Received 03/27/16
Revised 05/11/16
Accepted 05/12/16

The Role of Mindfulness in Reducing Trauma Counselors' Vicarious Traumatization

Charles J. Jacob and Rebecca Holczer

In a sample of mental health clinicians working primarily with trauma survivors (n = 71), self-reported mindfulness qualities correlated with lower levels of self-reported vicarious traumatization. Participants completed two questionnaires: (1) the Trauma Attachment and Belief Scale (TABS), which assesses the presence of vicarious traumatization, and (2) the Cognitive and Affective Mindfulness Scale–Revised (CAMS-R), which assesses mindfulness qualities. Results indicated that clinicians with higher CAMS-R scores (i.e., higher self-reported mindfulness qualities) had significantly lower TABS scores (i.e., lower levels of self-reported vicarious traumatization). The findings suggest that trauma-focused counselors should engage in mindfulness activities routinely to increase awareness of internal processes and decrease the likelihood of experiencing vicarious traumatization as a result of exposure to clients' trauma-related narratives.

Keywords: vicarious traumatization, counseling, mindfulness, awareness

Vicarious traumatization - counselors' cognitive disruptions as a result of empathizing with clients who have experienced trauma (McCann & Pearlman, 1990) - can cause a change in counselors' belief systems of self, others, and of the world in general (e.g., lack of trust, increased cynicism; Culver, McKinney, & Paradise, 2011). In counseling, much research has indicated the benefits of implementing self-care to address resulting psychological stress in practicing clinicians and clinicians in training (Abel, Abel, & Smith, 2012; Lawson & Myers, 2011; Myers, Mobley, & Booth, 2003). However, self-care demonstrates questionable outcomes in alleviating symptoms of vicarious trauma in practicing clinicians (Bober & Regher, 2006).

The purpose of this research is to explore the utility of mindfulness qualities in clinicians who work with trauma survivors in order to prevent the onset of vicarious traumatization. The literature reviewed suggests that (a) developing the counselor's ability to utilize mindfulness is connected to the prevention of vicarious traumatization, (b) the humanistic nature of counseling may play a role in the development of vicarious traumatization (i.e., recognizing the boundaries between individual experiences and the experiences of the empathy recipient), and (c) mindfulness qualities may help clinicians learn to increase self-other awareness and decrease anxiety or stress in response to exposure to clients' stories about trauma.

Vicarious Trauma

The effects of trauma work on clinicians, particularly its resulting psychological symptoms (also known as secondary traumatic stress; Bride, Robinson, Yegidis, & Figley, 2004), have been widely studied. Among the identified detrimental outcomes of trauma work for clinicians is vicarious traumatization, which is less of a resulting psychological symptom and more a change in belief systems about the self, others, and the world in general (Culver et al., 2011; McCann & Pearlman, 1990). While vicarious traumatization may naturally occur as a result of exposure to trauma narratives, scholarship suggests that it results in pervasive and long-term negative psychological effects (Culver et al., 2011; McCann & Pearlman, 1990). Previous research has explored the concept of vicarious traumatization as it pertains to clinical work with clients who have experienced natural disasters (Culver et al., 2011) and family violence (Ben-Porat & Itzhaky, 2009), as well as with sexual offenders (Moulden & Firestone, 2007). Outcomes of vicarious traumatization in clinicians include increased suspicion of others, decreased vulnerability with others, a need to

Charles J. Jacob and **Rebecca Holczer**, Department of Psychology, La Salle University. Correspondence concerning this article should be addressed to Charles J. Jacob, Department of Psychology, La Salle University, 1900 West Olney Avenue, Philadelphia, PA 19141 (e-mail: jacob@lasalle.edu).

reinforce personal safety precautions, feelings of helplessness, cynical views and beliefs regarding human nature, denial or emotional numbing, and a desire to define causality (Culver et al., 2011; McCann & Pearlman, 1990). Negative effects reported include depression, feeling drained in interpersonal relationships, and low self-esteem (Hunter, 2012). In addition, empathic engagement with a traumatized client has been correlated with symptoms of posttraumatic stress in the counselor (Jankoski, 2010; Schauben & Frazier, 1995).

