VICARIOUS TRAUMATIZATION:

AN INVESTIGATION OF THE EFFECTS OF TRAUMA WORK

ON MENTAL HEALTH PROFESSIONALS IN TURKEY

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VICARIOUS TRAUMATIZATION:
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Dissertation Abstract

Serap Altekin, “Vicarious Traumatization: An Investigation of the Effects of Trauma Work on Mental Health Professionals in Turkey”

The aim of the present study was to investigate the effects of trauma work on mental health professionals working in the trauma field in Turkey, as well as to identify protective factors and risk factors which predict vicarious traumatization. It was aimed to explore the probable association of demographic variables, level of education and special training on trauma, level of exposure to trauma work in terms of workload, caseload and experience years in the trauma field as well as the level of burnout in terms of emotional exhaustion, ways of coping in terms of active and passive coping styles, perceived social support and presence of a personal trauma history in predicting vicarious traumatization.

The study was composed of an integrative methodological design; the data of the quantitative part was based on a sample of 260 mental health professionals, including, psychologists, social workers, psychiatrists and psychological counselors who work with trauma in Turkey, while the data of the qualitative part was composed of in depth interviews with 7 psychologists who work in trauma field in İstanbul, Turkey.

The results of thequantitative analyses indicated that education level, profession, active coping style and emotional burnout were found as statistically significant predictors of vicarious traumatization. Especially, emotional burnout was found to be the most effective predictor. Emotional burnout fully mediated the relationship between caseload and vicarious traumatization. It was also found that the association between emotional burnout and vicarious traumatization was moderated by the coping style of the professionals. The results of the qualitative analyses supported these results, specifically indicating that workload, caseload and burnout were identified as risk factors for vicarious traumatization while education, training, support, active coping style and self-care as protective factors against vicarious traumatization; additionally and surprisingly, vicarious posttraumatic growth was also reported by the professionals who got use of these protective factors.

Tez Özeti

Serap Altekin, "Dolaylı Tramatizasyon: Travma ile Çalışmanın Türkiye'de Travma Sahasında Çalışan Ruh Sağlığı Uzmanları Üzerindeki Etkilerinin İncelenmesi"

Bu çalışmada, travma ile çalışmanın travma sahasında çalışan ruh sağlığı uzmanları üzerindeki etkilerini araştırmak, dolaylı travmatizasyonu açıklayan olası risk faktörlerini ve koruyucu faktörleri tanımlamak hedeflendi. Demografik değişkenlerin, eğitim düzeyinin, travma sahasındaki özel eğitimlerin, iş yükü, vaka yükü ve deneyim yılı üzerinden travma işine maruz kalma yoğunluğunun, tükenmişlik düzeyinin, sosyal destek düzeyinin, baş etme tarzının ve uzmanın kişisel travma öyküsünün, dolaylı travmatizasyonu açıklamada ne ölçüde etkili olduğunun araştırılması amaçlandı.

Çalışmada nicel ve nitel araştırma desenleri entegre edildi. Nicel veriler Türkiye genelinde travma sahasında çalışan 260 ruh sağlığı uzmanından oluşan bir örneklemden toplanmış olup, örneklem psikolog, psikiyatrist, sosyal hizmet çalışmacısı ve psikolojik danışmanlardan oluşturulmuştur. Nitel veriler ise İstanbul'da travma sahasında çalışan 7 psikologla yapılan derinlemesine yüz yüze görüşmelerin dökümüne dayanmaktadır.

Nicel veri analizinin sonuçları; mesleğin, eğitim düzeyinin, aktif baş etme tarzının ve duygusal tükenmişliğin dolaylı travmatizasyonu açıklamada anlamlı faktörler olduğunu ortaya koydu. Özellikle, duygusal tükenmişlik, dolaylı travmatizasyonun en güçlü yordayıcısı olarak saptandı. Duygusal tükenmişlik, vaka yükü ile dolaylı travmatizasyon arasındaki ilişkiyi tam aracı olarak açıklayan bir faktör olarak saptandı. Duygusal tükenmişlik ile dolaylı travmatizayon arasındaki ilişki ise baş etme tarzı tarafından etkilendiği saptandı.

Nitel veri analizinin sonuçları, bu sonuçları destekler yönde olup, iş yükü, vaka yükü ve tükenmişlik düzeyi, dolaylı travmatizasyon için risk faktörleri arasında tanımlanırken; formal eğitim, travma sahası eğitimleri, destek sistemleri, aktif baş etme tarzı ve öz-bakım alışkanlıkları ise dolaylı travmatizasyna karşı koruyucu faktörler arasında tanımlandı. Ek olarak ve beklenmedik biçimde, söz konusu bu koruyucu faktörlerden yararlanan uzmanların, dolaylı travma sonrası büyüme bildirdiği görüldü.

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CHAPTER 1

INTRODUCTION

"*I used to believe the world was basically fair and that people were basically good. Now I think fate is fickle and I don't trust anyone. I used to think life was predictable; now I know anything can happen to anyone at any time.",*

from a trauma field professional's self-report,

Saakvitne & Pearlman, Tranforming the Pain, page 31.

Think about a mental health professional who is a state-employed, who has just an undergraduate degree, has no special training on trauma work and/but who engages in trauma work full-time; which means at least a 60-hour-per week employment at trauma work in the clinical field with no access to supervision or peervision, furthermore working in one of the relatively under-developed but over-traumatized cities in Turkey to which s/he was assigned. How does it sound? Would it be surprising to observe this trauma field professional suffering from probable vicarious traumatization symptoms through a probable burnout syndrome?

From contemporary perspective, it can be stated that almost all mental health professionals in virtually all settings work with trauma survivors. Trauma or traumatic experiences can be described within a wide range from disasters or human made major traumas to relational minor traumas. Not only the survivors and witnesses but also the professionals working with those survivors and witnesses in the trauma field are subject to certain dialectic and effects of trauma. The aim of the present study is to investigate the effects of trauma work on mental health professionals working in the trauma field in Turkey.

Van Der Kolk (1991) defines trauma as an overwhelming life experience which may temporarily or permanently destroy people's capacity to regulate their affects and preserve their life quality and overall functioning leading to a kind of crash or a kind of breakpoint in their ongoing lives. Besides the fact that Van Der Kolk and Van Der Hart (1991) describe trauma in minor forms as an indispensable and essential part of human life; while in major forms, their enduring dramatic and negative impact on the survivors' lives are significantly noticeable. According to Allen (2001), the essence of trauma lies in the feelings of intense fear, sense of helplessness, loss of control and feeling lonely and abandoned; together with an increased arousal, a generalized anxiety, avoidance as well as numbness. So, from Allen's (2001) perspective, the essence of trauma lays not in the event itself but in the responses of both the survivor and the significant others in the survivor's relational and sociocultural context. With a more predominantly used formal definition, trauma can be defined as either experiencing, being exposed to or witnessing an event which involves an actual loss or injury as well as a threat to the physical or psychic integrity of self or others (APA, 2000; Figley, 2002).

Typical trauma reactions which are commonly observed in almost all kinds of traumas are intense fear, terror and helplessness as well as hypervigilance, avoidance and numbness. Besides, following a trauma, a significant level of arousal and anxiety are characteristically observed (APA, 2000; Dalenberg, 2000). A trauma may always bring potentially destructive impact on the sense of coherence and control, reality-testing and self-perception as well as on the world view of the trauma survivors and their social and intimate relationships with others including their therapists. More contemporary researchers prefer to use a broader definition of trauma referring to any life event or any situation which either occurs suddenly and

uncontrollably or is subjectively perceived as negative, disturbing and devastating by the individual (McCann & Pearlman, 1990; Carlson & Dalenberg, 2000; Creamer, McFarlane & Burgess, 2005). Therefore, the effects of trauma were not described as limited to the effects on the trauma survivors but on all significant others in close contact with those survivors, including the mental health professionals.

It is widely known and accepted that the essence of the therapeutic process is the therapeutic alliance between the therapist and the patient. The strength of the therapeutic alliance which can be defined in terms of safety, empathic attunement and a holding environment is one of the predictive factors for positive therapy outcomes (Feltham, 1999; Hubble, Duncan & Miller, 1999; Herman 2007). But, at the same time, on the other side of the coin, the therapeutic alliance through empathic attunement is also one of the critical contributing factors for potentially negative impact on the trauma field professionals.

Herman (2007) stated that engaging in psychotherapeutic work with trauma survivors may have significant impact on the therapist. This impact of trauma work on the professionals has been defined in varied forms throughout the literature since the 1990s up to today. These effects of working with trauma survivors were described by various researches throughout the literature in slightly different terminology almost all of which shared some common components with nuances.

Traumatic experiences which can also be defined as the ultimate confrontation with human brutality and cruelty can not leave a trauma field professional untouched. Not only the exposure to the traumatic memories, narrations, intense feelings and graphic details of violent scenes, but also the empathic engagement and therapeutic alliance between the trauma survivor and the professional may potentially trigger strong emotional and symptomatic reactions as

well as permanent cognitive and behavioral changes on the part of the trauma field professionals. Thus, trauma field professionals are at risk of complicated countertransference reactions, secondary traumatization or compassion fatigue as well as burnout and vicarious traumatization (Herman, 2007; Emery, Wade & McLean, 2009).

1.1 Definition of vicarious traumatization, related concepts and terminology

Throughout the literature, while most of the research focuses solely and directly on either the patients or indirectly the therapeutic techniques through their outcomes on the patients, there are relatively fewer studies which examine the probable effects of the patient or the therapeutic relationship on the therapist (Hunter & Schofield, 2006). This concern is crucially more important especially for therapists who work predominantly with trauma, due to the fact that they are vulnerable to a higher risk of chronic distress, burnout syndrome, companion fatigue, secondary traumatization and vicarious traumatization because of the empathic engagement as well as the exposure to the violent details of the traumatic experiences of the patients (Pearlman & Saakvitne, 1995; Schauben & Frazier, 1995).

1.1.1 Vicarious traumatization

McCann and Pearlman (1990), the pioneers who defined the phrase "vicarious traumatization" for the first time in the literature, explained the phenomenon in terms of "infection". They proposed that the trauma survivors' disturbing traumatic material with a flood of traumatic memories as well as their nightmares, fears, despair and distrust, "infect" the therapist. According to their infection model,

trauma narrations and traumatic materials of the survivors trigger depressive cognitive schemas and depressive feelings leading to misery, loss of both sympathy and empathy as well as loss of basic trust and sense of safety. These particular indicators of infection which were defined by McCann and Pearlman (1990) are also defined as the most characteristic symptoms of vicarious traumatization emphasizing the cumulative and transformative impacts on the trauma field professionals due to the recurrent exposure as well as companionship to the trauma story of the survivors. Therefore, one of the critical points was that this process of cognitive and behavioral change through vicarious traumatization does not come up with a single case, rather, it is more probable to be triggered in the long-term due to the recurrent exposure to various trauma cases as well as indirectly due to the empathic engagement which arises in the working alliance with the trauma survivors (Pearlman, & Mac Ian, 1995; Schauben, & Frazier, 1995; Eidelson, 2003; Salston & Figley, 2003; Trippany, Kress, & Wilcoxon, 2004).

Afterward, Pearlman and Saakvitne (1995) redefined the term vicarious traumatization in more detail, putting more emphasis on the role of empathic engagement which is one of the crucial prerequisites for therapeutic alliance and establishing rapport between the trauma survivor and the trauma-field professional. Studying incest survivors, Pearlman and Saakvitne (1995) described the concept of vicarious traumatization as a kind of affective, cognitive and relational transformation of the mental health professionals' beliefs, assumptions and expectations related to self, other people and the world mostly resulting from the emphatic engagement and working relationship with the trauma survivors and their traumatic material. So, using the concept of "transformation", relatively enduring

changes are emphasized in both cognitive schemas and relational patterns of the trauma-field workers.

Canfield, (2005) described and explained vicarious traumatization in terms of five components. An affective component involves intense and generally adverse emotional reactions such as grief, helplessness, anger, disgust or worry. A cognitive component basically involves changes in beliefs, thoughts, assumptions, expectations and attributions regarding self, others and the world; additionally includes mental preoccupation with the cases and traumatic stories. A behavioral component consists of defensive mechanisms as well as coping strategies such as avoidance, denial, detachment as well as boundary violations. A physical component involves somatic reactions such as physical complaints of aches, nausea, sickness, tiredness as well as sleep and appetite problems. Finally, a relational component refers to disruptions in close and intimate relationships.

1.1.2 Compassion fatigue

In the same era, Figley (1995) addressed "secondary traumatic stress reactions" or "compassion fatigue" among trauma therapists, evident in feelings of dizziness, confusion and isolation highlighting that the professionals who work with traumatized patients have the risk of indirectly showing similar symptoms of post traumatic stress disorder which may directly be observed in the patients who are primarily exposed to the actual trauma (Figley, 1995). Afterward, Figley (1995) widened the term "secondary traumatization" broadening its meaning and scope including not only the effects on the trauma-field professionals but also on family members and close social network members who have close relationships and connected lives with the trauma survivors (Figley, 1995; Porat 2009). More recently,

Figley (2002) used the term compassion fatigue in order to describe a wide range of potentially adverse effects of trauma work as a cost of caring. Compassion fatigue is specifically characterized by a state of numbing and avoidance regarding the traumatized cases and their traumatic material at one end, while on the other end, defined as a kind of mental preoccupation with the traumatized cases and their materials involving intrusive graphic images or sounds of the material of the traumatized cases (Figley, 2002; Collins & Long, 2003; Sabin-Farrell & Turpin, 2003). Compassion fatigue may arise due to a single trauma case while vicarious traumatization may occur due to repeated exposure to traumatic materials across time and across different trauma survivors (Figley, 1995; Helm, 2010).

1.1.3 Secondary traumatization

In terms of terminology, the "secondary traumatic stress reactions" are defined as normal, crisis-related and acute reactions following a secondary exposure to an emotionally crushing trauma story if the symptoms last for one or a few months. But, if the symptoms last six months or more, then it is defined as "secondary traumatic stress disorder" or "secondary traumatization" (Figley, 1995; Canfield, 2005). Secondary traumatization is observed generally in the trauma field professionals who are exposed to and affected by the traumatic event indirectly through the trauma survivors and their traumatic materials. Secondary traumatization is characterized by presence of symptoms which are very similar to the symptoms of posttraumatic stress disorder (Figley, 2002; Collins & Long, 2003; Sabin-Farrell & Turpin, 2003). More specifically, secondary traumatization presents itself with the same clusters of symptoms of posttraumatic stress disorder, namely; intrusion and reexperiencing (flashbacks,

intrusive thoughts, images, sounds and sensations), numbness and avoidance (of places, objects and people which trigger the trauma), as well as exaggerated arousal and hypervigilance (sleep disturbances, exaggerated startle reactions, irritability, intense anxiety, attention and concentration problems) (APA, 2000; Hamilton, 2008). This means that secondarily traumatized or fatigued trauma professionals may present very similar symptoms to those which are observed in the trauma survivors; they may be extremely preoccupied with their clients and with their traumatic stories, they may be affected by recurrent intrusive images and pieces of traumatic memories which they hear from their clients; also, they may have nightmares as well as hypersensitivity and irritability in their daily lives (Hamilton, 2008).

Simonds (1997) conceptualized vicarious traumatization as an occupational hazard, encompassing the changes in beliefs, thoughts and attitudes about self, other and the world due to the empathic engagement between the trauma survivors and the trauma therapists. So as Sexton (1999) indicated that empathic engagement was both a prerequisite for an effective therapeutic prognosis and a vulnerability factor for the therapist as well.

Throughout the literature vicarious traumatization is described as a process of transformation which is predominantly observed in professionals who not only are in a close contact and emphatic interaction with trauma survivors but also engage in all kinds of empathic interactions and accompany with others in private and social life (Palm, Polusny & Follette, 2004). But, the risk for mental health professionals was clearly defined as higher throughout the literature, due to the repeated and continual exposure to detailed narrations and vivid details of traumatic life events

such as neglect, abuse, rape, torture, sadistic violence as well as losses through disasters (Sexton, 1999; Canfield, 2008).

Despite the fact that vicarious traumatization seems like a similar phenomenon to secondary traumatization, vicarious traumatization is more generally used to refer to internal experiences in terms of deeper and enduring changes in the mental health workers' perceptions of self, others, life and the world as well as sometimes perception of body, gender and intimate relationships (Pearlman & Saakvitne, 1995; Rosenbloom, Pratt & Pearlman, 1999). In other words, vicarious traumatization is more related to changes in meaning constructions, regulation capacity and general adaptation, rather than symptoms (Canfield, 2005).

1.1.4 Countertransference

Working with trauma survivors may also bring quite complicated countertransference reactions in the therapist (Herman, 2007; Hamilton, 2008). Vicarious traumatization is closely related to but different from countertransference (Pearlman & Saakvitne, 1995). Countertransference which may be defined as all of the conscious and unconscious reactions of the therapist towards the client, -here specifically to the trauma survivor-, is more likely to be limited to the period of the therapeutic process while vicarious traumatization represents more enduring changes in the therapist's cognitions, emotions and relationships (Pearlman & Saakvitne, 1995; Bloom, 2003; Hamilton, 2008). Such changes may potentially affect and shape the countertransference reactions for good; increasing the intensity of the vicarious traumatization of the therapist and may elicit complicated and problematic countertransference responses which may lead to harmful results for the therapeutic prognosis (Canfield, 2005; Herman, 2007).

1.1.5 Burnout

The phenomenon of "burnout" is closely related to but different from vicarious traumatization and compassion fatigue. Despite the fact that they have some commonalities and similar presentations in terms of symptoms, the fundamental difference between burnout and vicarious traumatization is rooted in the cause. Throughout the literature burnout is generally explained by external causes and conditions. Burnout was first identified by Maslach (1976) referring to a syndrome which is characterized by an intense emotional exhaustion, fatigue and alienation together with a reduced sense of personal accomplishment caused by long-term involvement in emotionally demanding situations and distressing life or work conditions (Maslach, 1976; Pines & Aronson, 1988; Conrad & Perry, 2000). Then, Maslach and Jackson (1979) defined burnout more specifically with three underlying components, namely; emotional exhaustion; decrease in energy, motivation and commitment; and depersonalization characterized by loss of ideals with a general negative attitude toward both self and life. Later, Maslach and Leiter (1997) indicated six major environmental sources of burnout, namely; overloaded work, lack of control, inadequate reward or recognition, unfairness, breakdown of community, and value conflict. So, burnout basically refers to a state of emotional, mental and physical exhaustion together with a considerable dissatisfaction with one's work or general life conditions generally triggered due to a longterm involvement with a demanding, distressing and exhausting conditions (Valent, 2002; Hamilton, 2008). In other words, burnout is a state of emotional tiredness and physical collapse generally including negative affects, cognitions and attitudes toward the job as well as coworkers and clients, in parallel to an intense exhaustion,

wearing down of idealism as well as reduced sense of accomplishment and achievement (Ashforth & Lee, 1997; Gil-Monte & Peiro, 1997; Schaufeli & Peeters, 2000). It is important to note that burnout is not unique to the professionals who are working in the trauma field, rather, burnout may be prevalent among workers and professionals from different settings and working environments (McKenzie Deighton, Gurris, & Traue, 2007).

