have to constantly acknowledge it, and I think acknowledging it out loud makes it possible to have a conversation about it. For torture survivors and refugees who did not have the experience of being discriminated against because of their skin color, it is necessary to have a conversation about skin color and how things work in this country, and how they feel about it. Because I'm a white person and I'm privileged, I think I can really help them understand not only what is happening to them but also take a stand, whatever stand they feel they want to take.

Other participants discussed how gender issues take a central place in therapy when working with individual women, men, couples, and families who come from societies where women's choices and roles are severely restricted. Often times, difficult cultural transitions are exacerbated by oppressions due to ethnicity, class, and gender—generating additional hardships and adversities to overcome.

One of my clients was a very dark gentleman, educated and successful prior to his tragedy. He retrained as an assistant nurse, and had to leave this area because a fear of people connected to the regime that tortured him. Now he is living in a place where wealthy white people don't want him touching them. They don't want him to be their nurse. So we have clients who have experienced a lot of prejudice, racism, and consequently it's been harder. That's been a challenge in terms of his ability to be resilient in some ways.

These statements reflect that some therapists approach their work with a sophisticated understanding of the ways in which trauma and recovery are shaped by issues of power and privilege and lack thereof, and that resilience processes play out in different contexts depending on access and opportunity. Furthermore, therapists discussed the importance of having these conversations to assist clients in learning and navigating the new social context. Thus, trauma therapy involves addressing the multiple ways in which oppression plays out before, during and after torture, and in the context of recovery, including impact on the presence of or strength of resilience processes.

Therapists who discussed their privileges by virtue of their race, class, and sexual orientation, also discussed how they see having a responsibility to use it when appropriate to assist clients and speak out against injustice.

I think what pushes me towards the resilient end of the spectrum is that this work shapes my sense of self and my identity as a person who is trying in her own little way to be working towards a better world and speaking out against

injustice. When I do trainings, when I speak in public, when I testify in court, I'm helping to publicize and speak out against and document the impact of these injustices. So to me that connects with my sense of resilience.

Witnessing survivors' journeys to the United States, and paths to recovery and personal transformation, generates motivation, meaning making, and action to link the interpersonal work conducted in therapy with public action that makes visible the existence of torture and defends human rights.

Discussion

This exploratory study suggests that it is indeed possible to undergo positive and negative psychological processes as a result of exposure to clients' trauma. Trauma therapists can be potentially transformed by their clients' trauma and resilience in ways that are positive, even if not pain-free. Choosing to work in the trauma field with survivors of politically motivated violence, and becoming immersed in the profound, intertwined experiences of pain, joy and hope can enhance consciousness raising around one's personal and professional roles in advocating for rehabilitation and issues of equity and social justice. Weingarten (2010) describes reasonable hope in the context of family therapy as "a way of thinking about hope for therapist and client alike that makes it more accessible even in the grimmest circumstances" (p. 8). Our analysis of how trauma therapists make sense of vicarious trauma and resilience processes coincides with the characterization of reasonable hope as relational, consisting of a practice of expecting a future that is open, uncertain, and able to be influenced, while also accommodating doubt, contradictions, and despair. In the context of working with survivors of torture, the therapists interviewed described their ability, at least some of the time, to hold, let go and transform the pain and resilience of their clients, and to acknowledge the positive and negative impact that it vicariously brings.

Clinical Implications

At the clinical level, we believe that explicit attention to VR in training and supervision has the potential to prevent burnout and foster a sense of reasonable hope as described earlier. Attending to the strengths of clients, therapists, and the therapeutic process mutually reinforces the empowerment of the healing system, opens avenues for change, and increases a more complex and compassionate understanding of each other. In addition, therapists and their clients may greatly benefit from a sophisticated understanding of the ways in

which trauma and resilience are shaped by their gender identities, ethnicity, sexual orientation, class, and other markers in social context creating a conscious exploration that may bring new meaning in their work. We also recommend that scholars continue to fully integrate cultural competence, diversity and/or intersectional frameworks in trauma work as they relate to vicarious resilience and trauma. We encourage researchers, trainers and clinicians in the trauma field to develop more sophistication in this area consistent with their own preferred framework. In this day and age, it is simply unethical not to do so (Mattar, 2011).

Methodological Issues

The concept of vicarious resilience emerged in a purely inductive and experiential manner through an inductive knowledge building process. To advance its conceptual and practical utility, the authors are in the process of developing and validating a quantitative instrument addressing both VR and VT processes across torture survivor centers in the United States and in other countries. Finally, we selected to work with trauma therapists working with victims of torture because of the unique history of these centers in the United States, and the clear connectedness of their philosophical, political, and training culture. We do not yet know now if VR is a phenomenon in other areas of trauma work or if it is a process experienced primarily by seasoned therapists but this is also something we are investigating in the new study.

Appendix

Part I

1. What are your professional credentials and when did you receive them?
2. How many years have you worked with survivors of torture?
3. Can you give me an estimate as to how many torture survivors you have worked with?
   3a. Have you or do you now work with survivors of other forms of trauma besides torture? If so, briefly describe.
4. Have you taken coursework, advanced training, and/or continuing education on violence and trauma? If yes, probe for a brief description.
5. Can you describe for me your training in the field of resilience? Probe for formal and informal training.

Part II

1. Sometimes we identify the impact as secondary traumatic stress or vicarious trauma. Have you experienced symptoms of VT in relation to your work with survivors? If yes, probe for the type of symptoms.

2. Has VT been a constant in your work or does it have a dynamic where it affects you in distinct or varying patterns——for example, when you first began treating torture survivors or after especially brutal and graphic examples of torture, or if you've had several sessions close together in time?

3. Among the clients you have worked with, have you seen a client who impacted you because of his/her capacity to overcome adversity? If so, what challenges did you witness this person overcome while working in therapy with you?

   3a. Thinking about yourself, do you have any thoughts about how your perception of yourself may have been changed as a result of exposure to your clients' resilience?

   3b. Some therapists we have spoken to have stated that their clients' resilience has altered how their general outlook on the world, on human nature, and on their own lives. How about you?

   3c. In some of the interviews we have conducted, therapists like you have stated that their spirituality or spiritual views have changed as a consequence of their clients' resilience?

   3d. Do you have any thoughts about how your views on trauma work may have been impacted by your clients' resilience? Has this affected how you work with trauma survivors? If so, how?

   3e. Do you have any thoughts about how the ways you take care of yourself have been affected by exposure to your clients' resilience?

   3f. Do you have any thoughts about how your ways of relating to or connecting with torture survivor clients may have been impacted by exposure to your clients' resilience?

4. Do you have professional and personal supports in place to help you cope with the impact of treating traumatic stress? Describe.

5. Have there been times when your clients' resilience impacted the way you think about your own privileges and/or your own experiences of trauma or oppression?

6. When you think about the positive impact that your clients' resilience has had on you, do factors such as ethnicity, class, sexual orientation, religion, or other dimensions play a role in shaping your experience? How?

7. Looking back at both the negative and positive impact that working with survivors has—what we may call vicarious trauma and vicarious resilience—how do you see these two occurring in your life? Probe: When do you notice them? Have you experienced them interacting? Can you give me an example? If you work with both torture survivors and survivors of other types of trauma, is there any difference between the impacts of the two groups.

Declaration of Conflicting Interests

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