Development of Vicarious Traumatization and Awareness of Internal Processes

The outcomes of vicarious traumatization are more apparent than the internal processes that precede it, though the end product is a substantive change in cognitive schemas. For some clinicians, the experience of working with trauma survivors evokes an emotional response that is intense enough to compromise self-other awareness. To illustrate, Jankoski (2010) conducted a qualitative assessment in which child welfare workers described connecting to clients' stories to such a degree that their conceptualizations of the world appeared almost indistinguishable from the experiences of their traumatized clients. As participants in the study reported,

> I am not the same person today as I was when I started this job . . . I'm not able to be intimate with my husband. I just think of the kids who have been hurt by their own fathers . . . We don't live in a safe world, I keep my kids close . . . I won't allow my girls to sleep over at a friend's house. It really causes problems at home . . . I walk down the mall and see a man holding a child and I think, "perp." I see another man holding a child's hand, and I think, "perp." (p.113–114)

The deleterious effects of such a strong emotional reaction to, or connection with, client narratives are likely twofold. Clinicians become less capable of practicing effectively (Cummins, Massey, & Jones, 2007; Han, Lee, & Lee, 2012), and there exists the likelihood of serious disruptions in interpersonal functioning, such as changes to core beliefs regarding justice in the world and a lack of trust in others (Culver et al., 2011; Jankoski, 2010). In either case, research has focused on methods of reducing disruptions after the fact (Cummins et al., 2007) rather than on preventative practices that could potentially reduce the likelihood of distress.

Humanism and the Client-Focused Cognitive Schema

In a purely client-focused cognitive schema, core beliefs regarding the function of empathy and/or humanism, that is, accepting the client fully and recognizing the subjectivity of experience, (Hansen, 2006) may cause the objectivity of the counselor to become lost to the subjective connection with clients' experiences. Specifically, the counselor's core belief regarding the importance of humanism in counseling (e.g., Wampold, 2012) may result in a loss of objectivity in session. The outcome is an overidentification with client narratives such that impartiality becomes difficult, or the clinician begins to develop a lack of trust for others (Jankoski, 2010).

As Rogers (1957) indicated, counselors' ability to empathize with others relates to the therapeutic alliance, regardless of the clinicians' theoretical orientation (Feller & Cottone, 2003). However, a lack of awareness of internal processes (i.e., meta-observations of inner dialogue and emotional responses) and external processes (i.e., the physical experience of being with the client), as well as a lack of attention to personal wellness, leads to personal distress or even ineffective clinical practice later (see Cummins, Massey, & Jones, 2007 for a detailed review). In order to effectively regulate emotions and avoid distress, while showing empathy or engaging in an empathetic relationship, counselors need to be as aware of their own experiences as much as they are of their clients' (Decety & Jackson, 2004).

One of humanism's basic tenets is the counselor's capacity for compassion, which is contingent upon the ability to effectively understand and relate to others' emotions (Hansen, 2006). Rogers (1957) conceptualized empathy as one of the basics principles of effective counseling. In the following excerpt from his seminal article on the necessary conditions for therapeutic change, Rogers summarizes the process of empathy:

> To sense the client's private world as if it were your own, but without ever losing the "as if" quality–this is empathy, and this seems essential to therapy. To sense the client's anger, fear, or confusion as if it were your own, yet without your own anger, fear, or confusion getting bound up in it. (p. 243)

Based on Rogers's conceptualization and the humanist ideals of the profession, the counselor's emotions are an integral part of the therapeutic process. However, it can be problematic when the barriers of the *as if* process of empathy become less clear within the counselor's cognitive schema, resulting in the dilution of the

counselors' awareness of his or her internal experience as separate from the emotions of the client. The emphasis on others is one important component of developing empathy; however, empathy also requires a self-other awareness to effectively regulate emotions and avoid distress (Decety & Jackson, 2004).