A professional's burnout may be remedied when exhausting external conditions change or when that particular therapeutic process with the trauma survivor ends, but vicarious traumatization may not easily disappear even if the circumstances change (Figley, 2002). Rotschild (2006) described the burnout syndrome emphasizing the fundamental effect of workload as a source of distress and, in turn, as a source of exhaustion and dissatisfaction. According to Baird and Jenkins (2003), among the trauma field counselors, workload which is defined on the basis of the amount of exposure to trauma-cases were found to be related to emotional exhaustion in terms of burnout, while contrary to the expectations not to vicarious traumatization, or secondary traumatic stress. Furthermore, it was also revealed that more educated trauma field counselors reported less emotional exhaustion in terms of burnout as well as less vicarious traumatization even if their caseloads were high. Besides, younger trauma field counselors and those with more trauma field experience reported more emotional exhaustion in terms of burnout.

1.1.6 Vicarious posttraumatic growth

Besides its disturbing impact, working with trauma can also lead to growth-producing effects on the mental health professionals who are working in the trauma field.

Tedesdchi and Calhoun (1996) were the pioneers who first described the phenomenon of posttraumatic growth, pointing out the positive and growth-producing effects of trauma on trauma survivors in terms of their basic beliefs, assumptions and perceptions of their selves, relationships as well as world view. In a more recent study, these authors defined the concept of vicarious posttraumatic growth, revealing that not only the trauma survivors but also the trauma field professionals may experience certain positive changes in terms of their self-confidence as well as resilience, enhanced appreciation of life, better relationship, changed priorities, and a deeper and richer sense of spirituality (Arnold, Calhoun, Tedechi, & Cann, 2005).

1.2 Protective factors and risk factors predicting burnout and vicarious traumatization

Trauma caregivers who are composed of both trauma field mental health professionals and also volunteer paraprofessionals have a considerable risk of burnout and vicarious traumatization. This particular risk is quite significant unless preventive and protective factors are utilized by the trauma field workers. According to Pross (2006), formal clinical education as well as technical training on trauma work, and professional support involving supervision, peer-vision as well as personal psychotherapy, also, working within a supportive-team, limiting excessive caseloads and finally self-care habits are the vital protective strategies against burnout and vicarious traumatization. Among the important contributing risk factors for burnout and vicarious traumatization are the lack of adequate social recognition and financial and social support systems of counseling and support centers. According to Pross (2006), the most important resources of preventing burnout and vicarious traumatization in the field of trauma work is self-awareness through a therapy

training course. Self-awareness through regular supervision is one of the vital tools so as to confront the trauma field mental health professionals with their "dark side". Here the term "dark side" is used by Pross (2006) in order to characterize the risk of overidentification with the trauma survivors as well as the risk of losing their professional distance or in the other extreme the risk of detached avoidance and denial of the potential effects and affects of trauma narration to which they are exposed.

Harrison and Westwood (2009) indicated that the mental health professionals who fully work with trauma cases in their caseloads were observed to exhibit significantly more secondary traumatization symptoms; additionally they indicated a significant negative correlation between the professionals' years of clinical experience, their level of education and level of secondary traumatization. So, experience as well as education -more than a master's degree- were pointed out as protective factors against secondary traumatization.

The mental health professionals who work in human service fields especially in the trauma field are generally defined as at high risk for burnout (Freudenberger & Robbins, 1979; Maslach, 1978; Suran & Sheridan, 1985; Ackerly, Burnell, Holder, & Kurdolg, 1988). This considerable risk, especially over an extended period of time, may be due to the demands of being caring and empathetic toward the distressed clients or trauma survivors (Farber & Heifetz, 1982).

Mental health professionals should be alert and aware that the work they are engaged in may potentially make them more vulnerable to burnout and so they should engage in self-care practices in order to be able to protect themselves and to prevent burnout and vicarious traumatization. Norcross (2000) warned that therapists should be aware of the potential hazards of working with trauma and regularly

engage in self-care practices as a life-management habit in order to maintain both their personal and professional functioning and well-being. Norcross (2000) also indicated that developing and utilizing a strong social support network is one of the most crucial components of self-care to prevent burnout.

Rupert & Morgan (2005) indicated that burnout is a complicated and multifactored phenomenon which can not be solely explained in terms of factors related to the working environment. While Bloom (2003) suggested that burnout may be one of the results of vicarious traumatization, especially when it is unrecognized and unsupported, in general the literature could not clearly differentiate whether burnout is a cause or a result of vicarious traumatization, similarly the literature could not define and measure the concepts of vicarious traumatization, secondary traymatization, compassion fatigue and burnout with clear-cut distinctions, instead, most of the studies indicated that they go hand in hand probably in mutual interaction and association.

The nature of the trauma was defined among the risk factors which intensify vicarious traumatzation as well as complicated countertransference reactions in the mental health professional. According to Bloom (2003), the professionals may have a higher risk of begining to perceive other people as more dangerous and more untrustworthy, especially when working with human-made traumas such as incest, sexual abuse, neglect, physical violence and torture. Having shared or similar traumatic experiences with the trauma survivor (such as having a sexual abuse history, loss of a loved one, cancer etc) as well as having shared status or similar identifying characteristics (such as being a woman, having a daughter, being in the same ages etc) was also defined among the risk factors for the trauma field professionals throughout the literature (Sexton, 1999; Birck, 2002; Palm et al., 2004;

Canfield, 2008; Splevins et al., 2010). Therefore, most of these studies indicated that vicarious traumatization may be triggered not only due to repeated exposure to traumatic material, but also it may be intensified through having shared experiences or shared status with the trauma survivors with whom the professionals have been working. Through a qualitative research data on interpreters who were working in the trauma field for the trauma survivors, Lor (2012) revealed that all the participants either using a simultaneous translation or consecutive mode of interpreting had reported that having similar life experiences with the clients leaded them to experience a blend of emotions. More specifically, at one hand, most of the participant professionals reported a significant level of satisfaction and hope due to wittnessing the progress in their clients throughout time, as a part of vicarious posttraumatic growth (Tedesdchi and Calhoun, 1996; Arnold, 2005; Splevins et al., 2010). On the other hand, regardless of their interpretation method, most of the participant professionals reported that they exhibited a significant effort and struggled in order to stay neutral and unaffected as well as in order to cope with their intense thoughts and emotions related to their own personal traumatic life experiences which were triggered by the clients' stories during the working process in the field (Lor, 2012). Therefore, the resemblance between the professional and the survivor in terms of either traumatic life events or any other identifying characteristics may be among the risk factors for triggering or intensifying a probable vicarious traumatization in the professional.

Throughout the literature it was emphaized that both the degree and also the manner which vicarious traumatization would uniquely affect the professionals is a quite complicated and multidetermined interaction in which experience, education, self-care habits, coping skills, and psychosocial support and network systems of the

professionals collectively and mutually interact with each other (Sexton, 1999; Palm et al., 2004; Canfield, 2008).

Throughout the literature, most of the research related to vicarious traumatization is based on quantitative methods, applying surveys through self-assessment scales to mental health professionals. These studies in general describe the potentially changed and disrupted areas in the professionals' lives such as beliefs, thoughts, assumptions about self, others, life, world, safety, control and intimacy in close relationships; as well as identify the common protective factors such as having support systems, effective coping skills and making use of spirituality (Canfield, 2005). While some of these studies reveal similar results and agree on the certainty of particular risk and protective factors; some of the studies indicate controversial findings about some of those risk factors such as a history of past trauma of the professional, years of clinical experience and burnout. Pearlman and Mac Ian (1995) revealed that the professionals who work with trauma and who have personal histories of trauma exhibited more drastic negative effects in comparison with those without personal trauma histories. Their study also underlined the importance and necessity of training on trauma work, supervision as well as emotional support for protection against vicarious traumatization (Pearlman & Mac Ian, 1995).

According to Schauben and Frazier (1995), the clinicians who have a higher percentage of trauma survivors in their caseload report more disrupted cognitions as well as more symptoms of vicarious traumatization independently from their personal history of trauma (Arvay, 2002). According to Chrestman's (1999) study, exposure and companionship to the trauma story of the patient were found to be associated with boosting the symptoms such as avoidance and intrusion as well as sleep problems in the professional. Challenging some of the findings, a study reveals

that there may be a U-shaped relationship rather than a linear relationship, between the years of experience and coping of the therapists. This may be due to the possibility that the therapists who are the least and the most experienced with trauma work may be reporting the most distress and avoidance either due to being inexperienced or having a cumulative burden of burnout (Steed & Bicknell, 2001).

Young (2000) also indicated the importance of effective coping skills repertoire in minimizing the risk of vicarious traumatization. In other words, a relative absence of protective factors constitutes much more risk for vicarious traumatization in comparison to the presence of risk factors (Young, 2000).

A detailed understanding about the transformative effects of trauma work on the professionals and describing protective factors as well as risk factors related to vicarious traumatization can only be addressed through qualitative studies, more specifically though in depth interviews. But, due to the difficulty of qualitative data collection, there are fewer qualitative studies in the literature than quantitative research. These qualitative studies reveal consistencies as well as controversies in terms of protective and risk factors, too. According to Pierce (2000) the professionals who are more skillful and proficient at coping with and reducing the effects of the traumatic stories of the patients, are able to work more effectively with trauma. Awareness and insight were found as important determinants in that the professionals who do not monitor their own experiences and reactions are potentially more prone to experience drastic negative changes in their world views as well as in their cognitions related to safety and control (Pierce, 2000). Iliffe and Steed (2000) observed that the counseling professionals who work with trauma express more anger and sadness as well as reporting more difficulty in hearing about violent stories, especially hearing the traumatic stories in which children are victimized.

From a holistic perspective, Meyer and Ponton (2006) summarized their approach to professional well-being which defines the interaction between potential risk factors and protective factors by the help of a metaphorical tree. In their model, a healthy tree represents a resilient professional who has an adequate level of formal education, continuing field trainings, access to personal, social, professional and organizational support and an adequately rich repertoire of self-care strategies as well as a sense of spirituality.

It is critical for trauma field professionals to have an awareness and insight about risks and potential negative impact of working with trauma. The potentially harmful effects including compassion fatigue, vicarious traumatization and burnout may lead to both clinical and professional hazards as well as administrative and organizational malfunctions. From an organizational and administrative perspective, effects of compassion fatigue and burnout in the long run would cause an increase in turnover rates with the cost of losing qualified and experienced staff (Hamilton, 2008). More importantly, from a professional and clinical perspective, especially in terms of ethical considerations, the well-being of the trauma field professional is crucially important in order to be able to both ensure a positive prognosis of the therapeutic process and protect the necessary ethical frame and principles (Herman, 2007; Hamilton, 2008). As a common concern of the major principles of both national and international ethical codes and guidelines it is clearly stated that mental health professionals must avoid all kinds of attitudes, actions and applications that may harm their clients. The professional must also ensure the protect quality of therapeutic actions and applications, and must be aware the limits of his/her competence or limits of procedures and interventions. Furthermore, mental health professionals are responsible for taking necessary precautions in order to be able to

prevent or at least to minimize the probable foreseen but inevitable harm (Turkish Psychological Association Ethics Code, 2004; European Federation of Psychologists' Association Meta-Code of Ethics, 2005). Trauma field mental health professionals who are affected by vicarious traumatization, compassion fatigue or burnout may unknowingly spoil the therapeutic process and may unintentionally damage their clients (Monroe, 1995; Pearlman & Saakvitne, 1995; Hamilton, 2008). More specifically, vicariously traumatized or fatigued professionals may either become overly intrusive and overprotective or may withdraw and detach losing empathic connection (Herman, 2007; Hamilton, 2008). Some professionals may cause harm indirectly by being inattentive or impatient due to probable sleep disturbances, irritability and intrusive thoughts (Pearlman & Saakvitne, 1995; Herman, 2007; Hamilton, 2008). Therefore, it must be one of the major responsibilities of trauma field professionals to be aware about potentially harmful effects of trauma work and also to be well prepared and to take essential precautions to protect themselves from vicarious traumatization, compassion fatigue or burnout in order to be able to protect both the ethical and therapeutic frame of the treatment or support processes while working with trauma survivors (Cunningham, 2004; Herman, 2007; Hamilton, 2008). The literature undoubtedly points at the importance of awareness training as well as acquisition of personal and professional self-care strategies together while also indicating the significance of trauma field trainings, supervision and peer support (Pearlman & Saakvitne, 1995; Pearlman & Mac Ian, 1995; Monroe, 1995; Sexton, 1999; Cunningham, 2004; Hamilton, 2008; Baker, 2012).

Working in the trauma field is not only a challenging and devastating but also rewarding and inspiring experience for trauma field professionals (Pearlman & Saakvitne; 1995, Herman, 2007; Baker, 2012). Working with trauma and

accompanying a trauma survivor through his/her healing process may sometimes considerably transform the professionals not only as therapists, but as human beings, as members of the society, as women/men, as mother/father or as daughter/son as well. While the survivor clients of trauma heal and grow, the trauma field professionals vicariously grow, too. This parallel transformation and growth has particular layers.

Being a trauma field professional commonly creates a strong sense of being connected as a family or a community due to the intense sharing in professionals' network as well as through intense working relationships during disasters and crisis situations in the field (Pearlman & Saakvitne; 1995). In addition to intensive professional and technical connectedness, transformation of the trauma field professionals is experienced through the deep working relationship between the trauma survivor and the trauma professional. It is not just an intellectual participation or technical intervention, it is a mutual human relationship based on trust. Sometimes it may be fascinating for the trauma field professional to witness the resiliency, flexibility and creativity hidden inside human beings despite the catastrophic confrontation with the darkest and the cruelest sides of humanity. As the survivor clients of trauma achieve facing themselves and their traumatic past with courage, the trauma field professionals gain courage to face themselves with all their strengths and weaknesses (Kaiser, 1965; Searles, 1975; Pearlman & Saakvitne; 1995; Slavin & Kreigman, 1998). Also, sharing all those deep feelings and private moments of memories as well as sharing and witnessing the growth and healing process is a very honorable experience which makes the professional special or even privileged; the survivor clients of trauma in a way allow the professional to be there, to witness, to share and to help as well as to transform and grow together. Being able to share

sorrow and pain as well as joy and laughter is at the heart of the working relationship between the trauma field professionals and the trauma survivors as a source of transformation and growth. Finally, working in the trauma filed may be defined as a kind of activism or with a more ambitious definition, as a revolutionary experience of which one of the basic missions is to speak out the dark secrets of society.

At one hand, body of researches not only indicated but also warned the mental health professionals about disturbing and venomous impact of empathic engagement with the trauma survivors as well as the overall engagement with trauma work (Lerias & Byrne, 2003; Mclean, Wade, & Encel, 2003; Collins & Long, 2003; Sabin-Farrell & Turpin, 2003); on the other hand, some other research additionally emphasized the protective function of self-care habits which help to reduce both physical and psychological adverse effects of trauma work, and in turn, the risk of vicarious traumatization (Norcross, 2007). More specifically, the literature pointed out that those probable adverse effects of trauma work may include burnout (Jenaro, Flores, & Arias, 2007; Johnson & Hunter, 1997; Rupert & Morgan, 2005), general distress (Iliffe & Steed, 2000; Sabin-Farrell & Turnpin, 2003; Steed & Downing, 1998), and symptoms similar to PTSD (Brady et al., 1999; Kassam-Adams, 1995; Schaben & Frazier, 1995; Pearlman & MacIan, 1995). Probable adverse effects may also involve minor cognitive changes or major existential transformations in terms of basic beliefs, assumptions, attitudes, behaviors and relationships of the professionals (Schauben & Frazier, 1995; Pearlman & MacIan, 1995; Steed & Downing, 1998; Ilife & Steed, 2000; Ortlepp & Friedman, 2002).

It should be remembered that no psychotherapist can manage to work with trauma without any support, just like no trauma victim can heal alone (Herman, 2007). Psychotherapists have an ethical responsibility to be self-aware as well as to

continuously improve both their clinical knowledge and coping strategies in order to be able to prevent any potential harm that may emerge in the therapeutic process (Herman, 2007). Mental health workers should check what they need in order to sustain an effective therapeutic work as well as to keep their own well-being (Geller, Madsen & Ohrenstein, 2004).

Beyond defining the phenomenon, McCann and Pearlman (1990) speculated and worked on strategies which may be effective to alleviate vicarious traumatization. They pointed out the importance of regular case consultations as well as regular supervision in order to help the professionals to be aware and also to cope with the intense reactions evoked by trauma work. These kinds of professional support sources also help avoiding isolation which may be risky for vicarious traumatization. Additionally, they recommended balancing clinical trauma work with other professional engagements such as research or other academic and clinical responsibilities. They also emphasized the importance of balancing personal and professional lives, setting and protecting clear and realistic boundaries. Very similar to the recommendations of McCann and Pearlman (1990) for ameliorating the probable transformative effects of vicarious traumatization, Yassen (1995), Pearlman and Saakvitne (1995), Saakvitne and Pearlman (1996) pointed out the same aspects as protective factors.

In order to be able to ensure physical, mental and emotional stability and functioning and to avoid impairment, self-care practices as a life style is crucially important for mental health professionals especially for those who work in the trauma field. Lack of adequate self-care may easily lead to burnout as well as vicarious traumatization (Chacksfield, 2002). Self-care activities are defined in terms of different clusters throughout the literature. Some resources describe self-care

strategies in terms of four major domains (Carroll, Gilroy, & Murra, 1999). The first domain is composed of an intrapersonal dimension involving awareness and insight through either personal psychotherapy or spiritual and intellectual conscious-raising activities. The second domain is composed of an interpersonal domain through social support, involving both family bonds and romantic relationships as well as friendships and collegial relationships. The third domain involves professional and organizational support including supervision, peer vision and case consultation, attending special trauma field trainings, an effective time management, balancing and scheduling breaks as well as the caseload, determining realistic goals and expectations related to work. The fourth domain is related to physical well-being, including a healthy diet, regular sleep, regular exercise, vacations as well as leisure activities and hobbies (Carroll, Gilroy, & Murra, 1999).

Bell (2003) claims that psychotherapists especially who work with trauma should have five basic qualities which may be sources of their strength and resilience; namely, an adequate level of professional competence as well as a rich repertoire to cope with difficulties; an ability to maintain a realistic motivation and energy; an awareness, insight and adequate level of resolution of his/her personal traumas; having appropriate role models of surviving as well as supportive colleagues in the professional network or work environment; and finally having a life philosophy and personal belief system.

The most common self care strategies also constitute effective coping in prevention of burnout and vicarious traumatization. Saakvitne and Pearlman (1996) categorized these strategies very similar to Figley's (2002) conceptualization; they described three major categories, namely, professional strategies involving formal education, field trainings, supervision, peervision, case presentation meetings as well

as academic reading about the related literature; organizational strategies concerning the work environment and working conditions involving balancing the caseload and workload, having collaborative, cooperative and supportive colleagues, adequate recognition and encouragement, adequate breaks and holidays and also resource allocation for access to professional support systems; and personal strategies including awareness and insight, work-life balance between private, social and professional life, self care habits such as regular exercise, arts and crafts, leisure activities or hobbies, talking, writing, walking, dance, music, humor and spirituality.

1.3 Theoretical framework

The theoretical framework of the present study is based on Constructivist SelfDevelopment Theory (Pearlman, 1990). The phenomenon of vicarious traumatization was established on the Constructivist Self Development Theory (CSDT) which was developed by Pearlman (1990), as an integration of self-psychology and personality as well as cognitive development and social-learning theories (McCann & Pearlman, 1992; Brockman et al., 2006; Moeller, 2011). McCann and Pearlman (1990) stated that "adaptation to trauma is a result of a complex interplay between life experiences, including personal history, specific traumatic events, and the social and cultural context and the developing self including self capacities; ability to regulate self-esteem, as well as ego resources; serve to regulate interactions with others, psychological needs which motivate behavior, and finally cognitive schemas about self and world" (p. 6).

CSDT constituted the theoretical framework of the present study and it is crucial in conceptualizing and understanding the experience of vicarious traumatization due to the fact that it brings a theoretical explanation concerning how

traumatic materials may affect the affects, cognitions and attitudes of the trauma field mental health professionals. According to CSDT, the particular changes in the professionals' belief and thought systems and cognitive schemas are both adaptive and as well as pervasive, in that these changes have an indicative potential to influence various intimate, social, relational and spiritual aspects of the counselors' life. CSDT defines the self in terms of five major components which are potentially prone to be drastically changed and restructured due to vicarious exposure to the traumatic materials and due to the empathic engagement between the trauma survivor and the trauma-field professional. The first component is a frame of reference involving shifts in his/her sense of identity as well as spirituality, his/her view of world and relationships. The second component is called self capacities referring to fine tuning and coping abilities to regulate intense affects maintaining a consistent and coherent sense of self. The third component is composed of ego resources which are necessary for awareness, insight and empathy as well as realistic perception and decision making. Ego resources are also crucial for defining and maintaining personal boundaries. The fourth one is the core component which is composed of cognitive schemas around the basic psychological needs of safety, trust, esteem, control and intimacy. And the final component which is prone to be challenged and changed by trauma cases is memory including not only retrieval but also perception processes (Saakvitne & Pearlman, 1996; Helm, 2010).

1.4 Vicarious traumatization literature in Turkey

Turkey has always been a land of traumas and losses, unfortunately. The Great Marmara Earthquake (1999) was one of the turning points in Turkey, especially catalyzing a significant increase in trauma literature, besides the other significant

traumatic events and disasters such as the Erzincan Earthquake (1992), Afyon, Dinar Earthquake (1995), battles or the civil war in the South East Region of Turkey from the 1990's, terrorist attacks in Istanbul (2003), the Isparta Plane Crash (2007), Antakya Flood (2009) as well as the Van Earthquake (2011). More recently, the Gezi Park Protests (2013) and losses due to the unsolved crimes not only created a natural healing and growth through activism but also triggered certain traumatic effects on the society. And the most recent trauma, the explosion at the coal mine in Soma, Manisa (2014) went down in Turkey's history as the worst mine disaster in which 301 people were killed. Despite the fact that there were limited numbers of studies in Turkey on trauma field professionals, it may be expected to increase in the near future due to all these social and communal traumatic experiences. Despite the fact that the present study was submitted in 2014, its data collection process had ended in the first moths of 2013, so the important experiences of the trauma field professionals concerning the Gezi Protests and the Soma Disaster were not able to be included in the research data.

There are certain studies in the Turkish literature on the probable effects of trauma work with different working conditions as well as few ones on burnout and vicarious traumatization of the mental health professionals in Turkey.

Yilmaz (2006) investigated the effects of trauma in search and rescue workers and pointed out the risk of being in search and rescue operations after traumatic events may trigger certain negative effects. Yilmaz revealed that education, marital status and past trauma history were found to be the variables affecting posttraumatic stress symptoms, while past trauma history, marial status and an effective coping style were found to be effective in predicting posttraumatic growth.

Akatlı-Mertkan (2009) investigated the prevalence of trauma syptoms and related problems in 30 volenteers who were working in 18 women protection and counselling centers from different cities through self-report scales as well as semi-structured interviews. The results pointed out that posttraumatic stres syptoms and depression were observed as well as burnout and compassion fatigue. Results have shown the effect of the quantity of violence application on compassion fatigue. It was pointed out that the presence of a co-worker at a women protection and counseling center was a protective factor for compassion fatigue.

Kaya (2010) investigated posttraumatic stress disorder (PTSD) and related factors among the emergency and intensive care unit staff and found that PTSD was observed as more common in the staff of emergency and intensive care unit groups than in a control group. Furthermore, anxiety, depression and emotional burnout were found significantly more common in PTSD developing groups than in non-PTSD developing groups. Finally and most importantly, it was also found that the subjects with high PTSD used much more passive coping strategies than non-PTSD developing group.

Yesil (2010) investigated the prevalence of depression and traumatic stress symptoms on medical healthcare professionals who were working as personnel of 112-Ambulance Services in Turkey. The results revealed that posttraumatic stress symptoms increased as the level of exposure to violence and death increased. Past history of sexual abuse history in the medical health professional personal life did not bring any difference in terms posttraumatic stress reactions.

As one of the most significant and important studies in Turkey, Zara and Icoz (2011) investigated secondary traumatization among 133 mental health workers including psychologists, psychiatrists, counselors, social workers and field

volunteers, in Turkey. They basically revealed a positive association between secondary traumatic stress reactions and burnout. Besides, they indicated that the constructs of secondary traumatization and burnout are closely related in terms of the effects of workplace, profession, geographical region, supervision, level of education, type of the trauma as well as personal trauma history. Icoz (2011) investigated the factors which potentially give rise to burnout in mental health professionals with a sample of 205 professionals from Turkey, and revealed that all the factors which were detected by Zara and Icoz (2011) were also effective in increasing burnout except the level of education. Icoz (2011) especially emphasized the crucial role of supervision as a protective factor against secondary traumatization.

1.5 Aim and mission of the present study

The major aims and missions of the present study are specified and formulated as follows.

One of the major aims of the present study was to investigate the prevalence of vicarious traumatization among mental health professionals working in the trauma field in Turkey. In parallel, one of the missions of the study was to draw necessary attention to the probable effects of trauma work on trauma field professionals, especially on the ones whose workloads and caseloads are high, education levels are relatively low and working conditions lack adequate support systems such as supervision, peervision or case consultation meetings. Within the frame of this particular aim, the following hypotheses were specified:

Hypothesis 1: It was hypothesized that there would be significant differences between different groups of professions in terms of level of vicarious traumatization.

Hypothesis 2: It was hypothesized that social workers would have the highest level of vicarious traumatization among the four groups of professions.

In essence, the primary aim of the study was to attract attention as well as to identify protective factors and risk factors which predict vicarious traumatization. More specifically, it was aimed to explore the probable association of demographic variables, level of education and special training on trauma, level of exposure to trauma work in terms of workload, caseload and experience years in the trauma field as well as the level of burnout in terms of emotional exhaustion, ways of coping in terms of active and passive coping styles, perceived social support and presence of a personal trauma history in predicting vicarious traumatization.Within the frame of this inclusive aim, the following series of hypotheses were specified to be tested:

Hypothesis 3: It was hypothesized that there would be a significant negative correlation between formal education of the professionals and level of vicarious traumatization.

Hypothesis 4: It was hypothesized that there would be a significant negative correlation between having a special training on trauma and level of vicarious traumatization.

Hypothesis 5: It was hypothesized that there would be a significant positive correlation between experience years in clinical field and level of vicarious traumatization.

Hypothesis 6: It was hypothesized that there would be a significant positive correlation between experience years in the trauma field and level of vicarious traumatization.

Hypothesis 7: It was hypothesized that there would be a significant positive correlation between workload and level of vicarious traumatization.

Hypothesis 8: It was hypothesized that there would be a significant positive correlation between caseload and level of vicarious traumatization.

Hypothesis 9: It was hypothesized that there would be a significant positive correlation between emotional burnout, desensitization-depersonalization levels of professionals and the level of vicarious traumatization while a significant negative correlation between the personal accomplishment level of professionals and level of vicarious traumatization.

Hypothesis 10: It was hypothesized that there would be a significant negative correlation between perceived social support and vicarious traumatization.

Hypothesis 11: It was hypothesized that there would be a significant negative correlation between an active coping style of the professionals and level of vicarious traumatization while a significant and positive correlation between a passive coping style of the professionals and level of vicarious traumatization.

Hypothesis 12: It was hypothesized that there would be a significant negative correlation between the number of traumatic events in the past life history of the professionals and level of vicarious traumatization.

Hypothesis 13: It was hypothesized that protective factors, namely, education, special trauma training, access to any support as well as perceived social support and active coping style would be negatively and significantly associated with vicarious traumatization while risk factors, namely, emotional burnout, workload, caseload and passive coping style would be positively and significantly associated with vicarious traumatization.

Hypothesis 14: It was hypothesized that emotional burnout would be found to be the most effective predictor of vicarious traumatization.

Hypothesis 15: It was hypothesized that emotional burnout would mediate the relationship between caseload and vicarious traumatization of the professionals.

The present study was the first methodologically integrative investigation in Turkey in which both qualitative and quantitative methods were used in combination in order to be able to explore the effects of trauma work on professionals as well as to grasp the whole picture with as much more detailed data as possible. Particularly, by the help of in depth research interviews, it was aimed to have a closer glance with a deeper insight about the subjective experiences of trauma field psychologists working in Istanbul, in Turkey.

Therefore, on the basis of the overall findings, the most significant mission of the study would be to generate applicable projects and psychoeducation programs which would invest in and implement on protective factors, especially on self-awareness and self-care in order to be able to prevent probable burnout and vicarious traumatization in mental health professionals as well as the candidate-mental health professionals in Turkey. It would be suggested with an emphasis in the light of the findings of the present study, psychoeducation on vicarious traumatization including awareness, insight and self-care should be life-long continuing lectures or supportive training programs starting in undergraduate education and preferably going on professional-life-long. And this should be far beyond just curriculum management, rather, it should be admitted as a technical and an ethical requirement for trauma field mental health professionals in accordance with the universal ethical principles and standards defined by the Turkish Psychological Association's Ethics Code especially in terms of competency and responsibility as well as beneficence and maleficence (TPA, 2004).

CHAPTER 2

METHOD

This chapter is composed of presentation of the method of the present research in two parts. The first part, Method 1 introduces the quantitative procedure and the second one, Method 2 defines the qualitative procedure applied in the study.

2.1 METHOD 1:

This part is composed of the presentation of the operational measures and methodological procedures of the quantitative part of the present research. The first section of this chapter is devoted to describe the participants of the study. The second section presents the instruments used in the data collection process of the study. The third section defines data collection procedure while the final section describes data analysis procedures.

2.1.1 Participants

For the quantitative part of the present research, participants were composed of mental health professionals, including, psychologists, social workers, psychiatrists and psychological counselors who work with trauma in Turkey. More specifically, the participants of the study were trauma field professionals who were either at the time of their participation in the research or once had engaged in trauma work.

Out of 310 people who clicked on the online survey link of the research, 239 of them went on completing; and while out of 108 potential participants to whom the survey batteries were either delivered by hand or sent by mail, only 48 participants sent them back. After 27 participants had been eliminated from the subject pool due

to their incomplete survey sets, a total of 260 subjects constituted the final sample (N=260) of the present research. This sample included 174 (66.9%) females and 86 (33.1%) males mental health professionals whose ages ranged from 23 to 69, with a mean of 37.05 years (SD = 8.23).

Among these 260 participating mental health professionals, 116 (44.6%) were psychologists, 65 (25.0%) were social workers, 57 (21.9%) were psychiatrists and 22 (8.5%) were counselors.

In terms of education, 126 (48.5%), 88 (33.8%) and 46 (17.7%) participants held bachelor's, master's and doctorate degrees, respectively. Among all the participants who identified themselves as professionals working with trauma, 162 (62.3%) professionals reported that they had had no special trauma training, while only 98 (37.7%) participants had received a special training on trauma work.

The sample of the study was composed of participants from 40 different cities in Turkey. However, Istanbul (N=70;26.9%), Ankara (N=40; 15.4%), Izmir (N=33; 12.7%), Antakya (N=16; 6.2%), and Van (N=13; 5.0%) constituted the largest groups of this sample.

In terms of working conditions and positions, 69 (26.6%) participants reported to be working at multiple settings. 196 (75.4%) mental health professionals were state employee, 74 (28.5%) were working at private either exclusively or parallel with state employment, while 62 (23.8%) participants reported to be working for nongovernmental organizations (NGOs) in addition to their positions either state or private employment.

In terms of years in professional clinical experience, the participants reported to be working as mental health professionals for an average time of 13.23 years (SD =7.882), ranging from 1 to 40 years. More specifically in terms of trauma

field experience, the participant professionals' years of experience in trauma field ranged from 1 to 35 with a mean of 11.40 years (SD =7.773).

In terms of the client population with whom the participating mental health professionals worked, 74 (28.5%) of them worked with children and/or adolescents, while 70 (26.9%) worked with adults and/or elderly. 116 (44.6%) of the participants reported to work with all age groups, including children and/or adolescents and adults and/or elderly.

Total working hours of the participants ranged from 5 to 74 hours per week with a mean of 39.98 hours (SD=11.822). The participants' total working hours with trauma cases specifically, ranged from 0 to 60 hours per week with a mean of 23.21 hours (SD=16.558). Out of total number of 260 final participants, 22 (8.46%) professionals reported that they had no trauma cases at the moment of filling out the research survey.

Among the trauma types with which the participating mental health professionals worked most frequently, 201 (77.3%) participants reported to work with sexual abuse, 192 (73.8%) with physical violence, 142 (54.6%) with neglect, 112 (43.1%) with sudden death of a significant loved one, 81 (31.2%) with natural disasters, 74 (28.5%) with serious illness, 65 (25.0%) with torture and/or prisonship, and, 51 (19.6%) with war and/or terrorism. The trauma type which was found to be the hardest to work with among all the trauma types was sexual abuse by far as indicated by 174 (66.9%) participants.

The number of participants who had an access to receive support for their trauma work, especially for the difficult cases to cope with, was 152 (58.5%).

In terms of spirituality, 174 (66.9%) participants reported that they had a conviction.

2.1.2 Instruments

The research data is based on both quantitative and qualitative resources. Quantitative data is obtained by a non-experimental survey with convenience sampling. In order to test the research hypotheses, five inventories, namely, the Trauma and Attachment Belief Scale (TABS), the Ways of Coping Inventory, Multidimensional Scale of Perceived Social Support (MSPSS), Maslach Burnout Inventory (MBI) and Posttraumatic Stress Diagnostic Scale (PDS) were utilized as measurement instruments in addition to a brief screening questionnaire composed by the researcher.

2.1.2.1 Screening Questionnaire

The screening questionnaire is developed specifically for the present research in order to obtain both demographic information regarding the subjects' city of residence, age, gender, profession, the years of work experience in the trauma field, their working positions (state, private or non-governmental organization), and as well as specific conditions related to their trauma work in terms of formal education, special training on trauma work; specific practice field and age groups (children, adolescents, adults, elders); their caseload in terms of average number of hours worked and the average number of trauma cases in their overall caseload; and also their professional (supervision, peervision), social, personal or spiritual support systems (see Appendix 1).

2.1.2.2 Trauma and Attachment Belief Scale (TABS)

Trauma and Attachment Belief Scale (TABS) is originally developed by Traumatic Stress Institute (TSI) to use for trauma survivors; later, it is revised by Pearlman in

2003 to be used in the assessment of probable effects of vicarious traumatization(see Appendix 2). It aims to assess cognitive schemas related to beliefs and assumptions towards self, other human beings, life and world in terms of five major themes, namely; safety, trust, esteem, intimacy, and control. These five particular areas are identified due to their significant potential to be affected by either direct or vicarious exposure to psychological traumas.

TABS is a self-report questionnaire, composed of 84 items each of which has a rating scale of 1 to 6 (from 1= Strongly Disagree to 6= Strongly Agree). It is applicable to both adolescents and adults. Besides a total score, TABS also computes ten subscale scores, namely; 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. TABS has a face validity in that it directly asks and inquires the subjects' beliefs and assumptions related to self, others and life in terms of safety, trust, esteem, intimacy and control. It has an internal consistency with .96 Cronbach's Alpha score (Pearlman, 2003); and its test-retest reliability is indicated to be 0.75 (Pearlman, 2003) for the TABS total scores. It has construct validity in that its total score is strongly associated with Trauma Symptom Inventory's scores of impaired self-reference, dissociation behavior and depression (Pearlman, 2003).The intercorrelations between the two tests' subscales also support the construct validity of TABS. According to Mas (1992), psychiatric patients who had childhood sexual abuse history and had chronic psychological disturbances, had significantly higher TABS scores than those who had no trauma history. Similarly, Dutton, Burghardt, Perrin, Chrestman, and Halle (1994) revealed that the cognitive schemas of battered women had more disrupted beliefs in the form of high TABS scores in correlation to elevated posttraumatic stress symptoms scores. Additionally, Goodman and Dutton

(1996) stated a significant positive correlation between the frequency and variance of abuse reported by homeless women and disruption in cognitive schemas in the form of elevated TABS scores. Furthermore, according to Frazier (1995), counselors who had higher number of trauma victims in their caseloads were found to report significantly more disrupted beliefs than those who carry less or no trauma cases as indicated by their elevated TABS scores. So, TABS has criterion validity in terms of its correlation with both vicarious traumatization and posttraumatic stress symptoms.

TABS was translated into Turkish by back-translation method. Its Turkish form is firstly used by Zara and İçöz in 2011. Turkish adaptation and standardization of TABS is being conducted by Gürdil (2014) as a part of her dissertation.

2.1.2.3 Maslach Burnout Inventory (MBI)

Among the various inventories that measure work and job related burnout in human service professionals, the Maslach Burnout Inventory (Maslach & Jackson, 1981) is the most widely used due to its high reliability and validity as indicated by many (see Appendix 3)research (Maslach, Jackson, & Leiter, 1996). The Maslach Burnout Inventory is a self-report questionnaire which consists of 22 items each of which is rated on a 5-point scale ranging from 1 (Never) to 5 (Always). It aims to assess burnout in terms of three major aspects which also constitute the three subscales of the inventory; namely, 1) Emotional Exhaustion (EE), Depersonalization (D), and Personal Accomplishment (PA). Nine items (1, 2, 3, 6, 8, 13, 14, 16, 20) are aimed to measure emotional exhaustion; five (5, 10, 11, 15, 22) depersonalization, and eight (4, 7, 9, 12, 17, 18, 19, 21) personal achievement. High scores on EE and D subscales, and low scores on PA subscale indicate burnout.

Maslach et al. (1996) reported internal consistency of 0.90, 0.79, and 0.71, respectively, for the EE, DP, and PA subscales. Its test-retest reliability values are 0.83 for EE, 0.72 for D, and 0.72 for PA, respectively.

Turkish version of MBI was adapted by Ergin (1993) on nurses and doctors.The internal reliability scores of the Turkish version of MBI were 0.83, 0.65 and 0.72 respectively for emotional exhaustion, depersonalisation, and personal accomplishment subtests; while the test-retest reliability was 0.83 for emotional exhaustion, 0.72 for depersonalisation and 0.67 for personal accomplishment (Ergin, 1993).