This is not to suggest that a humanistic approach is problematic in and of itself, but rather to point out that a counselor's ability to practice objectively has an impact on treatment outcomes. The notion of self, may, in some cases, be lost in the humanistic facets of the profession or the empathetic process, with Cummins and colleagues (2007) suggesting that counselors should engage in continual self-monitoring. Williams, Hurley, O'Brien, and DeGregorio (2003) argue that a lack of self-awareness is likely a precursor to countertransference reactions among practicing counselors. Additionally, counselors who are able to be more objective and judicious in their use of specific treatment approaches are more likely to produce better outcomes with clients as a result of treatment (Owen & Hilsenroth, 2014). When counselors develop cognitive schemas that embrace humanism to the point that objectivity is lost, the outcome may be detrimental to both client and practitioner.

Mindfulness Qualities and Vicarious Traumatization

Perhaps the most succinct definition of mindfulness is "the state of being attentive to and aware of what is taking place in the present" (Brown & Ryan, 2003, p. 822). Mindfulness is different from simple concentrative techniques, as the goal in the latter is single-minded attention. In contrast, mindfulness is a basic level of attention to all thoughts that enter conscious awareness. It is not the suppression of thoughts and feelings or simple relaxation. Instead, it is an exercise in mental discipline intended to maintain a sense of nonjudgment and awareness of all thoughts, feelings, and emotions, as well as to reduce stress and anxiety responses (Brown, Marquis, & Guiffrida, 2012). In addition to its usefulness in the area of self-care, mindful awareness has become a topic of interest in counseling and counselor education literature as a method for improving overall clinical practice (Brown et al., 2012).

Researchers have examined the connection between mindfulness practice in counselors and various aspects of the counseling process. For example, Greason and Cashwell (2009) analyzed the relationship between mindfulness, attention, empathy, and counseling self-efficacy in counselor trainees. The results showed that mindfulness was a predictor of counseling self-efficacy, attention was a mediator of that relationship, and mindfulness was a predictor of empathy. Additionally, a small sample of clinicians who had previously worked with trauma survivors indicated that maintaining a sense of awareness and acceptance of the present helped them accept limits related to their ability to effect change, as well as to maintain clarity of self and other (Harrison & Westwood, 2009).

Awareness, or the ability to monitor the internal as well as the external environment, (Brown & Ryan, 2003) is a key component of mindfulness and counseling. Sommer (2008) recommended that instructors and supervisors make an effort to increase mindful awareness of the process and effects of vicarious traumatization in clinical work. In examining the outcomes of vicarious traumatization, Han, et al. (2012) have highlighted the importance of teaching clinicians how to differentiate between a potentially detrimental phenomenon such as emotional contagion (i.e., *catching* the emotions of others; Hatfield, Rapson, & Le, 2009) and the more ideal notion of empathic concern. Empathy requires "the examination and objectification of the self" (Han et al., 2012, p.451), and increased awareness of the present may help to prevent *catching* the emotions of others.

Counselors benefit from awareness with regard to both personal wellness and alliance building with clients. Fauth and Nutt-Williams (2005) examined the importance of in-session awareness as a function of effective psychotherapy. Clients participated in 20 to 30 minute sessions with graduate counselor trainees, followed by completion of a process review of the session, as well as quantitative measures of impact on clients and in-session awareness of counselor trainees. The results suggested that increased awareness of internal states is not only an asset as perceived by counselors, but is also related to clients' feelings of connection with the counselors. Building from these studies, the utility of mindfulness as a preventative measure against vicarious traumatization warrants further exploration.