2.1.2.4 Ways of Coping Inventory (WCI)

The Ways of Coping Inventory is a self-report questionnaire which was developed to screen the range of thoughts and actions which people tend to use to cope with stress. It was originally developed by Folkman & Lazarus (1985) as The Ways of Coping Checklist which was composed of 68 items which aim to assess thoughts and behaviors used to cope with stressful life encounters (see Appendix 4). Later in 1989, it was revised by Folkman & Lazarus and transformed into a 66-item inventory on a 4-item Likert type scale, with scores ranging from "0" (Never Used), "1" (Used Somewhat), "2" (Used Often), to "3" (Used Almost Always).

The inventory was firstly used in Turkey by Siva (1988) who added culture-specific items composing a 74-item inventory. Later, the revised and shortened form of the inventory was developed by Şahin and Durak (1995). This shortened Turkish version of the Ways of Coping Inventory which was used for the present study is composed of 30 items on a 4-point Likert type scale with percentages ranging from “0%” (Never Used), "30%" (Used Somewhat), "70%" (Used Often), to "100%"

(Used Almost Always). It has 5 subscales which define different approaches of ways coping with stress. These subscales and their factor-items are as follows; self-reliance approach (8, 10, 14, 16, 20, 23, 26), optimistic approach (2, 4, 6, 12, 18), helpless approach (3, 7, 11, 19, 22, 25, 27, 28), submissive approach (5, 13, 15, 17, 21, 24) and use of social support approach (1, 9, 29, 30). On the basis of Şahin and Durak's Turkish adaptation study, Cronbach Alpha values were .66 for optimistic approach, .77 for self-reliance approach, .73 for helpless approach, .73 for submissive approach and .61 for asking for social support approach; with reliability values ranged between .47 and .80 (Şahin and Durak, 1995).

2.1.2.5 Multidimensional Scale of Perceived Social Support (MSPSS)

The Multidimensional Scale of Perceived Social Support was developed by Zimet et al. (1988). It is a 12-item self-report questionnaire (see Appendix 5)which aims to assesses both the perceived availability and adequacy of social support on a 7-point Likert type scale ranging from "1" (Very Strongly Disagree) to "7" (Very Strongly Agree). It measures perceived social support in terms of 3 factors each of which composed of 4 items, relating to the source of the social support system; namely, Family (3, 4, 8, 11); Friends (6, 7, 9, 12); and Significant Other (1, 2, 5, 10). The higher the scores, the higher the perceived support of the respondent is. Internal consistency of the scale was reported between 0.79 and 0.98 on various samples while its test-retest reliability in 2-3 month-periods was reported at 0.72 and 0.85.

Its Turkish adaptation was developed by Eker and Arkar (1995).On the basis of their adaptation study which used samples of university students consisting of normal subjects and subjects with medical or mental health problems, the original three subscales were confirmed. The internal consistencies of the scale with its three

subscales were high. In general, the scale was found to be correlated significantly in the expected direction with measures of depression and anxiety, supporting the construct validity of the Multidimensional Scale of Perceived Social Support. Cronbach's alpha values ranged between 0.77 and 0.92, showing a good internal consistency for the subscales and the total scale.

2.1.2.6 Posttraumatic Stress Diagnostic Scale (PDS)

The Posttraumatic Stress Diagnostic Scale (PDS) was originally developed and validated by Foa (1997) as a brief self-report measure of post-traumatic stress disorder. The scale is a 50-item self-report questionnaire which was developed in order to assess and diagnose posttraumatic stress disorder (Foa et al., 1997). The general structure, frame and content of the scale were based on the DSM-4 (Diagnostic and Statistical Manual) diagnostic criteria for PTSD. The scale aims to assess both the frequency and intensity of distressing and intrusive thoughts, avoidance and hyperarousal. It is applicable to adults between the ages of 18-65.

The scale is composed of four sections/parts(see Appendix 6). The first part aims to determine the type(s) of the trauma (such as natural disaster, violence, sexual abuse, serious illness etc.) that the subjects had experienced or witnessed. The first part is called as “list of traumatic events experienced”. In the second part, -if the subjects indicated more than one trauma-, they are requested to choose one of these trauma(s) which bothered and troubled them the most. This part additionally involves 6 yes-or-no items which aim to determine the intensity of that specific trauma. The second part of the scale is called as “event severity” subscale. In the third part, there are 17 items in a four-point scale in order to rate the cardinal symptoms of PTSD experienced in the past 30 days. This part of the scale is called as “posttraumatic

stress symptoms" subscale. This subscale categorizes the symptoms into three major dimensions; reexperiencing symptoms through intrusive thoughts or flashbacks; avoidance and emotional numbness symptoms; and hyperarousal symptoms categories. In the final part, subjects are asked to rate the level of impairment caused by their symptoms across nine areas of life functioning. It was reported that the posttraumatic stress symptoms subscale yielded a high internal consistency (α = 0.92) with a significant correlation (0.83) in terms of test-retest reliability (Foa et al, 1997).

The Turkish adaptation of the scale was developed by Işıklı (2006). Internal consistency for all items was found to be high (α = 0.93), while item-total test correlations were obtained to change between the coefficients of 0.39 and 0.82 (Işıklı, 2006). In terms of internal validity, the scale was tested by both principal axis factoring and also varimax rotation in order to check the factor analysis of the three defined categories which were basically the reexperiencing, avoidance and hyperarousal categories. It was observed that all the items, with an exception of two (the sixth and seventh items of the third part) were found under the categories that they theoretically ought to be. In terms of external validity, scores obtained from the scale were compared with other scales of which validity was statistically controlled. On the basis of the Turkis Adaptation study, Işıklı (2006) revealed that the posttraumatic stress symptoms subscale was found to be correlated with the Brief Symptom Inventory (0.70); the Beck Depression Inventory, (0.60); the Beck Anxiety Inventory, (0.63).

2.1.3 Data Collection Procedure

The research battery which was composed of 5 inventories and a brief questionnaire was administered after getting approval of the Ethics Committee of the BoğaziçiUniversity. All the participants were treated in accordance with BoğaziçiUniversity's ethical codes of conduct for treatment of human subjects. Participation was voluntary, and all participants were informed in terms of their right not to participate in the study, as well as their right to quit participation at any time. At the beginning of the data collection procedure, participants were assured about confidentiality and anonymity of their responses, and provided informed consent (See Appendix 7). Consent forms were collected and filed out separately from the completed batteries, in order to be able to ensure anonymity and confidentiality.

The battery was counterbalanced in 6 different versions in order to check and eliminate the potential effect of sequences of the inventories in the research survey battery.

In order to reach a large number of subjects from different cities and from diverse locations, all the research instruments, including the inventories, screening questionnaire, as well as the informed consent form were converted into electronic format using Survey Monkey online survey tool. The related web link which is needed to reach the online survey was sent to the professionals' e-groups with a cover letter for invitation together with a brief description of the research. According to Surveymonkey online system records, 310 respondents visited the survey link, 287 of them went on responding; but, only 239 of them completed the research survey.

2.1.4 Data Analysis Procedure

Before conducting statistical analysis, all variables were entered and randomly double-checked for the data entrance, then examined for the missing values as well as for multivariate analysis in terms of normality, linearity and the outliers.

Out of a total of 287 returned respones, 27 cases were removed from the data due to a large number of missing responses and incompleted surveys. The other missing variables which were defined within the limits of conservative-acceptable ratio were substituted by the mean value of that variable. During the examination for outliers, no cases were identified as univariate outlier. There was only one case identified as an multivariate outlier, but it was not eliminated from the data set due to its theoretical and practical significance.

After the necessary eliminations, the statistical analyses of the present study were run for the total sample of 260 participants. Statistical Program for the Social Sciences (SPSS) version 17.0 was used for the statistical analysis.

In order to present the overall picture related to the general characteristics of the participants, descriptive statistics was run firstly. Basic mean comparisons were run through t-tests and ANOVAs. Then, in accordance with the research questions of the study, besides Pearson correlations; moderation-mediation analysis and hierarchical regression analysis were run in order to explain how the relationship between the predictor -which was defined as vicarious exposure to trauma cases- and the outcome -which was defined as the level of vicarious traumatization- was moderated by the measured variables which were described in terms of burnout, ways of coping, percieved social support, personal trauma history as well as other characteristics that defined the professionals and their trauma work conditions.

2.2 METHOD 2

This part is composed of the presentation of the methodological procedures of the qualitative part of the present research. The first section of this part is devoted to describe the profile of the participant interviewees. The second section presents the questions which guide the general flow and frame of the research interviews held in the data collection process of the study. The third section defines data collection procedure while the final section describes the method and steps of the qualitative data analysis procedure.

For the present study, quantitative method was integrated with and consolidated by qualitative design in order to enhance the knowledge and understanding about the certain phenomenon being studied. More specifically, the qualitative part of the research is added in that it may provide richer and deeper understanding in order to describe the potential protective factors as well as risk factors which may be involved in the professionals' experience of vicarious traumatization. The potential factors may be included but might not be limited to the history of personal trauma, coping style, support systems, burnout, length of time in practice in trauma field, specific academic training, or number of trauma cases within one's caseload. Qualitative design, as pointed out by Creswell (2007), is precious when probable variables are needed to be explored. It is a method of systematic and scientific inquiry into meaning and essence (Shank, 2002). Ultimately, it aims to transforme the obtained data into information that can be used and benefited (Rossman & Rallis, 1998).In the present study the qualitative part of the research was included to provide a richer and deeper understanding of the potential protective factors as well as risk factors that may be involved in the professionals' experiences of vicarious traumatization. These potential factors may include but are not limited to

personal trauma history, ways of coping, social support systems, burnout, length of practice time in the field of trauma, specific academic training, or number of trauma cases within one's caseload.

2.2.1 Participants

The participants of the qualitative part of the study were composed of seven psychologists with whom research interviews were held. All the participant interviewees were selected from İstanbul, through purposive and snowball sampling in order to reach the targeted psychologists who have experience with different trauma types and knowledge about different theoretical orientations. The participants also represented different but comparable demographic characteristics in terms of their sex, age, marital status, working conditions, clinical practice and theoretical orientation.

Out of the 7 participants which constituted the sample of the qualitative part of the research (N=7), 5 were females and 2 were males. The ages of the participants ranged from 29 to 46, with a mean of 38.43 years (SD = 6.106). In terms of marital status, 3 of the participants were single, 2 were divorced with no child, and 2 were married with two children. In terms of education, out of the 7 participants, 1 had bachelors degree on psychology, 2 had M.A Degree on clinical psychology, 1 had Master Degree on art therapy and 3 had Ph.D on clinical psychology. Only 1 participant is employed by state, the other 6 participants work in private practice while 2 of them also work for non-govenmental organizations in parallel to their private practice. Out of 7 participant psychologists, 3 work as academician 2 of whom are also supervisors.

Considering the fact that the clinical society in İstanbul is narrow and furthermore the society of the specialized trauma field psychologists in İstanbul is narrower, protecting anonymity and confidentiality is a duty to be defined as one of the major concerns and responsibilities of the researcher. In order to keep the participants' anonymity as much as possible, the participants who constituted the sample would only be numbered, like P1, P2 and so on. It was intentionally and meticulously avoided to give even code-names or nicknames to the participants in order to be able to prevent any probable misassociations or misattributions of the readers.

Psychologist 1 (P1) is a 29-year-old female, single. She has a bachelors degree on psychology and master degree on art therapy. She has been working at various hospitals for 7 years, beginning of her professional career. She works at child oncology service where she works with cancered children as well as with their families, especially with the ones in the terminal term of the illness. She also works with children and adults who have chronic diseases as well as with whom operations or treatment processes are traumatic such as scoliosis, MS, Huntington Disease, HIV, traffic accidents, burns etc. In parallel to her work at these inpatient clinics, she works for the infertility clinic as well as outpatient psychiatry clinic in the same hospital. She uses art therapy techniques, she attended individual psychotherapy for herself as well as various group therapies. She gets supervision for the cases that she has hard time to work and to cope with.

Psychologist 2 (P2) is a 33-year-old female, divorced. She has M.A degrees both on social psychology and clinical psychology following her bachelors degree on psychology. She works for two distinct non-governmental organizations. She most frequently works with survivors of physical violence, sexual abuse, rape, torture, war

and terrorism. She works with refugee and immigrant adolescents and adults who have multiple losses and traumas. She is a psychoanalyticaly oriented psychotherapist. She regularly gets supervision for her trauma cases within the system of the organizations in which she employed. Besides, she attends individual psychotherapy for herself.

Psychologist 3 (P3) is a 38-year-old female, single. After she had her bachelors degree on psychology, she got her M.A degree on clinical psychology, then, she got her Ph.D on forensic psychology. She works as a lecturer for a university. In parallel to her academic work, she works at a private clinic as a psychotherapist. She also works as a coordinate for various projects in trauma field. She works with survivors of natural disasters, physial violence, sexual abuse, rape, neglect and multiple losses. She also also works with forensic cases. She attended individual psychotherapy in the past. She gets supervision as well as peervision when she needs while working with trauma cases. Her clinical practice is based on psychodynamically oriented theory and therapy techniques.

Psychologist 4 (P4) is a 46-year-old female, married with children. She has an M.A degree on clinical psychology, following her bachelors degree on psychology. She has been working for a non-gevernmental organization since the beginning of her professional career. In parallel to her almost totaly volunteer work with women survivors of physical violence, sexual abuse, rape and torture, she works at a private clinic as a psychotherapist and trainer. In the past, she also worked with children and adolescents who lives at streets and orphanages.

Psychologist 5 (P5) is a 39-year-old male, divorced. He has a Ph.D on clicinal psychology, M.A on clinical psychology following his bachelors degree on psychology. He works as a part-time instructor and a clinical supervisor in addition

to his private clinical practice. He most frequently works with multiple trauma survivors who have physical violence, sexual abuse, neglect and multiple losses history in their past. He works with individual adults as well as couples and families. He frequently works with relational traumas such as infidelity, separation or divorce. He also works with survivors of natural disasters. In terms of theoretical and practical orientation, he uses solution-focused systemic therapy, EMDR and cognitive-behavioral therapy, he also bases his practice on Conservation of Resources Theory.

Psychologist 6 (P6) is a 40-year-old female, single. She has Ph.D and M.A on clinical psychology following her bachelors degree on psychology. She works as a part-time instructor and a clinical supervisor in addition to her private clinical practice. She works both with individuals and groups. She works with both children and adolescents as well as adults. Most frequently, she works with survivors of complex traumas involving physical violence, sexual abuse, rape, neglect and relational traumas as well as survivors of natural disasters. She is also active in women's studies. She attends individual therapy as well as support groups. She regularly gets supervision and peervision. She works on the basis of cognitive-behavioral theory and therapy techniques as well as Gestalt approach.

Psychologist 7 (P7) is a 45-year-old male, married with children. He has a bachelors degree on psychology. He is a state employed, works for a child and juvenile center in which refugee and immigrant children and adolescents are sheltered and protected, together with the children who lost their families or who were left by their families. He also works for police station for specialized for childen for the cases of sexual abuse, physical violence and neglect. He did not specify any theoretical orientation as basis for his practice in the field. He can not get

and afford supervision, he can also no access for peervision despite his need for professional support while working with trauma.

2.2.2 Instruments

As a part of the qualitative research method, semi-structured interviews were used in order to provide richer and deeper understanding to describe the potential protective factors as well as risk factors which may be involved in the professionals' experience of vicarious traumatization. The interviews were held in a semi-structured flow on the basis of 21 guiding questions (see Appendix 8). Most of these guiding questions were open-ended in order to be able to stimulate conversation and encourage authentic responses. Despite the fact that the flow of the research interview questions were standard for all the participants, additional questions were asked spontaneously to give participants the opportunity to fully convey their experiences, qualifying and clarifying their responses.

The flow of the research interview questions were organized in three segments, namely, warm-up phase, research-focused working phase and closure phase. The questions in the warm-up phase were related to the subjects' profession, working conditions, reasons, meaning or mission behind their career choice, and the costs as well as rewarding characteristics of their job. In the working phase of the interview, the research questions were regarded to the years of experience in trauma work, whether they had experienced any personal trauma, kinds of traumas that they mostly engaged in their caseload, as well as the kinds of traumas which they found most difficult to work with. The research questions essentially inquired whether the subjects' basic assumptions and beliefs toward self, others, and the world changed over time, as a result of having worked with trauma cases. Those who expressed any

kind of change in their cognitive schemas were requested to explain and elaborate those changes in detail. Additionally, their support systems and coping mechanisms were inquired through the closure phase of the interview. Finally, the subjects were asked whether they had anything else to address that they found important or meaningful about the research topic.

2.2.3 Data Collection Procedure

The qualitative data of the present study is based on in depth semi-structured interviews which were conducted with psychologists who identified themselves as professionals "working with psychological trauma" or "working in the trauma field". Before the data collection phase of the study was started, four pilot semi-structured interviews were conducted in order to test the flow of the questions, as well as to get feedback about the general frame of the interview. The pilot interviews were carried out with two policemen, one lawyer and one psychologist. The policemen and the lawyer were chosen on the basis of the fact that they are regularly exposed to trauma narrations and trauma cases as a natural part of their work. Hence, their experiences are not exactly similar but bear resemblence to those of mental health professionals' who work with trauma cases.

The participants with whom the reseach interviews were conducted were recruited among the subjects of the quantitative part of the research. The last page of the survey battery included an invitation to the qualitative part of the research; and those who completed the inventories and seperately sent their contact information to the researcher via e-mail indicating their willingness to be interviewed were identified as the participants of the qualitative phase of the research. Although the interviews were initially planned to be conducted with the representatives of all four

professional groups (namely, psychologists, social workers, psychiatrists and councelors), there was only one social worker who volunteered to participate in the interview phase of the research. All other volunteers were psychologists. So, the interview conducted with this social worker was excluded from the data in order to eliminate a probable confounding factor. The research interviews with seven psychologists (five females and two males) were used in the final qualitative data analysis. Other participants were selected from İstanbul, through purposive and snowball sampling in order to reach psychologists who have experience with different trauma types and knowledge about different theoretical orientations. They also represented different but comparable demographic characteristics.

The research interviews were conducted in Turkish. All the interviews were held by the researcher, recorded by a digital voice-recorder and transcribed verbatim by the researcher. The interviews took approximately 1 - 3 hours to carry out. Appointments were arranged with the volunteers on the phone or by e-mail. The interviews were conducted individually in a quiet and comfortable place. After a brief description of the interview process and an explanation about the purpose of the study were provided, their oral consents were re-confirmed for using a voice recorder. Necessity of having verbatim transcripts for the qualitative analysis of the content was explained as the rationale for using a recorder. Emphasing on the principle of confidentiality, it was ensured that records would be deleted after completion of the analyses. After a brief warming-up and ice-breaking talk, the interviews were held in a semi-structured flow on the basis of 21 guiding questions (see Appendix 3) most of which were open-ended questions. Despite the fact that the interview questions were same for all the participants, the open-ended nature of the questions served to stimulate conversation and guided the interview with probings.

These questions sometimes led to related further questions. Additional questions were asked spontaneously to give participants the opportunity to fully convey their experiences. This nature of semi-structured interview, giving space for spontaneity and authenticity, is one of the most enriching gains of qualitative methods.