Methods

This study sought to examine the extent to which mindfulness qualities (e.g., awareness of internal processes, focus on the present, acceptance) prevent the development of vicarious traumatization in clinicians working primarily with traumatized clients. An online survey consisting of two self-report questionnaires, one assessing mindfulness and one assessing vicarious traumatization, was developed and distributed to listservs for organizations of trauma professionals.

Participants

Participants were recruited from trauma-professional organizations including the International Society for Traumatic Stress, as well as through institutions in the northeastern United States that were directly involved in the treatment of trauma. The required sample size for power of .90 with a medium effect size (f^2 = .20, α = .05) with one predictor is 68. A total of 80 participants agreed to participate in the online survey, though 9 sets of participant data were deleted due to missing data, with a final sample of 71 participants. The sample was 80% female, with an average age of 37.43 years (*SD* = 11.05). The majority of the sample identified as heterosexual (88.8%) and European American (85%), followed by African American (3.8%), Asian American (2.5%) and Middle Eastern American (2.5%). The participants identified themselves as mostly clinical psychologists (52.5%), followed by social workers (16.3%), licensed professional counselors (12.5%), marriage and family therapists (7.5%), and certified drug and alcohol counselors (1.3%). The average number of years working with trauma was 9.52 (*SD* = 8.30), with an average of 23.43 active clients per participant at the time of the survey (*SD* = 17.25). Clinicians reported spending an average of 62.42% of their clinical time working with trauma (*SD* = 23.99) and working in the following settings: outpatient clinic (30%), trauma specialized setting (27.5%), private practice (20%), hospital or medical setting (20%), college counseling center (6.3%), forensic setting (5%), substance abuse rehabilitation setting (2.5%), educational setting (2.5%), residential facility (1.3%), and women's outreach center (1.3%).

Measures

Trauma Attachment and Belief Scale. The Trauma Attachment and Belief Scale (TABS; Pearlman, 2003) is an 84-item self-report questionnaire that was designed to measure the psychological impact of traumatic life events across the domains of safety, control, trust, esteem, and intimacy. These areas are further divided across the respondent's perception of self and others, to yield a total of ten subscales. Items are scored via a six-point Likert scale from 1 (*disagree strongly*) to 6 (*agree strongly*). The subscales of the measure are (1) Self-Safety, (2) Other-Safety, (3) Self-Trust, (4) Other-Trust, (5) Self-Esteem, (6) Other-Esteem, (7) Self-Intimacy, (8) Other-Intimacy, (9) Self-Control, and (10) Other-Control. The TABS has been demonstrated to be reliable. Internal consistency and test-retest reliabilities for the total score are good (.96 and .75, respectively). Further, it isolates the cognitive components of vicarious traumatization that distinguish vicarious traumatization from other constructs such as secondary traumatic stress and burnout (Jenkins & Baird, 2005).

The Cognitive and Affective Mindfulness Scale–Revised. The Cognitive and Affective Mindfulness Scale–Revised (CAMS-R; Feldman, Hayes, Kumar, Greeson, & Laurenceau, 2007) is a 12-item self-report instrument that assesses mindfulness qualities of individuals across the domains of attention, present focus, awareness, and acceptance. Items are scored via a four-point Likert scale from 1 (*rarely/not at all*) to 4 (*almost always*). The overall CAMS-R scores have been shown to have acceptable levels of internal consistency and discriminant validity, but not the subscales (Attention, Present Focus, Awareness, and Acceptance). As such, the total CAMS-R score is used to assess mindfulness qualities of the individual, with higher scores indicating a greater propensity for mindfulness qualities.

Results

Because CAMS-R scores were significantly correlated with TABS scores, r = -.63 ,p < .001, linear regression was used to assess the impact of clinician-reported mindfulness qualities on the development of vicarious traumatization. The total variance explained by the model was 34.4%, $F(1, 69) = 36.18$, $p < .001$. As CAMS-R scores increased, total TABS scores decreased (*beta* = -.59, $p < .001$). Subscales of the TABS were not explored because of problems with multicollinearity; specifically, all subscales were correlated significantly at $\propto$.01.

Exploratory analysis was conducted to examine the main characteristics of the sample that correlated with higher scores on the TABS and the CAMS-R, though professional identity was the only variable that demonstrated a significant relationship with either. A one-way analysis of variance was conducted to explore the impact of professional identity on development of vicarious traumatization. Subjects were divided into seven groups according to indicated professional identity: Psychologist, Mental Health Counselor or Licensed Professional Counselor, Social Worker, Marriage and Family Therapist, Certified Drug and Alcohol Counselor, Multiple Professional Identities (e.g., licensed both as a counselor and a psychologist), and Other. There was a statistically significant difference at the p = .05 level in TABS scores for the seven professional identity groups, $F(1, 72) = 2.31$, p = .05; however, the actual difference in mean scores between the groups was small. The effect size, calculated using eta squared, was .15. Mean TABS

scores were highest for individuals with multiple professional identities (M = 194, SD = 37.42), followed by social workers (M = 191.46, SD = 10.38), licensed professional counselors (M = 189.25, SD =13.23), psychologists (M = 158.79, SD = 6.07), and marriage and family therapists (M = 152.75, SD = 18.71).

A one-way analysis of variance was conducted to explore the impact of professional identity on mindfulness qualities of the clinician. There was a statistically significant difference at the p = .05 level in CAMS-R scores for the seven professional identity groups,: $F(1, 74) = 4.17$, $p < .001$, and the actual difference in mean scores between the groups was larger than with vicarious traumatization scores. The effect size, calculated using eta squared, was .25. Mean scores were highest for individuals with multiple professional identities (M = 44, SD = 4.76), followed by marriage and family therapists (M = 42, SD = 2.38), psychologists (M = 38.23, SD = .75), licensed professional counselors (M = 35, SD = 1.68), and social workers (M = 33.31, SD = 1.32).

Discussion

The findings of this study suggest that mindfulness qualities of practicing trauma clinicians have an impact on the likelihood of developing vicarious trauma. Specifically, increased reports of mindfulness qualities among practicing clinicians significantly predicted a decreased report of traumatization symptoms. The data overall suggest that clinicians who work with survivors of trauma and who perceive themselves as having qualities of mindfulness are less likely to experience disruptions to notions of self that may lead to the development of vicarious traumatization.

Additionally, while not an intended focus of the study, professional identity had a significant correlation with the development of vicarious traumatization. However, the effect size for the difference among varying professions was larger for mindfulness qualities. Participants who identified as having more than one professional identity were more likely to report having mindfulness qualities and to report symptoms of vicarious traumatization.

Implications for Practicing Clinicians

Teaching clinicians to make use of mindfulness practice may reduce stress in session that will improve later awareness and interpretation of their own affect and emotional responses. Vicarious trauma is maintained in the aftermath of trauma exposure, and accuracy of recalled information worsens with time; however, in the cases of information that is emotionally intense, individuals tend to have greater faith in the accuracy of this information, even when the memories in question are inaccurate or have degraded (Talarico & Rubin, 2003). In clinical practice, gaps in recall of information may occur in the days, weeks, or months between sessions, suggesting that training in accurate, or more objective, recall of information acquired during session may be an asset in reducing the likelihood of later cognitive schema adjustments. This may be particularly true following sessions that are emotionally taxing for the counselor.

One of the complications of working with trauma survivors is the stress accompanying this work, resulting in clinician reports of emotional drain (Hunter, 2012). Schure, Christopher, and Christopher (2008) suggest that regular or daily mindfulness practice is an asset for practicing clinicians in general, and particularly for stress reduction. According to the authors, this can include myriad activities related to the practice of mindful awareness, such as yoga, Tai Chi, or regular meditation practice. For example, Qigong, an ancient Chinese practice involving a combination of movement and meditation, was associated with increases in mindfulness among counseling students (Chrisman, Christopher, & Lichtenstein, 2009), and even brief yoga practice (e.g., 60 minutes a week for 8 weeks) was correlated with mindfulness in a nonclinical sample (Shelov, Suchday, & Friedberg, 2009).