2.2.4 Data Analysis Procedure

For qualitative data analysis, the transcribed interviews of the participants were analyzed by the help of a qualitative analysis software Atlas.ti Version 6.0, utilizing the constant comparative method, following certain steps. First of all, after the interviews were transcribed verbatim for each interviewee, as the initial step, each interview transcript was read in its entirety to gain understanding about the essence and meaning of the interviewee's experience. In the following step, each transcript was coded to indicate significant and relevant statements; more specifically, neutral but descriptive information, statements related to vicarious traumatization and risk factors, and those regarding self-care and protective factors that might have constituted resiliance for vicarious traumatization were identified. The statements which were found meaningful for further understanding of potential variables that might have served as mediators or moderators were also indicated and coded.

After codings were completed, the next step was composing a list of statements from the texts of the transcripts which were related to the vicarious traumatization phenomenon and were identified as essential components of the mental health professionals' trauma work experience. In parallel, major themes reflecting affects, cognitions and actions were labeled, and later both individual and group-common depictions of participants' expressions were developed in order for grasping the essence of their experience.

The whole qualitative data was coded by the researcher. To have an idea about reliability of the deriven categories and themes, the thesis advisor doublechecked the codings. Only minor differences were noticed, and those discords in coding or labeling processes were resolved either by discussing to reach an agreement or by adding a new label or theme. Integrating the minor and major themes revealed from the data, it was aimed to both conceptually and practically describe vicarious traumatization in terms of protective and risk factors.

CHAPTER 3

RESULTS

This chapter is composed of presentation of the results of the study in two sections. The first section, Results 1 presents the findings of quantitative part of the research and the second section, Results 2 presents the major and minor themes revealed through the qualitative part of the research.

3.1 Results 1

Results 1 is presented under seven subheadings. The first subheading is composed of preliminary analyses on the research data involving examination of missing values, skewness, normality, linearity and outliers. Under the second subheading, descriptive measures are presented in terms of means, standard deviations and reliabilities for research variables, namely for vicarious traumatization, burnout, coping style, perceived social support, workload (working hours of the participants), caseload (participants' total working hours specifically with trauma cases), experience years, special trauma training, access to any support, as well as spirituality, together with distribution of demographic variables such as sex, age, profession and education. The third subheading presents results of One-Way Analysis of Variance in order to test the differences between professions in terms of vicarious traumatization. The fourth subheading is composed of results of Pearson Correlation presenting the intercorrelations between research variables. Under the fifth subheading, the research variables associated with vicarious traumatization were examined through hierarchical multiple regression analyses in order to determine the significant predictors of vicarious traumatization as an outcome. The fifth subheading also presents mediation analysis in order to test the potentially mediator role of emotional

burnout between trauma caseload and vicarious traumatization. Additionally, the fifth subheading is composed of results of hierarchical multiple regression analysis in order to examine significant predictors of emotional burnout. The sixth subheading is moderation analysis involving hierarchical multiple regression analyses to examine whether the association between emotional burnout and vicarious traumatization is moderated by coping style as well as intensity of use of that coping style. The seventh and the last subheading presents Multivariate Analysis of Variance (MANOVA) which examines whether demographic variables, gender, age, and education predicts coping style.

3.1.1 Preliminary analyses

Before carrying out main statistical analyses, the data was examined for the presence of missing values, skewness, normality, linearity as well as for univariate and multivariate outliers by the help of Statistical Program for the Social Sciences (SPSS) version 17.0. After all variables (N=287) had been entered and randomly double-checked for the accuracy of data entrance, frequencies of research variables as well as the minimum and maximum values were checked in order to ensure that the scores were within the possible appropriate ranges.

During the test for outliers, no univariate outlier case was detected. There was only one case which was identified as a multivariate outlier, but it was not eliminated from the data set due to the theoretical and practical significance that it pointed out. The data set presented no problem in terms of normality, linearity and skewness.

Out of a total of 287 returned responses, 27 cases were totally removed from the data because of missing responses and incomplete surveys in that none of the

inventories of those cases were appropriately completed. The other missing variables which were defined within the limits of conservative-acceptable ratio were substituted by the mean value of that variable due to the fact that the percentage of missing values were less than %5. After the necessary eliminations, the main statistical analyses of the present study were run for the total sample of 260 participants.

3.1.2 Descriptive Measures

Descriptive statistical analyses were conducted in order to portray demographic variables and research variables.

The total sample of 260 mental health professionals who were working with trauma were composed of 174 (66.9%) females and 86 (33.1%) males, whose ages ranged from 23 to 69, with a mean of 37.05 years (SD = 8.23). Among these 260 participating mental health professionals, 116 (44.6%) were psychologists, 65 (25.0%) were social workers, 57 (21.9%) were psychiatrists and 22 (8.5%) were counselors. In terms of education, 126 (48.5%), 88 (33.8%) and 46 (17.7%) participants held bachelor's, master's and doctorate degrees, respectively. In order to see gender distribution of demographic variables see Table 1.

In terms of years in professional clinical experience, the participants reported to be working as mental health professionals for an average of 13.23 years (SD =7.882), ranging from 1 to 40 years in clinical field. But the participants' years of experience specifically in trauma field ranged from 1 to 35 with a mean of 11.40 years (SD =7.773).

Table 1. Gender Distribution of Education and Professional

	Gender					
	Female		Male		Total	
	N	Percent	N	Percent	N	Percent
Education						
BA	78	44.8%	48	55.8%	126	48.5%
MA	63	36.2%	25	29.1%	88	33.8%
PhD	33	19.0%	13	15.1%	46	17.7%
Professional						
Social Worker	34	19.5%	31	36.0%	65	25%
Psychologist	95	54.6%	21	24.4%	116	44.6%
Psychiatrist	31	17.8%	26	30.2%	57	21.9%
Psychological Counselor	14	8.0%	8	9.3%	22	8.5%
Total	174		86		260	

Total working hours of the participants, referred to as workload hereafter, ranged from 5 to 74 hours per week with a mean of 39.98 hours (SD=11.826). But the participants' total working hours specifically with trauma cases, referred to as caseload -ranged from 0 to 60 hours per week with a mean of 23.21 hours (SD=16.559). Out of total number of 260 final participants, 22 (8.46%) professionals reported that they were not working with any trauma cases at the moment of filling out the research survey despite the fact that they had previously and regularly worked with trauma in years.

Among all the participants who identified themselves as professionals working with trauma, 162 (62.3%) professionals reported that they had had no specific trauma training, while only 98 (37.7%) participants reported that they had received some training in the field of trauma. The number of participants who received support for their trauma work, especially for the complex cases to cope with, was 152 (58.5%) out of 260. Table 2 presents the sources of this support.

In terms of spirituality, 174 (66.9%) participants reported that they had a conviction. 136 of them specifically defined and explained the scope and essence of their conviction through the optional open-ended part of this question reporting what

kind of spiritual belief system they have as well as what kinds of reflections and effects it has on their lives.

Table 2. Distribution of Sources of Received Support According to Type of Professional

		Professional									
		Psy		Social Worker		Psychiatrist		Psy. Counselor		Total	
		N	Pct. (%)	N	Pct. %	N	Pct. %	N	Pct. %	N	Pct. %
Now, have any trauma case?	Y*	103	88.8	59	90.8	57	100	19	86.4	238	91.5
	N	13		6		0		3		22	
Specific trauma training	Y	59	50.9	12	18.5	17	29.8	10	45.5	98	37.7
	N	57		53		40		12		162	
Support from peers	Y	68	58.6	29	44.6	21	36.8	11	50	129	49.6
	N	48		36		36		11		131	
Support from supervision	Y	43	37.1	6	9.2	10	17.5	8	36.4	67	25.8
	N	73		59		47		14		193	
Support from therapy	Y	25	21.6	3	4.6	2	3.5	5	22.7	35	13.5
	N	91		62		55		17		225	
Support from family	Y	12	10.3	5	7.7	1	1.8	0	0	18	6.9
	N	104		60		56		22		242	
Support from friend	Y	17	14.7	4	6.2	3	5.3	2	9.1	26	10.0
	N	99		61		54		20		234	
Support from partner	Y	18	15.5	7	10.8	3	5.3	2	9.1	30	11.5
	N	98		58		54		20		230	
Access to any support	Y	80	69.0	34	52.3	24	42.1	14	63.6	152	58.5
	N	36		31		33		8		108	

*Y = Yes; N = No

Table 3 shows the means, standard deviations, and reliabilities of the measures used in the present study.

Table 3: Means, Standard Deviations, and Reliabilities of the Measures Used in Present Study

	N	M	SD	Min.	Max.	α
TABS Total	260	243.68	71.66	119	374	.98
Burnout Emotional	258	28.61	11.16	10	45	.97
Burnout Desensitization	258	10.24	3.90	5	34	.97
Burnout Self Accmp.	258	29.32	4.53	16	40	.81
Support Total	258	58.84	19.38	19	84	.97
Support Family	258	19.42	6.55	4	28	.96
Support Friend	258	20.30	6.52	5	28	.97
Support Sign. Intimate	258	19.12	8.05	4	28	.98
Coping Optimistic	256	7.95	2.78	1	15	.74
Coping Self Confident	256	12.90	4.60	2	21	.93
Coping Helpless	256	10.50	5.15	0	21	.86
Coping Submissive	256	7.32	2.91	0	14	.62
Coping Seeking Soc Sup	256	6.72	3.69	0	12	.91
Coping Active	256	27.57	10.00	4	47	.94
Coping Passive	256	17.82	7.36	3	35	.87
Trauma Past Total	260	1.71	1.63	0	7	-

Note: TABS total = TABS total scores, Burnout Emotional = emotional burnout subscale scores, Burnout Desensitization = burnout depersonalization and desensitization subscale scores, Burnout Self Accmp. = burnout personal accomplishment subscale scores, Support Total = perceived support total scores, Support Family =perceived support from family subscale scores, Support Friend = perceived support from friends subscale scores, Support Sign. Intimate = perceived support from significant intimate subscale scores, Coping Optimistic = optimistic coping style, Coping Self Confident = self confident coping style, Coping Helpless = help seeking coping style, Coping Submissive = submissive coping style, Coping Seeking Soc Sup = social support coping style, Coping Active = active coping style, Coping Passive = passive coping style, Trauma Past Total = total number of traumatic events in the professionals' personal past history.

The total scores of Trauma Attachment Belief Scale (TABS total) were calculated through summation of the raw scores of the respondents' answers. 21 questions were recoded reversely. The TABS total scores which reflect vicarious traumatization severity of the professionals were used in the statistical analyses as the dependent variable. TABS total scores of 260 participants ranged between 119 and 374 with M = 243.68, SD = 71.66. Despite the fact that the categorical levels of TABS total scores were not used in the analysis, they are presented below (see Table 4) in order to provide a general idea about the distribution of vicarious traumatization

levels on the basis of the original cut-off points for TABS total scores as presented in the TABS Manual (Pearlman, 2003).

Table 4: Distribution of TABS total scores according to original cut-off points

Cut-off points	N	Pct.	Cum. Pct.
1= Extremely low = 90-110 (very little disruption)	0	0%	0%
2= Very low = 111-141	13	5.0%	5.0%
3= Low average = 142-159	21	8.1%	13.1%
4= Average = 160-209	70	26.9%	40.0%
5= High Average = 210-230	22	8.5%	48.5%
6= Very high = 231-284	33	12.7%	61.2%
7= Extremely high = 285-323+ (substantial disruption)	101	38.8%	100.0%
Total	260	100.0%	

Before conducting further statistical analyses, a t-test was conducted in order to see whether there was any difference in terms of source of the data collection (online versus paper and pencil) between the vicarious traumatization levels as measured by TABS Total scores.Additionally, one-way independent measures ANOVAs were conducted in order to compare five counterbalanced versions of the research data battery. To begin with, no significant difference was found between five versions of the research data collection batteries which were counterbalanced in order to test whether there was any effect of the order of the inventories on the measured variables. Similarly, with respect to the source of the data collection process, the t-test revealed that there was no significant difference between groups of participants from whom data were collected through online system or directly by the help of paper and pencil.

3.1.3 Results of One-Way Analysis of Variance

Hypothesis 1: It was hypothesized that there would be significant differences between the different groups of profession in terms of level of vicarious traumatization.

Hypothesis 2: It was hypothesized that social workers would be found to have the highest level of vicarious traumatization among the four groups of profession.

The differences between professions in terms of vicarious traumatization was tested by a between subjects One-Way Analysis of Variance (ANOVA) in which profession was treated as the independent variable and vicarious traumatization, the TABS Total scores was treated as the dependent variable. Results revealed a significant main effect for profession, $F(3, 256) = 3.64$, $p < .05$. In other words, a significant difference in vicarious traumatization levels was found between the different groups of profession. More specifically, social workers were found to have the highest level of vicarious traumatization among the four groups of profession while psychological counselors showed the lowest level. Results of pairwise comparisons, by the help of post-hoc tests, revealed that social workers had higher TABS total scores than psychologists. Psychiatrists showed slightly more intense vicarious traumatization than psychologists, however, the difference was not significant. The other groups of profession did not display any specific significant differences on pairwise comparisons (See Table 5).

Table 5. Distribution of TABS Total Scores with Respect to Professions

Profession	N	M	SD
Psychologists	116	230.8	73.32
Social Workers	65	260.1	68.37
Psychiatrists	57	257.8	68.34
Psychological Counselors	22	226.7	67.90
Total	260	243.7	71.66

3.1.4 Results of Pearson Correlation

Hypothesis 3: It was hypothesized that there would be a significant negative correlation between formal education of the professionals and level of vicarious traumatization.

Hypothesis 4: It was hypothesized that there would be a significant negative correlation between having a special training on trauma field and level of vicarious traumatization.

Hypothesis 5: It was hypothesized that there would be a significant positive correlation between experience years in clinical field and level of vicarious traumatization.

Hypothesis 6: It was hypothesized that there would be a significant positive correlation between experience years in trauma field and level of vicarious traumatization.

Hypothesis 7: It was hypothesized that there would be a significant positive correlation between workload and level of vicarious traumatization.

Hypothesis 8: It was hypothesized that there would be a significant positive correlation between caseload and level of vicarious traumatization.

Hypothesis 9: It was hypothesized that there would be a significant positive correlation between emotional burnout, desensitization-depersonalization levels of professionals and level of vicarious traumatization while a significant negative correlation between personal accomplishment level of professionals and level of vicarious traumatization.

Hypothesis 10: It was hypothesized that there would be a significant negative correlation between perceived social support and vicarious traumatization.

Hypothesis 11: It was hypothesized that there would be a significant negative correlation between active coping style of the professionals and level of vicarious traumatization while a significant and positive correlation between passive coping style of the professionals and level of vicarious traumatization.

Hypothesis 12: It was hypothesized that there would be a significant negative correlation between the number of traumatic events in the past life history of the professionals and level of vicarious traumatization.

Pearson Correlation Coefficient was computed in order to examine the relationships among the variables used in the study. The correlations among variables are presented in Table 6.

As can be seen in the Zero Order Correlation Table (Table 6), both formal education of the participants (r = -0.35, p<.01) as well as special training on trauma work (r = -0.47, p<.01) were negatively and significantly correlated with the TABS total scores, representing the level of vicarious traumatization. As education and training level increased, vicarious traumatization severity significantly decreased, pointing out the probable protective function of education and training against vicarious traumatization.

Vicarious traumatization, TABS Total scores were also found to be positively and significantly correlated with experience years in clinical field (r = 0.22, p<.01) and experience years in trauma field (r = 0.40, p<.01) as well as workload, referring total working hours per week (r = 0.37, p<.01) and caseload, referring total working hours engaged with trauma cases per week (r = 0.64, p<.01). In other words, as the exposure to trauma work increased, the severity of vicarious traumatization was also increased.

The intercorrelations among research variables which are prerequisite for further regression analyses were found to be highly significant. Of particular interest, TABS Total scores were found to be significantly correlated with burnout with significant and strong positive correlations with emotional burnout (r = 0.86, p<.01). The other subscales of burnout were also found to be significantly correlated with TABS Total scores that TABS Total score was positively associated with desensitization and depersonalization (r = 0.70, p<.01) subscales of burnout measure while it was negatively associated with personal accomplishment (r = -0.68, p<.01) subscale. As the overall level of burnout increased, vicarious traumatization also increased.

Perceived social support was found to be negatively and significantly correlated with vicarious traumatization. There was a negative significant correlation between TABS Total scores and support total scores (r = -0.74, p<.01) as well as TABS Total scores and all the subscales of the perceived social support measure; family support (r = -0.67, p<.01), friend support (r = -0.72, p<.01) and support of a significant intimate (r = -0.65, p<.01). So, support can be defined among the probable protective factors against vicarious traumatization of the professionals who work in the field of trauma.

In terms of ways of coping strategies, in general, TABS Total scores of the professionals were found to be negatively and significantly correlated with active coping style (r = -0.78, p<.01) and positively and significantly with passive coping style (r = 0.64, p<.01).More specifically, TABS Total scores werenegatively and significantly correlated with optimistic approach (r = -0.64, p<.01), self-confident approach (r = -0.75, p<.01), and seeking social support approach (r = -0.71,

$p<.01$)and which were the subscales that constituted active coping style; while they were

Table 6. Zero Order Correlation Matrix

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
1.Tabs.Total	1																	
2.Experience years in clinical field	.217 (.000)	1																
3.Experience years in trauma field	.404 (.000)	.757 (.000)	1															
4. Total working hours per week	.369 (.000)	.135 (.029)	.222 (.001)	1														
5. Trauma cases per week, hours	.640 (.000)	.298 (.000)	.431 (.000)	.396 (.000)	1													
6. Burnout Emotional	.857 (.000)	.262 (.000)	.408 (.000)	.456 (.000)	.691 (.000)	1												
7. Burnout Desensitization	.702 (.000)	.158 (.011)	.256 (.000)	.365 (.000)	.600 (.000)	.780 (.000)	1											
8. Burnout Personal accomp.	-.680 (.000)	-.049 (.430)	-.172 (.008)	-.283 (.000)	-.410 (.000)	-.689 (.000)	-.610 (.000)	1										
9. Support Total	-.738 (.000)	-.258 (.000)	-.407 (.000)	-.327 (.000)	-.554 (.000)	-.709 (.000)	-.569 (.000)	.531 (.000)	1									
10. Support Family	-.669 (.000)	-.183 (.003)	-.322 (.000)	-.233 (.000)	-.480 (.000)	-.613 (.000)	-.465 (.000)	.455 (.000)	.898 (.000)	1								
11. Support Friend	-.717 (.000)	-.256 (.000)	-.404 (.000)	-.320 (.000)	-.519 (.000)	-.687 (.000)	-.543 (.000)	.517 (.000)	.920 (.000)	.753 (.000)	1							
12. Support Sign. Intimate	-.653 (.000)	-.264 (.000)	-.392 (.000)	-.340 (.000)	-.524 (.000)	-.654 (.000)	-.551 (.000)	.488 (.000)	.932 (.000)	.740 (.000)	.793 (.000)	1						
13. Coping Active	-.782 (.000)	-.259 (.000)	-.415 (.000)	-.341 (.000)	-.521 (.000)	-.725 (.000)	-.531 (.000)	.598 (.000)	.761 (.000)	.666 (.000)	.743 (.000)	.687 (.000)	1					
14. Coping Passive	.638 (.000)	.177 (.004)	.336 (.000)	.300 (.000)	.477 (.000)	.660 (.000)	.497 (.000)	-.405 (.000)	-.628 (.000)	-.538 (.000)	-.604 (.000)	-.585 (.000)	-.682 (.000)	1				
15. Coping Optimistic	.635 (.000)	-.179 (.004)	-.308 (.000)	-.249 (.000)	-.408 (.000)	-.568 (.000)	-.423 (.000)	.508 (.000)	.597 (.000)	.537 (.000)	.569 (.000)	.539 (.000)	.863 (.000)	-.497 (.000)	1			
16. Coping Self Confident	.747 (.000)	-.185 (.003)	-.348 (.000)	-.364 (.000)	-.469 (.000)	-.683 (.000)	-.496 (.000)	.602 (.000)	.701 (.000)	.623 (.000)	.673 (.000)	.635 (.000)	.956 (.000)	-.630 (.000)	.809 (.000)	1		
17. Coping Helpless	.702 (.000)	-.185 (.003)	.344 (.000)	.310 (.000)	.519 (.000)	.697 (.000)	.525 (.000)	-.439 (.000)	-.657 (.000)	-.581 (.000)	-.630 (.000)	-.598 (.000)	-.730 (.000)	.953 (.000)	-.570 (.000)	-.668 (.000)	1	
18. Coping Submissive	.371 (.000)	.120 (.055)	.242 (.000)	.209 (.001)	.287 (.000)	.437 (.000)	.329 (.000)	-.246 (.000)	-.426 (.000)	-.331 (.000)	-.413 (.000)	-.423 (.000)	-.432 (.000)	.843 (.000)	-.248 (.000)	-.411 (.000)	.641 (.000)	1
19. Coping Seeking Soc. Sup	-.710 (.000)	-.338 (.000)	-.463 (.000)	-.282 (.000)	-.519 (.000)	-.684 (.000)	-.501 (.000)	.488 (.000)	.737 (.000)	.623 (.000)	.746 (.000)	.663 (.000)	.663 (.000)	-.687 (.000)	.575 (.000)	.734 (.000)	-.715 (.000)	-.472 (.000)

positively and significantly correlated with helpless approach (r = 0.70, p<.01) and submissive approach (r = 0.37, p<.01) which were the subscales that constituted passive coping style. In sum, active coping style may be defined as one of the probable protective factors against vicarious traumatization while passive coping style may be among the probable risk factors for vicarious traumatization severity of the mental health professionals who work in the field of trauma.