Counselors who practice mindfulness have sustained long-term benefits as well. In a follow-up study of graduate counseling students who had participated in a mindfulness-based training program, 13 out of 16 randomly selected students continued to engage in some type of formal mindfulness practice an average of four years after completing the training program (Christopher et al., 2010). Counselors reported lasting benefits including a sense of openness, increased awareness, and increased self-compassion as a result of this training. Insofar as the following excerpt illustrates the group experience, they also noted stronger boundaries related to self and the longevity of these benefits:

> I think that I can tend to get overwhelmed by other people's emotions and through the class I think I really learned to be able to separate people's emotions and be strong in my own sense of self in that moment. To be just fully aware of what I'm experiencing and being able to separate what other people are experiencing. (Christopher et al., 2010, p. 333)

These results are comparable to those of Schure et al. (2008), who found that students who participated in mindfulness training reported improved emotional strength and the ability to detach from emotions. Furthermore, students reported having more peace in

their lives and trust in themselves in addition to an increased capacity for empathy (Schure et al., 2008).

Though the findings of this research were significant, increased awareness of stress responses may not be universally beneficial in preventing changes to cognitive schemas. Talarico and Rubin (2003) found that while flashbulb memories (i.e. emotionally intense memories related to a specific event such as a trauma) worsen over time in much the same way as other memories, the individual's confidence in the accuracy of memories is more constant. Accordingly, mindfulness practice to cope with vicarious traumatization may not have a direct impact on core beliefs for all clinicians because confidence in accuracy of recalled information may not be malleable.

There also exists the risk of counselors trying too hard to curb symptoms of vicarious traumatization through mindful awareness. While Fauth and Nutt-Williams (2005) found support for the benefits of counselor self-awareness as perceived by clients and counselors alike, clients rated the counseling relationship less positively when counselor efforts to manage self-awareness (e.g., thought stopping, self-coaching, relaxation in the moment) increased. This suggests that there may be an additive effect, with a lack of self-awareness having similar detrimental effects to excess self-awareness.

Limitations and Future Research

One of the challenges of assessing mindfulness is that there are myriad scales that assess various components of mindfulness. For this study, the CAMS-R was used because it provides a general assessment of basic mindfulness qualities inherent to the individual (Feldman et al., 2007). However, the Philadelphia Mindfulness Scale is more specifically designed to assess acceptance and present-moment awareness (Cardaciotto, Herbert, Forman, Moitra, & Farrow, 2008) and the Toronto Mindfulness Scale examines constructs such as curiosity and decentering (Lau et al., 2006). One limitation is that the study addressed self-reported mindfulness *qualities*, not actual mindfulness *practices*. Future exploration of the impact of mindfulness qualities on vicarious traumatization should explore the various facets of mindfulness, as more specific aspects may account for the benefits detected in this research.

Conclusion

Empathy has been established as an integral part of counseling, but awareness of internal and external processes is worthy of further exploration given the potential for counselors to acquire maladaptive cognitive schemas regarding self, others, and the world. In cases where the client's presenting issues are related to trauma, counselors can lose sight of the self-other awareness required to avoid development of maladaptive cognitive schemas. Whereas traditional self-care activities have lacked efficacy according to some studies, mindfulness may aid in the process of identifying and ameliorating the effects of vicarious traumatization. If clinicians are more mindful in their clinical work, they may gain increased awareness of the internal processes leading up to vicarious traumatization. This, in turn, may help to prevent or ameliorate maladaptive cognitive schemas in clinicians as a function of exposure to emotionally charged client narratives.

References

Abel, H., Abel, A., & Smith, R. L. (2012). Effects of a stress management course on counselors in-training. *Counselor Education and Supervision, 51*, 64-78. doi: 10.1002/j.1556-6978.2012.00005.x

Ben-Porat, A. & Itzhaky, H. (2009). Implications of treating family violence for the therapist: Secondary traumatization, vicarious traumatization, and growth. *Journal of Family Violence, 24*, 507-515. doi: 10.1007/s10896-009-9249-0

Bober, T., & Regher, C. (2006). Strategies for reducing secondary or vicarious trauma: Do they work?. *Brief Treatment and Crisis Intervention, 6*, 1-9. doi:10.1093/brief-treatment/mhj001

Bride, B. E., Robinson, M. M., Yegidis, B., & Figley, C. R. (2004). Development and validation of the secondary traumatic stress scale. *Research on Social Work Practice, 24*(4), 27-35. doi: 10.1177/1049731503254106

Brown, K. W., & Ryan, R. M. (2003). The benefits of being present: Mindfulness and its role in psychological well-being. *Journal of Personality and Social Psychology, 84*, 822-848. doi: 10.1037/0022-3514.84.4.822

Brown, A. P., Marquis, A., & Guiffrida, D. A. (2012). Mindfulness-based interventions in counseling. *Journal of Counseling and Development, 91*, 96-104. doi: 10.1002/j.1556-6676.2013.00077.x

Cardaciotto, L., Herbert, J. D., Forman, E. M., Moitra, E., & Farrow, V. (2008). The assessment of present-moment awareness and acceptance the Philadelphia mindfulness scale. *Assessment, 15*, 204-223. doi: 10.1177/1073191107311467

Chrisman, J. A., Christopher, J. C., & Lichtenstein, S. J. (2009). Qigong as a mindfulness practice for counseling students: A qualitative study. *Journal of Humanistic Psychology, 49*, 236-257. doi: 10.1177/0022167808327750

Christopher, J. C., Chrisman, J. A., Trotter-Mathison, M. J., Schure, M. B., Dahlen, P., & Christopher, S. B. (2010). Perceptions of the long-term influence of mindfulness training on counselors and psychotherapists: A qualitative inquiry. *Journal of Humanistic Psychology, 51,* 318-349. doi:10.1177/0022167810381471

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

Cummins, P. N., Massey, L., & Jones, A. (2007). Keeping ourselves well: Strategies for promoting and maintaining counselor wellness. *Journal of Humanistic Counseling, Education, and Development, 46*, 35-49. doi: 10.1002/j.2161-1939.2007.tb00024.x

Decety, J., & Jackson, P.L. (2004). The functional architecture of human empathy. *Behavioral and Cognitive Neuroscience Reviews,* 3, 71-100. doi: 10.1177/1534582304267187

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

Feldman, G., Hayes, A., Kumar, S., Greeson, J., & Laurenceau, J. P. (2007). Mindfulness and emotion regulation: The development and initial validation of the Cognitive and Affective Mindfulness Scale-Revised (CAMS-R). *Journal of Psychopathology and Behavioral Assessment, 29*, 177-190. doi: 10.1007/s10862-006-9035-8

Feller, C., & Cottone, R. R. (2003). The importance of empathy in the therapeutic alliance. *Journal of Humanistic Counseling, Education and Development, 42*, 53-61. doi: 10.1002/j.2164-490X.2003.tb00168.x

Greason, P., & Cashwell, C. S. (2009). Mindfulness and counseling self-efficacy: The mediating role of attention and empathy. *Counselor Education and Supervision, 49*, 2-19. doi:10.1002/j.1556-6978.2009.tb00083.x

Han, M., Lee, S. E., & Lee, P. A. (2012). Burnout among entering MSW students: Exploring the role of personal attributes. *Journal of Social Work Education, 48*, 439-457. doi: 10.5175/JSWE.2011.201000053