Finally, trauma history of the professionals was found to be negatively and significantly correlated with vicarious traumatization (r = -0.33, p<.01). As the number of traumatic events in the past life history of the mental health professionals increased, severity of their vicarious traumatization decreased. Traumatic experiences of the professionals might have served as a vaccine, a kind of protection against vicarious traumatization.

3.1.5 Results of Hierarchical Multiple Regression

Examining the predictors of vicarious traumatization and testing the mediator role of emotional burnout in the relationship between caseload and vicarious traumatization were the main interests of the present study. As mentioned above, it was hypothesized that emotional burnout would be found as the most effective predictor of vicarious traumatization and would have a mediator role. Related to this, understanding the predictors of emotional burnout would have a critical importance in order to understand whole picture. So, examining predictors of emotional burnout was defined as one of the interests of the present study and because of the strong association between emotional burnout and vicarious traumatization, it was hypothesized that vicarious traumatization would be found as the most effective predictor of emotional burnout. A series of hierarchical multiple regression analyses

were conducted in order to test these hypotheses.

Before conducting major hierarchical multiple regression analyses of the research, underlying assumptions which must be met as the prerequisites for multiple regression analysis were checked. The essential assumptions are defined as (1) variable types are appropriate as quantitative and categorical; (2) nonzero variance of all research variables are met; (3) in terms of multicolinearity, no problem was detected, research variables' variance inflation factor (VIF) were found to beranged between 1.11 to 4.34, with tolerance ranged between .23 to .90; (4) homoscedasticity criterion was met; (5) normality distributed errors; (6) linearity; (7) independence of errors criterion was met with Durbin-Watson values which were 1,86 for vicarious traumatization and 1.81 for emotional burnout; (8) independent observations criterion was met, too.

In order to enter into the regression models, education category was transformed into two different dummy variables as MA degree and PhD degree, and BA degree was treated as base group. Similarly, profession category was transformed into three different dummy variables in order to enter into the regression model. The newly created groups were psychiatrist, social worker, and psychologist, while psychological counselor group was treated as base.

3.1.5.1. Results Concerning the Predictors of Vicarious Traumatization

Hypothesis 13: It was hypothesized that protective factors, namely, education, special trauma training, access to any support as well as perceived social support and active coping style would be negatively and significantly associated with vicarious traumatization while risk factors, namely, emotional burnout, workload, caseload and

passive coping style would be positively and significantly associated with vicarious traumatization.

Hypothesis 14: It was hypothesized that emotional burnout would be found to be the most effective predictor of vicarious traumatization.

A Hierarchical multiple regression analysis was conducted in order to examine the potential predictors of vicarious traumatization in terms of potential risk factors and protective factors. In regression analysis, workload which was composed of weekly-total working hours, caseload which was composed of weekly-total working hours engaged with trauma cases, emotional burnout, coping style, perceived social support and existence of traumatic experience in personal history of the mental health professional as well as descriptive demographic variables were tested hierarchically as major predictive variables. More specifically, in the model, the dependent variable was set as vicarious traumatization by the TABS Total scores and sex, age, education and profession were defined as the first cluster of predictive variables. In the next step, explanatory variables were set as the second cluster including specifically workload, caseload, existence of any trauma in the past of the professional, total number of past traumas in the past of the professional, years of experience in trauma field, coping style specifically in terms active and passive coping styles, any specific trauma field training, access to any kind of support as well as perceived total social support and finally spirituality meaning whether to have any conviction. Because of the positively strong correlation between TABS Total scores and emotional burnout scores, emotional burnout was entered in the third and the final cluster in the regression analysis.

When all the potentially predictive variables were hierarchically regressed on vicarious traumatization variable which was measured by and defined as TABS

total scores, the results indicated that demographic variables which were entered as the first cluster explained 25 % of the total variance with F (7, 228) = 11.988, p< .001. Among the demographic variables, age, education of mental health professional and her/his profession were found significantly associated with vicarious traumatization. More specifically, results revealed that firstly, vicarious traumatization increases as age increases; secondly, in terms of profession, only being psychiatrist compared to being psychological counselor found significantly associated with vicarious traumatization; finally, in terms of education, results indicated that vicarious traumatization decreases as the professionals' education level increases (See Table 7).

Table 7. Summary of Hierarchical Regression Model of Vicarious Traumatization

	R	Adj. R^2	ΔR^2	*B*	SE	β	t
Step 1	.52	.25					
Gender				6.81	9.33	.05	.73
Age				1.86	.54	.21	3.48**
Education							
MA				-49.94	10.44	-.32	-4.78***
PhD				-101.73	13.28	-.55	-7.66***
Profession							
Psychiatrist				64.84	17.77	.38	3.65***
Social worker				14.52	17.30	.09	.84
Psychologist				14.20	16.26	.10	.87
Step 2	.87	.74	.49***				
Gender				-2.34	5.85	-.02	-.40
Age				-.29	.45	-.03	-.64
Education							
MA				-17.25	6.71	-.11	-2.57*
PhD				-19.48	9.15	-.10	-2.13*
Profession							
Psychiatrist				28.17	11.15	.17	2.53*
Social worker				10.69	10.65	.07	1.00
Psychologist				14.06	10.06	.10	1.40
Workload				.15	.26	.02	.58
Caseload				.81	.22	.19	3.76***
Existence of past trauma				10.54	7.77	.07	1.36
Number of past trauma				-2.54	2.14	-.06	-1.19
Years of experience in trauma field				-.12	.51	-.01	-.24
Passive Coping Style				.81	.48	.08	1.69
Special trauma training				-6.24	6.27	-.04	-1.00

Table 7, *continued*

	R	Adj. R^2	ΔR^2	*B*	SE	β	t
Step 2, cont.							
Access to any support				-19.54	7.88	-.13	-2.48*
Spirituality				-9.17	5.33	-.06	-1.72
Active Coping Style				-2.68	.43	-.38	-6.24***
Perceived Social Support				-.62	.23	-.17	-2.65**
Step 3	.91	.81	.07***				
Gender				-.35	5.02	<-.01	-.07
Age				-.08	.39	-.01	-.20
Education							
MA				-13.46	5.77	-.09	-2.33*
PhD				-18.71	7.85	-.10	-2.38*
Profession							
Psychiatrist				23.03	9.58	.14	2.40*
Social worker				8.80	9.14	.05	.96
Psychologist				9.02	8.65	.06	1.04
Workload				-.25	.23	-.04	-1.12
Caseload				.17	.20	.04	.88
Existence of past trauma				8.90	6.67	.06	1.33
Number of past trauma				-1.27	1.84	-.03	-.69
Years of experience in trauma field				-.10	.44	-.01	-.23
Passive Coping Style				-.05	.42	-.01	-.11
Special trauma training				-3.09	5.39	-.02	-.57
Access to any support				-11.64	6.82	-.08	-1.71
Spirituality				-3.50	4.62	-.02	-.76
Active Coping Style				-1.74	.38	-.25	-4.54***
Perceived Social Support				-.39	.20	-.10	-1.90
Emotional Burnout				3.31	.37	.52	8.88***

*p < .05; **p < .01; ***p < .001

It was also revealed that the explanatory and descriptive variables which were entered in the second cluster predicted an additional 49% of the variance in the TABS total scores (with an increase to 74% in the total variance predicted), beyond the effects of demographic variables,$F(18, 217) = 37.89$, $p < .001$ ($F_{change}(11, 217) = 40.80$, $p<.001$). Among these variables, specifically, education and only one level of profession were again significantly predicted vicarious traumatization. Additionally, results also indicated that vicarious traumatization increases as the professionals' caseload increases. Finally, it was revealed that there is a negative association

between vicarious traumatization and access to any support, active coping style and perceived total social support.

In the third and the final cluster, emotional burnout was tested as a potential predictor. Emotional burnout was revealed to make a significant contribution with a 7 % increase in the total variance explained with F (19, 216) = 52.95, p< .001 (F_{change} (1, 216) = 78.93, p<.001) and to an increase to 81 % in the total variance predicted. In the last model, only education level, profession, active coping style and emotional burnout were found as statistically significant predictors of vicarious traumatization. Especially, emotional burnout was found to be the most effective predictor.

3.1.5.2 Results of Mediation Analysis

Hypothesis 15: It was hypothesized that emotional burnout would mediate the relationship between caseload and vicarious traumatization of the professionals.

The probable mediator was tested individually via mediation analysis method, recommended by Baron and Kenny (1986). To begin with, there must be significant relations among independent, dependent, and mediator variables as prerequisites of a mediation analysis. As depicted in Table 6 (Zero Order Correlation Matrix), there is a significant correlation between participants' caseloads, TABS Total scores and emotional burnout scores.

In the mediation analysis, emotional burnout was tested as the mediator between vicarious traumatization which was defined as dependent variable and caseload which was defined as predictor. More specifically, education, profession, access to any support, active coping style and perceived total social support were entered as control variables because they were found as significant predictors of

vicarious traumatization on the second step of previous hierarchical regression analysis of vicarious traumatization.

According to Baron and Kenny's (1986) suggested model, there are four criteria for mediation: (1) predictor variable must significantly predict the outcome variable; (2) the predictor variable must significantly predict the mediator; (3) the mediator must significantly predict the mediator; and (4) the predictor variable must predict the outcome variable less strongly after the mediator added to the model.

In order to test first criteria of mediation, a hierarchical multiple regression analysis was run. Control variables were entered in the first step of analyses and caseload was entered in the second step. Results indicated that caseload significantly predicts vicarious traumatization, $b = 0.94$, 95% CIs [0.57, 1.30], $t = 5.017$, $p < .001$. As caseload increases, the total score of vicarious traumatization increases, too. A new hierarchical multiple regression analysis was run to check the second criteria. In this analysis, the potential mediator, namely the emotional burnout was defined as outcome variable while control variables were again entered in the first step and caseload was entered in the second step. It was found that caseload significantly predicts emotional burnout, $b = 0.23$, 95% CIs [0.17, 0.29], $t = 7.211$, $p < .001$. To examine the last criteria for mediation, control variables were entered on the first step, and caseload was entered as independent variable on the second step while emotional burnout was entered as potential mediator on the third step. Results showed that emotional burnout predicts vicarious traumatization significantly, $b = 3.054$, 95% CIs [2.42, 3.69], $t = 9.474$, $p < .001$, while the effect of caseload is non-significant, $b = 0.24$, 95% CIs [-0.11, 0.59], $t = 1.360$, *ns*. So, the significant relationship between trauma caseload and vicarious traumatization became non-significant after emotional burnout was controlled (see Table 8). Thus, the results

Table 8. Summary of Hierarchical Regression Model that Examining Mediator Role of Emotional Burnout

Predictors	Adj. R^2	ΔR^2	ΔR	*B*	SE	β	t
Step 1	.71	.72	.72***				
Education							
MA				-19.28	6.43	-.13	-3.00**
PhD				-28.51	8.43	-.15	-3.38**
Profession							
Psychiatrist				37.09	10.49	.21	3.54**
Social worker				19.21	9.94	.12	1.93
Psychologist				22.24	9.24	.16	2.41*
Access to any support				-22.70	6.70	-.16	-3.39**
Active Coping Style				-3.27	.38	-.46	-8.53***
Perceived Social Support				-.95	.21	-.26	-4.57***
Step 2	.74	.03	.03***				
Education							
MA				-19.79	6.13	-.13	-3.23**
PhD				-23.11	8.12	-.12	-2.85**
Profession							
Psychiatrist				32.72	10.05	.19	3.26**
Social worker				10.12	9.66	.06	1.05
Psychologist				14.14	8.96	.10	1.58
Access to any support				-12.68	6.70	-.09	-1.89
Active Coping style				-3.02	.37	-.42	-8.18***
Perceived Social Support				-.78	.20	-.21	-3.87***
Caseload				.94	.19	.22	5.02***
Step 3	.81	.07	.07***				
Education							
MA				-16.65	5.27	-.11	-3.16**
PhD				-19.96	6.97	-.11	-2.87**
Profession							
Psychiatrist				19.62	8.72	.11	2.25*
Social worker				2.17	8.32	.01	.26
Psychologist				4.50	7.75	.03	.58
Access to any support				-7.36	5.77	-.05	-1.28
Active Coping Style				-1.90	.34	-.27	-5.63***
Perceived Social Support				-.39	.18	-.10	-2.17*
Caseload				.24	.18	.06	1.36ns
Emotional Burnout				3.05	.322	.48	9.47***

*p < .05; **p < .01; ***p < .001

indicated that emotional burnout fully mediates the relationship between caseload and vicarious traumatization (see Figure 1). As can be seen in Table 8, Sobel test results confirmed that significant decrease indicating the mediator role of emotional burnout.

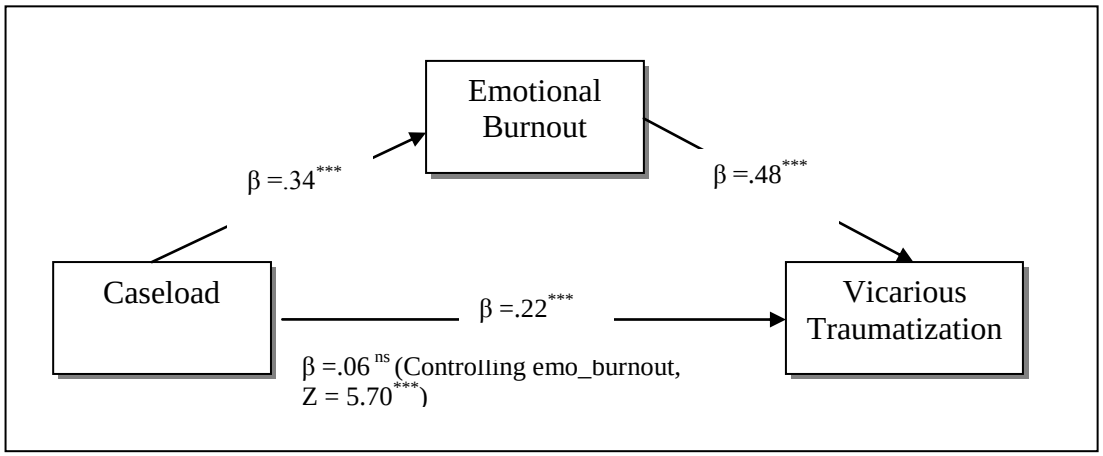

Figure 1. Regression of mediator on vicarious traumatization

3.1.5.3. Results Concerning the Predictors of Emotional Burnout

An additional hierarchical multiple regression analysis was conducted in order to be able detect potential protective and risk factors which tend to increase or decrease emotional burnout. In the model, again, workload, caseload, coping style, perceived social support and existence of traumatic experience in personal history of the mental health professional as well as descriptive demographic variables were tested hierarchically as major predictive variables. On the other hand, in this model, vicarious traumatization was tested as predictor instead of emotional burnout.

More specifically, the dependent variable was set as emotional burnout and sex, age, education and profession were defined as the first cluster of predictive variables. Then, explanatory variables were entered into the second cluster including

specifically workload, caseload, existence of any trauma in the past of the professional, total number of past traumas of the professional, years of experience in the field of trauma, coping style specifically in terms active and passive coping styles, any specific trauma field training, access to any kind of support as well as perceived total social support and finally spirituality. Because of the positively strong correlation between vicarious traumatization and emotional burnout scores, vicarious traumatization was entered in the third and the final cluster.

When all the potentially predictive variables were hierarchically regressed on emotional burnout variable the results revealed that demographic variables which were entered as the first cluster explained 18 % of the total variance with $F(7, 228) = 8.223$, $p < .001$. Similarly to the first regression analysis results, age, education and one type of profession was found significant predictors of emotional burnout in the first step. Mental health professionals' education level was negatively associated with emotional burnout while age and being psychiatrist compared to being psychological counselor was found to be positively associated with emotional burnout (See Table 9).

The explanatory and descriptive variables which were entered in the second cluster predicted an additional 56% of the variance in the emotional burnout scores (with an increase to 74% in the total variance predicted), beyond the demographic variables of the first step$F(18, 217) = 37.46$, $p < .001$ ($F_{\text{change}}(11, 217) = 44.96$, $p<.001$). In the second step, demographic variables were not significant anymore. Instead, the mental health professionals' caseload, workload and passive coping style were found positively associated with emotional burnout scores, while having a conviction and active coping style were found negatively associated with emotional burnout.