Hansen, J. T. (2006). Postmodernism and humanism: A proposed integration of perspectives that value human meaning systems. *Journal of Humanistic Counseling, Education, and Development, 44*, 3-15. doi: 10.1002/j.2164-490X.2005.tb00052.x

Hansen, J. T. (2006). Humanism as moral imperative: Comments on the role of knowing in the helping encounter. *Journal of Humanistic Counseling, Education, and Development, 45*, 115-125. doi: 10.1002/j.2161-1939.2006.tb00011.x

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

Hatfield, E., Rapson, R. L., & Le, Y-C. L. (2009). Emotional contagion and Empathy. In J. Decety & W. Ickes (Eds.), *The social neuroscience of empathy* (pp. 19-28). Cambridge, MA: Massachusetts Institute of Technology.

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

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

Jenkins, S. R., & Baird, S. (2005). Secondary traumatic stress and vicarious trauma: A validational study. *Journal of Traumatic Stress, 15*, 423-432. doi: 10.1023/A:1020193526843

Lau, M. A., Bishop, S. R., Segal, Z. V., Buis, T., Anderson, N. D., Carlson, L., ... & Devins, G. (2006). The Toronto mindfulness scale: Development and validation. *Journal of Clinical Psychology, 62*, 1445-1468. doi: 10.1002/jclp.20326

Lawson, G., & Myers, J. E. (2011). Wellness, quality of life, and career-sustaining behaviors: What keeps us well?. *Journal of Counseling and Development, 89*, 163-171. doi: 10.1002/j.1556-6678.2011.tb00074.x

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

Moulden, H. M., & Firestone, P. (2007). Vicarious traumatization: The impact on therapists who work with sexual offenders. *Trauma, Violence, and Abuse, 8*, 67-83. doi: 10.1177/1524838006297729

Myers, J. E., Mobley, A. K., & Booth, C. S. (2003). Wellness of counseling students: Practicing what we preach. *Counselor Education and Supervision, 42*, 264-274. doi: 10.1002/j.1556-6978.2003.tb01818.

Owen, J. & Hilsenroth, M. J. (2014). Treatment adherence: The importance of therapist flexibility in reation to therapy outcomes. *Journal of Counseling Psychology, 61*, 280-288. doi: 10.1037/a0035753

Pearlman, L. A. (2003). *Trauma and Attachment Belief Scale (TABS) manual.* Los Angeles, CA: Western Psychological Services.

Rogers, C. R. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology, 21(2)*, 95-103. doi: 10.1037/h0045357

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

Schure, M. B., Christopher, J., & Christopher, S. (2008). Mind-body medicine and the art of self-care: Teaching mindfulness to counseling students through yoga, meditation, and Qigong. *Journal of Counseling & Development*, *86*, 47-56. doi:10. 1002/j.1556-6678.2008.tb00625.x

Shelov, D. V., Suchday, S., & Friedberg, J. P. (2009). A pilot study measuring the impact of yoga on the trait of mindfulness. *Behavioural and Cognitive Psychotherapy, 37*, 595-598. doi: 354000182054 93.0090

Sommer, C. A. (2008). Vicarious traumatization, trauma-sensitive supervision, and counselor preparation. *Counselor Education and Supervision, 48*, 61-71. doi: 10.1002/j.1556-6978.2008.tb000 62.x

Talarico, J. M., & Rubin, D. C. (2003). Confidence, not consistency, characterizes flashbulb memories. *Psychological Science, 14*, 455-461. doi: 10.1111/ 1467-9280.02453

Wampold, B. E. (2012). Humanism as a common factor in psychotherapy. *Psychotherapy, 49*, 445-449. doi: 10.1037/a0027113

Williams, E. N., Hurley, K., O'Brien, K., and DeGregorio, A. (2003). Development and validation of the self-awareness and management strategies (SAMS) scales for therapists. *Psychotherapy: Theory, Research, Practice, Training, 40*(4), 278-288. doi: 10.1037/0033-3204. 40.4.278