Table 9. Summary of Hierarchical Regression Model of Emotional Burnout

	R	Adj. R^2	ΔR^2	*B*	SE	β	t
Step 1	.45	.18					
Gender				.92	1.52	.04	.61
Age				.28	.09	.21	3.25**
Education							
MA				-6.24	1.70	-.26	-3.67***
PhD				-13.54	2.16	-.47	-6.27***
Profession							
Psychiatrist				8.93	2.89	.34	3.09**
Social worker				3.15	2.82	.12	1.12
Psychologist				3.13	2.65	.14	1.18
Step 2	.87	.74	.56***				
Gender				-.60	.92	-.03	-.66
Age				-.06	.07	-.05	-.91
Education							
MA				-1.15	1.05	-.05	-1.09
PhD				-.23	1.43	-.01	-.16
Profession							
Psychiatrist				1.55	1.74	.06	.89
Social worker				.57	1.67	.02	.34
Psychologist				1.52	1.57	.07	.97
Workload				.12	.04	.12	3.01**
Caseload				.19	.03	.29	5.70***
Existence of past trauma				.50	1.22	.02	.41
Number of past trauma				-.38	.33	-.06	-1.14
Years of experience in trauma field				-.01	.08	<-.01	-.08
Passive Coping Style				.26	.08	.17	3.45**
Special trauma training				-.95	.98	-.04	-.97
Access to any support				-2.39	1.23	-.11	-1.94
Spirituality				-1.71	.834	-.07	-2.06*
Active Coping Style				-.28	.07	-.26	-4.23***
Perceived Social Support				-.07	.04	-.12	-1.95
Step 3	.91	.81	.07***				
Gender				-.41	.79	-.02	-.53
Age				-.04	.06	-.03	-.67
Education							
MA				.25	.91	.01	.27
PhD				1.34	1.24	.05	1.08
Professional							
Psychiatrist				-.73	1.52	-.03	-.48
Social worker				-.29	1.43	-.01	-.20
Psychologist				.39	1.36	.02	.29
Workload				.11	.04	.11	3.16**
Caseload				.13	.03	.19	4.25***
Existence of past trauma				-.36	1.05	-.01	-.34
Number of past trauma				-.18	.29	-.03	-.62
Years of experience in trauma field				<-.01	.07	<-.01	.06
Passive Coping Style				.19	.06	.13	2.98**
Special trauma training				-.45	.84	-.02	-.53
Access to any support				-.81	1.07	-.04	-.75
Spirituality				-.97	.72	-.04	-1.35
Active Coping Style				-.07	.06	-.06	-1.08
Perceived Social Support				-.02	.03	-.04	-.66
Vicarious Traumatization				.08	.01	.52	8.88***

*p < .05; **p < .01; ***p < .001

In the third and the final cluster of the second regression analysis, vicarious traumatization was entered and tested as a potential predictor. Vicarious traumatization was revealed to make a significant contribution with a 7 % increase in the total variance explained with F (19, 216) = 52.38, p< .001 (F_{change} (1, 216) = 78.93, p<.001) and to an increase to 81 % in the total variance predicted. In the last step, vicarious traumatization was found to be the most effective predictor. Results indicated that emotional burnout increases as vicarious traumatization increases. The other significant predictors of emotional burnout were found as mental health professionals' caseload, workload and passive coping style.

On the basis of the results of the previous regression, a more simplified regression model was tested for emotional burnout in order to be able to clearly portray the significant predictors of emotional burnout which were composed of workload, caseload, passive coping style and vicarious traumatization (See Table 10). The results revealed that the model was significant, explaining 80% of total variation of emotional burnout, F(4,251) = 243.49, p<.001.

Table 10. Summary of Simplified Multiple Regression Model of Emotional Burnout

	R	Adj. R^2	ΔR^2	*B*	SE	β	t
	.89	.79	.80				
Constant				-5.39	1.44		-3.74***
Workload				.11	.03	.11	3.57***
Caseload				.13	.03	.19	5.00***
Passive Coping Style				.24	.06	.16	4.26***
Vicarious Traumatization				.09	.01	.59	13.58***

***p < .001

3.1.6 Results of Moderation Analysis

Hypothesis 16: It was hypothesized that the association between emotional burnout and vicarious traumatization would be moderated by coping style of the professionals.

Two different hierarchical multiple regression models were tested in order to examine whether the association between emotional burnout and vicarious traumatization is moderated by coping style as well as intensity of use of that coping style. In the first regression model, the moderator role of passive coping style was tested, while the active coping style was tested as moderator in the second regression model. In both models, education, profession, caseload, perceived total social support and access to any support were entered as control variables because of their association with vicarious traumatization which had been found in previous regression analyses. In addition, active coping style used by the professionals was entered as control variable during the investigation of the passive coping style's effect as moderator. In both models, before conducting the moderation analysis, both predictor variable (emotional burnout) and moderator variable (passive or active coping style) were centralized as suggested by Aiken and West (1991). Moreover, control variables which were continuously scaled were also centralized as suggested by Dawson (http://www.jeremydawson.co.uk/slopes.htm). Finally, in both model, the control variables were entered in the first cluster, the predictor and moderator variables were entered in the second cluster while the interaction term of centralized predictor and centralized moderator was entered in the final step.

Results of the first model in which passive coping style was tested as moderator, indicated that emotional burnout (the predictor) (b = 2.85, SEb = .34, β = 44, p< .001) was associated with higher vicarious traumatization, while main effect

of passive coping style (moderator) (b = .14, SEb = .40, β = 01, ns) had not revealed a statistically significant effect. Results revealed that the effect of interaction between emotional burnout and coping passive (moderator) was also significant (b = -.07, SEb = .03, β = -.07, p< .05), suggesting that the effect of emotional burnout on vicarious traumatization depended on the amount of the use of passive coping style. Results also indicated that variables in the second cluster (without interaction) explained 81% of the total variance in the vicarious traumatization scores, $F(11, 255) = 97.68$, $p < .001$. It was found that last model was still explained the 81% of the total variance in vicarious traumatization scores after interaction term was added to the model, $F(12, 255) = 91.50$, $p < .001$ with a significant F_{change}between two models$F_{\text{change}}(1, 243) = 5.17$, p<.05). Effects of control variables on vicarious traumatization can be seen in Table 11.

More specifically, the simple slope tests for the association between emotional burnout and vicarious traumatization were run for low (-1 SD below the mean) and high (+1 SD above the mean) levels (amounts of use) of passive coping style scores. Simple slope test results revealed that a positive relationship between emotional burnout and vicarious traumatization was significant for both high level of passive coping style, $t(243)= 7.425$, $p< .001$ and low level of passive coping style, $t(243) = 7.889$, $p< .001$. As seen in Figure 2, low level of emotional burnout leads more vicarious traumatization in high level of passive coping style than low level. On the other hand, high level of emotional burnout leads less vicarious traumatization in high level of passive coping style than low level.

Table 11. Summary of Hierarchical Regression Model that Examining Moderator Role of Passive Coping Style

	R	Adj. R^2	ΔR^2	*B*	SE	β	t
Step 1	.86	.74					
Education							
MA				-19.79	6.13	-.13	-3.23**
PhD				-23.11	8,12	-.12	-2.85**
Professional							
Psychiatrist				32.72	10.05	.19	3.26**
Social worker				10.12	9.66	.06	1.05
Psychologist				14.14	8.96	.10	1.58
Caseload				.94	.19	.22	5.02***
Access to any support				-12.68	6.70	-.09	1.89
Perceived Social Support				-.78	.20	-.21	-3.87***
Active Coping Style				-3.020	.37	-.42	-8.18***
Step 2	.90	.81	.07***				
Education							
MA				-16.58	5.30	-.11	-3.13**
PhD				-19.89	6.99	-.11	-2.84**
Professional							
Psychiatrist				19.61	8.74	.11	2.24*
Social worker				2.18	8.34	.01	.26
Psychologist				4.53	7.77	.03	.58
Caseload				.24	.18	.06	1.36
Access to any support				-7.45	5.81	-.05	-1.28
Perceived Social Support				-.39	.18	-.11	-2.17*
Active Coping Style				-.1.92	.35	-.27	-5.45***
Passive Coping Style				-.06	.40	-.01	-.16
Emotional Burnout				3.07	.33	.48	9.25***
Step 3	.91	.81	<.01*				
Education							
MA				-17.69	5.28	-.18	-3.35**
PhD				-20.65	6.94	-11	-2.98**
Professional							
Psychiatrist				19.37	8.67	.11	2.24**
Social worker				2.01	8.27	.01	.24
Psychologist				5.14	7.71	.04	.67
Caseload				.33	.18	.08	1.84
Access to any support				-8.48	5.78	-.06	-1.47
Perceived Social Support				-.41	.18	-.11	-2.30*
Active Coping Style				-1.97	.35	-.28	-5.62***
Passive Coping Style				.14	.40	.01	.34
Emotional Burnout				2.85	.34	.44	8.32***
E_burnout X Pas. Cop.				-.07	.03	-.07	-2.27*

*p < .05; **p < .01; ***p < .001

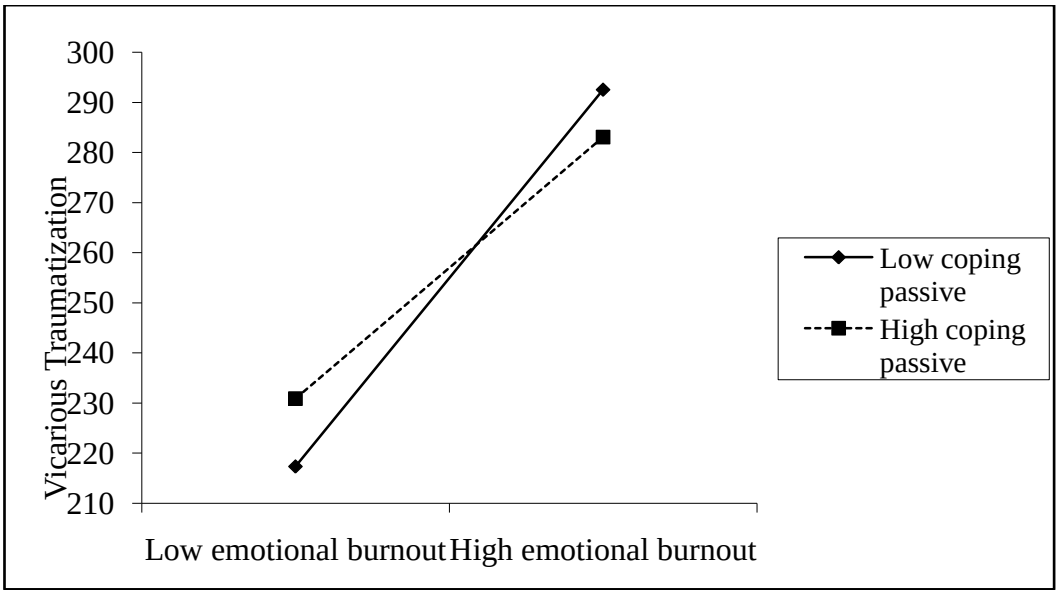

Figure 2. Graph for interaction between emotional burnout and passive coping style

In the second model, active coping style was tested as moderator. Emotional burnout (the predictor) (b = 2.83, SEb = .34, β = 44, p< .001) was again significantly associated with higher vicarious traumatization. Results additionally showed that active coping style (the moderator) (b = -1.99, SEb = .34, β = -.28, p< .001) was associated with low vicarious traumatization.

Finally, results indicated that the effect of emotional burnout on vicarious traumatization was also moderated by the amount of use of active coping style; the interaction between emotional burnout and active coping style (b = .05, SEb = .02, β = .07, p< .05) was statistically significant. Parallel to the first regression analysis results, both the second (without interaction) and the last model (with interaction) explained the 81% of total variance in vicarious traumatization scores (F(10, 255) = 107.87, p < .001; F(11, 255) = 100.11, p < .001, respectively). The F_{change} between two model was found as significant, too, F_{change} (1, 244) = 4.98, p<.05. As can be seen in Table 12, the significant effect of the control variables on vicarious traumatization did not change between two models, although there were some minor

changes on the standardized coefficients of the control variables between two models.

Table12. Summary of Hierarchical Regression Model that Examining Moderator Role of Active Coping Style

	R	Adj. R^2	ΔR^2	*B*	SE	β	t
Step 1	.82	.67					
Education							
MA				-16.70	6.89	-.11	-2.22*
PhD				-23.00	9.13	-.12	-2.52*
Professional							
Psychiatrist				30.11	11.30	.17	2.66**
Social worker				3.66	10.83	.02	.34
Psychologist				7.39	10.05	.05	.74
Caseload				1.14	.21	.27	5.49***
Any Support				-21.28	7.45	-.15	-2.86**
Support Total				-1.74	.19	-.47	-9.37***
Step 2	.90	.81	.14***				
Education							
MA				-16.65	5.27	-.11	-3.16**
PhD				-19.96	6.97	-.11	-2.87**
Professional							
Psychiatrist				19.61	8.72	.11	2.25*
Social worker				2.17	8.32	.01	.26
Psychologist				4.50	7.75	.03	.58
Caseload				.24	.18	.06	1.36
Any Support				-7.36	5.77	-.05	-1.28
Support Total				-.39	.18	-.10	-2.17*
Coping.Active				-.1.90	.33	-.27	-5.63***
Emotional Burnout				3.05	.32	.48	9.47***
Step 3	.91	.81	<.01*				
Education							
MA				-16.78	5.23	-.11	-3.21**
PhD				-19.30	6.92	-10	-2.79**
Professional							
Psychiatrist				18.78	8.66	.11	2.19*
Social worker				.98	8.27	.01	.12
Psychologist				4.20	7.69	.03	.55
Caseload				.35	.18	.08	1.92
Any Support				-8.86	5.76	-.06	-1.54
Support Total				-.44	.18	-.12	-2.47*
Coping.Active				-1.99	.34	-.28	-5.90***
Emotional Burnout				2.83	.34	.44	8.45***
E_burnout X Cop. Act.				.05	.02	.07	2.32*

*p < .05; **p < .01; ***p < .001

Simple slope tests for the association between emotional burnout and vicarious traumatization were conducted for low (-1 SD below the mean) and high

(+1 SD above the mean) levels (amounts of use) of active coping style scores. Simple slope test results indicated that a positive relationship between emotional burnout and vicarious traumatization was significant for both high level of active coping style, $t(244)= 8.916$, $p< .001$ and low level of active coping style, $t(244) = 8.723$, $p< .001$. As can be seen in Figure 3, in both level of emotional burnout, high level of active coping style leads less vicarious traumatization than low level. However, probable protective effect of active coping style seemed more obvious in low level of emotional burnout.

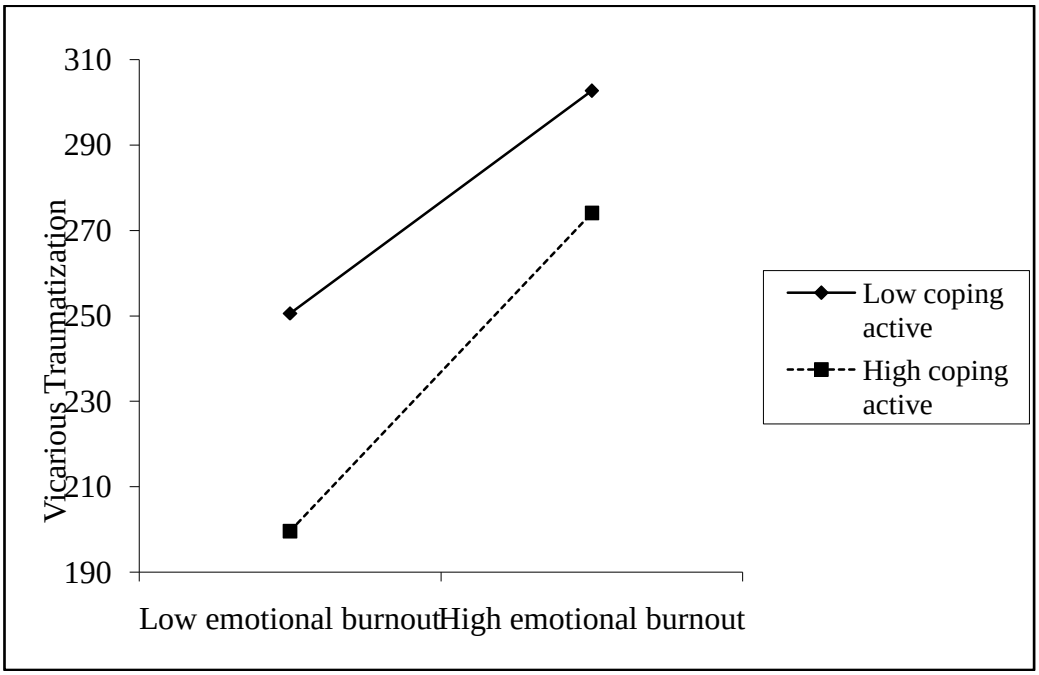

Figure 3. Graph for interaction between emotional burnout and active coping style

3.1.7 Results of Multivariate Analysis of Variance

Hypothesis 17: It was hypothesized that demographic variables, gender, age, and education and their interactions would have effect on both coping style.

A Factorial between subjects Multivariate Analysis of Variance (MANOVA) was performed in order to examine effect of gender (male and female),

age (equal or less than 37 and more than 37), and education (BA, MA, and PhD degree) on mental health professional's coping style. As can be seen Table 6, there is a moderate negative correlation (r = -0.68, p<.001) between coping active and coping passive scores. In order to control Type Ierror, MANOVA was conducted instead of two separate ANOVAs on each dependent variable. Prior to analysis, age variable was converted into two categories with respect to median of age variable and it was entered into the model as two category (See Table 13).

Table 13. Means and Standard Deviations of Coping Styles by Gender, Age, and Education Categories

			Coping Active		Coping Passive	
		N	M	SD	M	SD
Gender	Female	171	28.9	8.88	17.1	6.88
	Male	85	24.8	11.52	19.4	8.07
Age	Less or equal to 37	127	30.8	8.29	15.9	6.13
	More than 37	129	24.4	10.56	19.7	7.97
Education	BA	124	25.4	10.50	18.9	8.50
	MA	86	28.2	9.03	17.7	6.26
	PhD	46	32.3	8.66	15.1	4.99
Total		256	27.6	10.00	17.8	7.4

Box's M (44.92) results (p = .143) indicated that there was not significant difference between the covariance matrices of dependent variables. Thus, homogeneity of covariance matrices assumption of MANOVA was confirmed. With the use of Wilks' criterion, the combined DVs were significantly affected by both age, F(2,243) = 12.12, p< .001 and education, F(4,286) = 3.50, p< .01, but not by gender, F(2,243) = 0.24, *ns.* In terms of two-way interactions between three independent variable, both interaction between gender and age, F(2,243) = 6.64, p< .01 and interaction between age and education, F(4,486) = 2.77, p< .05 have a significant effect on combined DVs, while it was not significantly affected by

interaction between gender and education, $F(4,486) = 0.60$, *ns*. Additionally, results indicated that effect of three-way interaction between gender, age, and education was not significant on combined DVs, $F(4,486) = 0.15$, *ns* (See Table 14).

Table 14. MANOVA of Dimensions of Coping Style by Gender, Age, and Education

	Wilks' λ	F	df	Error df	η	Observed power
Gender	.998	0.240	2	243	<.01	.09
Age	.909	12.123***	2	243	.09	.99
Education	.945	3.496**	4	486	.03	.86
Gender * Age	.948	6.635**	2	243	.05	.91
Gender * Education	.990	0.604	4	486	.01	.20
Age * Education	.956	2.771*	4	486	.02	.76
Gender * Age * Education	.998	0.151	4	486	<.01	.08

*** p< .001; ** p <.01; * p < .05

Two separate Factorial between subjects ANOVAs on each of the two dependent variables were conducted as follow-up tests to the MANOVA. Prior to conducting ANOVAs, the homogeneity of variance assumption was tested for passive coping style and active coping style variables. Homogeneity of variance was not significant for active coping style, *Levene's* $F(11, 244) = 1.54$, *ns*, while it is significant for passive coping style, *Levene's* $F(11, 244) = 3.73$, $p < .001$ indicating that the assumption underlying the application of ANOVA was not met for passive coping style variable. As can be seen in Table 13, none of the largest standard deviations were more than four times the size of the smallest, so it was decided that ANOVA would be robust in this case (Howell, 2007). As can be seen in Table 15, age has a significant main effect on both active coping style, $F(1, 244) = 23.20$, $p < .001$ and passive coping style, $F(1, 244) = 14.76$, $p < .001$. Results indicated that coping active scores of older group ($M = 24.4$, $SD = 10.56$) is less than younger group's coping active scores ($M = 30.8$, $SD = 8.29$), while their coping passive scores ($M = 19.7$, $SD = 7.97$) are higher than coping passive scores of younger group ($M =$

15.9, *SD* = 6.13). Results showed that education has a significant main effect on active coping style, $F(2, 244) = 6.70$, $p < .01$, while its effect on passive coping style was non-significant, $F(2, 244) = 1.89$, *ns.* Post-hoc comparisons using Tukey's HSD test revealed active coping styles of mental health professionals who has PhD degree (*M* = 32.3, *SD* = 8.66) was significantly higher than all other groups. Tukey's HSD test indicated that there is no significant difference between coping active scores of professionals who has MA degree (*M* = 28.2, *SD* = 9.03) and professionals who has BA degree (*M* = 25.4, *SD* = 10.50).

Table 15. Summary of ANOVA Result

	SS	Df	MS	F	η	Observed power
Coping Active						
Gender	38.18	1	38.18	0.46	<.01	.10
Age	1926.14	1	1926.14	23.20***	.09	.99
Education	1162.20	2	581.10	6.70**	.05	.93
Gender * Age	574.70	1	574.70	6.92**	.03	.75
Gender * Education	54.56	2	27.28	0.33	<.01	.10
Age * Education	26.52	2	13.26	0.16	<.01	.08
Gender * Age * Education	8.92	2	4.46	0.05	<.01	.06
Error	20259.43	244	83.03			
Total	25510.87	255				
Coping Passive						
Gender	4.25	1	4.25	0.09	<.01	.06
Age	665.26	1	665.26	14.76***	.06	.97
Education	170.62	2	85.31	1.89	.02	.39
Gender * Age	590.25	1	590.25	13.10***	.05	.95
Gender * Education	45.72	2	22.86	0.51	<.01	.13
Age * Education	388.16	2	194.08	4.31*	.03	.75
Gender * Age * Education	15.89	2	7.946	0.18	<.01	.08
Error	10997.00	244	45.07			
Total	13813.09	255				

***p< .001; **p <.01; *p < .05

Results indicated that the interaction between gender and age has a significant effect on both active coping style, $F(1, 244) = 6.92$, $p < .01$ and passive coping style, $F(1, 244) = 13.10$, $p < .001$. However, the interaction between age and education has a significant effect on passive coping style, $F(2, 244) = 4.31$, $p < .05$;

while its effect on active coping style is not significant, $F(2, 244) = 0.16$, *ns.* More specifically, results indicated that younger and older females have similar active ($M = 30.2$, $SD = 7.85$; $M = 27.0$, $SD = 9.96$, respectively) and passive coping scores ($M = 16.7$, $SD = 6.06$; $M = 17.8$, $SD = 7.97$, respectively), while younger males' coping active score ($M = 33.0$, $SD = 9.76$) more than older males' coping active score ($M = 21.4$, $SD = 10.51$) and their coping passive scores ($M = 12.5$, $SD = 5.30$) were less than older males' coping passive scores ($M = 22.2$, $SD = 7.26$) (See Figure 4 and Figure 5).

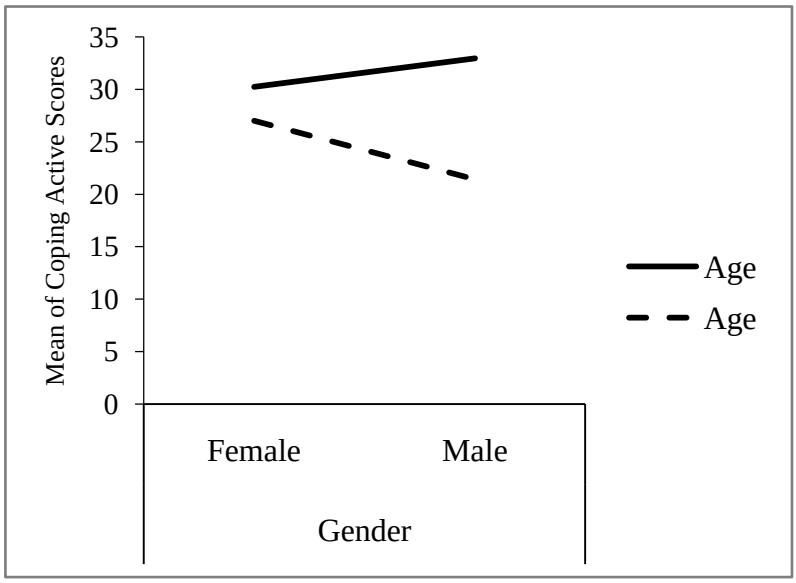

Figure 4. Interaction between gender and age on active coping style

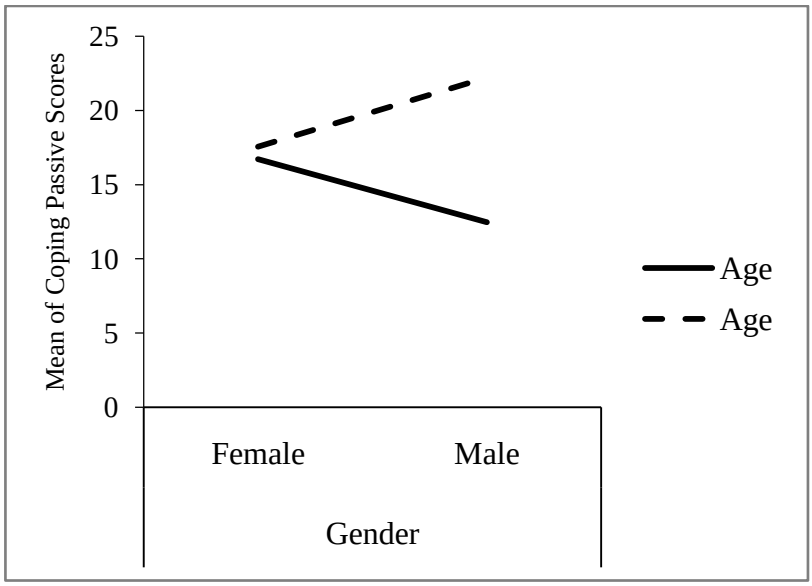

Figure 5. Interaction between gender and age on passive coping style

Finally, as can be seen in Figure 6, coping passive scores were similar for younger mental health professionals who has BA degree (*M* = 15.5, *SD* = 7.14), MA degree (*M* = 16.4, *SD* = 5.50), and PhD degree (*M* = 15.8, *SD* = 4.58). On the other hand, for older professionals, coping passive scores decreases as education level increases. Thus, mental health professionals who has BA degree had highest coping passive score (*M* = 21.8, *SD* = 8.52), professionals who has PhD degree had lowest coping passive score (*M* = 14.7, *SD* = 5.32), and coping passive scores of professionals who has MA degree (*M* = 19.6, *SD* = 6.85) were between these two.

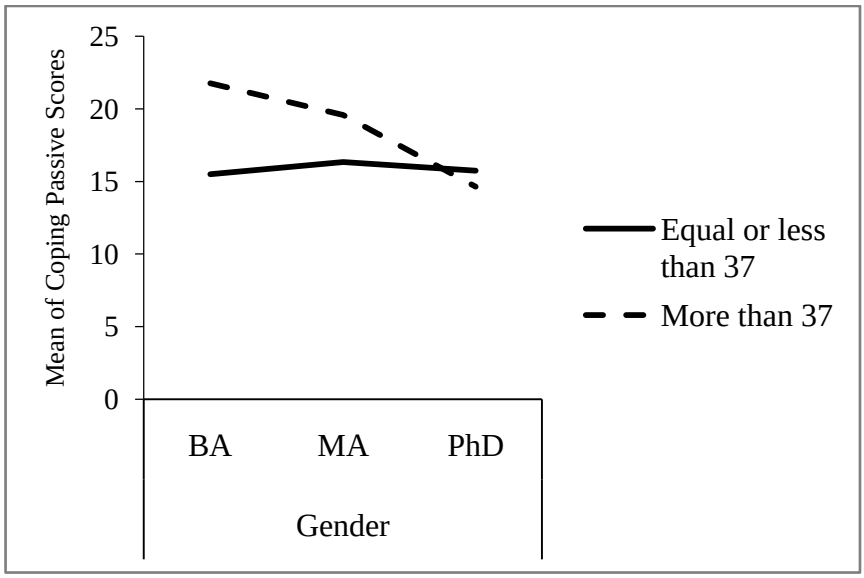

Figure 6. Interaction between age and education on passive coping style

3.2 Results 2

Results 2 is presented under four subheadings which were composed of the major themes emerged from the data, each of which composed of related minor themes. The first major theme is presented under the subheading of vicarious traumatization, involving adverse effects of working with trauma in terms of emotional, mental and physical adverse effects as well as changes in the professionals' worldview. Under the second subheading, vicarious posttraumatic growth is presented which was revealed unexpectedly, in terms of improving and transformative positive effects of working with trauma. The third and fourth subheadings present potential risk and protective factors which more or less determine both the direction and intensity of effects of working with trauma. Protective factors were constituted by the minor themes in terms of significance of education and special training on trauma field, importance of both clinical and life experience and age as both a professional and a human, significance of support systems, significance of self-care strategies, significance of spirituality and meaning-making as; while risk factors involved

workload, caseload, types of the trauma, age of the survivor as well as the characteristics of both trauma survivor and the trauma field professional.

3.2.1 Major Theme 1: Vicarious traumatization

Theme: Changes in assumptions and beliefs towards world and human beings

In a way, all of the participants clearly stated that they were not same persons anymore, more specifically; all participants reported a kind of difference in terms of their way of being and relating as well as their beliefs, assumptions, attitudes and behaviors as a result of working in trauma field.

Six participants out of seven definitely reported a significant change in their basic beliefs and assumptions about human nature as well as about safety of the world. The participant trauma field professionals reported that exposing and empathicaly listening to the traumatic experiences of the clients made them more doubtful about human and world. In parallel, they explained how they started to have difficulties to trust in other people and to maintain relationships.

P2, 33-year-old, female clinical psychologist who works for a non-governmental organization, predominantly with the cases of torture, rape, physical violence and refugees, defined how working with trauma in years change and transform her inner world, her basic beliefs and statements about human nature. According to P2, “listening to those traumatic stories may sometimes affect and change the clinician’s own inner world”. P2 exemplified that she once had statements such as ‘human beings are good’ in which she had really believed. But then, in years, when she had started to work with trauma, she reported to realize that she began to notice the bad and the dark side of human nature. She particularly defined that exactly this confrontation with the dark side of human beings constituted the turning

point which caused her to change and be transformed. More specifically, according to P2, change and transformation had come true through witnessing, tolerating, confronting and bearing with those traumatic stories as well as being able to maintaining relationships in spite of those stories and the hidden dark side of human beings. ("Bazen bu da o hikayeleri dinlerken, bir klinisyenin kendi iç dünyasını etkileyebiliyor, değiştirebiliyor yani... Mesela benim şey söylemlerim vardı bir zamanlar, "insanlar iyidir" falan gibi, ve hakikaten inanıyordum da buna, gerçekten... Travma ile çalışmaya başlayınca, travmayla çalışırken zaten insanların, insanlığın kötü, karanlık taraflarını görmeye başlıyorsunuz ister istemez... Beni en çok değiştiren, etkileyen, beni en çok dönüştüren şey tam olarak bu oldu galiba... Bunları görmek, bunlarla yüzleşmek, bunlara sabretmek, bunlara tahammül etmek, bunlara rağmen insanlarla ilişkileri sürdürmek...").

P3, the clinical-forensic psychologist, similarly defined and explained how her world view and basic beliefs and assumptions about human beings had changed and sensitizied over time parallel to her working experience in trauma field. P3 also reported how her attitudes and behaviors changed as a direct result of the changes in her schemas related to world and human beings exemplifying that "I do never go into somewhere which I would not able to go out easily, I started automatically to check out where the security force is located when I go into a crowd." She additionally reported that she automatically scan and observe people in order to be able to grasp whether they are telling the truth or they are lying, whether there is anything risky or dangereous. She also added that if she one day she would have had a child, she would never prefer to use school bus, instead, she would take her child to school by herself; similarly, she guessed that she would not allow her child to stay out. She reported that especially since she had started to work with pedophilia and child

sexual abuse, she was looking with a significant suspicion at the men who are wandering around the playgrounds, ("İnsana ve hayata dair algımın hayatıma daha doğrudan yansımaları da var, tutum ve davranış olarak yani... Mesela, kolay çıkamayacağım bir yere asla girmem, bir kalabalığa girdiğimde güvenlik gücü nerede bir bakarım hemen. Otomatik şekilde herkesi tararım, insanları incelerim mesela; acaba yalan mı söylüyor, doğru mu söylüyor, tehlikeli, riskli bir şey var mı... Ya da mesela, bir gün çocuğum olsa, asla servisle okula göndermem, ben getirir ben götürürüm. Başka bir evde, dışarda kalmasına da izin vermek istemem çocuğumun... Pedofili ve çocuk cinsel istismarı ile çalıştığımdan beri, çocuk parklarının yakınlarında gezinen adamlara epey şüpheyle bakıyorum.").

P4, a 46-year-old female clinical psychologist who works with women survivors of physical, relational and economic violence as well as sexual abuse, stated that when she had begun working with trauma -when she was 22-, she had been more or less familiar with physical violence from community, but incest, sexual abuse, rape, torture or other sadistic and violent acts were quite strange for her. P4 also reported that listening and witnessing these traumatic life experiences radically changed her world view in time. Furthermore, she claimed that working with trauma not only changed but also reconstructed and totally recreated her basic beliefs and assumptions which constituted her world view. She stated that when she first started to work in trauma field, especially in the first couple of years, she had begun to perceive people as potentially abuser, thinking that everybody used or may use physical violence. She added that she began to be in doubt about all men with whom she was acquainted. In her experience P4 emphasized the catalyzing role of age and experience as well as support and training in order for an acceptance and an adaptation as a reconstruction of her world view. ("22 yaşında şiddetin her türüyle

çalışmaya başladım; fiziksel şiddete toplumsal olaylardan dolayı aşidaydım ama ensest, cinsel istismar, işkence, sadistik şiddetler, sadistik tecavüzler bunlar benim için yeni oldu… Bunları görmek, duymak dünya görüşümü radikal biçimde değiştirdi. Hatta değiştirdi değil, oluşturdu, ya da yeniden yapılandırdı. İlk bu alanda çalışmaya başladığım yıllarda, bir süre için "herkes tacizci", "herkes şiddet uyguluyor veya uygulayabilir" diye bir algı gelmişti bana. Tanıdığım tüm erkeklerden şüphe eder bir hale gelmiştim. Bu ilk birkaç yıl sürdü... Ama sonra bir kabul ve yeniden uyum süreci başlıyor, deneyim, yaş, özellikle de eğitim, destek bu uyumlanmayı katalize etti").

P6, who is a 40-year-old female clinical psychologist who works as a part-time instructor and a clinical supervisor in addition to her private clinical practice in trauma field, explained her feelings and her subjective experience of change using metaphors of "a sour taste"and "a smudgy stain" as a heritage of trauma work. She reported that "after listening all those traumatic histories as well as learing what kind of things human beings can do to eachother, life would not be the same life for you anymore, and, you would not be the same person, either. There would always be a sour taste, a smudgy stain inside you, and you know that it would always be with you…" ("O kadar çok travmatik yaşantı dinledikten sonra, insanoğlunun birbirine neler yapabileceğini öğrendikten sonra, hayat aynı olmuyor artık, sen de aynı kişi olmuyorsun artık. Buruk bir leke, bir iz daima kalacak orada, içinizde…Biliyorum ki o hiç geçmeyecek...").

Theme: Adverse emotional effects

All seven participants reported experiencing some degree of adverse emotional effects that they had difficulty to cope with at least once throughout their working

experience with trauma cases. Among the adverse emotional effects the participants mostly reported helplessness and anger as well as sadness, fearfulness and intolerance. Sometimes feeling distant and detached were revealed among the more rare experiences they reported. The results specifically revealed that, out of seven participants, six professionals reported that they sometimes feel quite concerned and anxious for others' safety, not only for the trauma survivors whom they work, but also the signifinat others in their (the professionals') personal lives. Especially three professionals reported feeling much more alert, fearful and pessimistic than in the past about human nature as well as about probable risks and threats in daily life.

P1, the psychologist who works at child oncology service described her increased anxiety, hypervigilance and pessimism reporting that "For instance, in the past, I was not an anxious-type person, but now, any slightest symptom or complaint of a person triggers the worst scenario in my mind; I associate it with the stories of the patients whom I work here, then I feel worry, panic and fear. An intense fear and panic get bigger inside me. I am trying to remind myself that this a professional deformation but I could not stop thinking and worrying about it. I internalize the stories as well as worries of my patients I think, and then I am affected, I can not get rid of it…" ("Mesela eskiden ben hiç evhamlı bir tip değildim, ama şimdi en ufak bir belirti ya da birinin en ufak bir fiziksel şikayeti benim kafamda hemen en kötü senaryoları çağrıştırıyor, burada gördüğüm hastaların hikayeleri ile bağlantı kuruyorum, korkuyorum, evhamlanıyorum. Direkt içimde çok büyük bir korku, panik oluyor… Kendi kendime saçmalama bu mesleki deformasyon diyorum ama tam da durduramıyorum kendimi; hastaların endişelerini, hikayelerini içime alıyorum ve atamıyorum, etkileniyorum...").

The same professional, P1, who is 29-year-old female psychologist who works with chronically and terminally ill children also described a significant negative change in her overall life energy and habits in her daily life. She reported that “After working the whole day in the child oncology service engaging with those children as well as with their grieving families, I feel as if I leave all my life energy there, as if there is nothing left back. I just want to go home, eat something and sleep, that is it.” (“Sanki bütün yaşama sevincimi orada bırakmış gibi, bırakmış ve çıkmış gibi, sanki geriye hiçbir şey kalmamış gibi hissediyorum. Eve gidip bir şeyler atıştırıp sadece ve sadece uymak isterim, o kadar.”) She also added that due to these complicated feellings her wearing style and even her use and preference of colour changed in time; she shared that “Even it affects my wearing style, I do not wear colourful things anymore... Though I had liked wear colourfully once as well as liked using colourful accessories. But then I realized that I do not use them anymore, honestly, my mother and my friends realized this nuance first... I started not to use colour in my privateand social life, I feel as if I do not have right to do this, I do not want to use...” (“Giyim tarzımı dahi etkiliyor... renkli giymiyorum artık, eskiden renk kullanmayı çok severdim, takı kullanmayı çok severdim mesela, ama artık kullanmadığımı fark ettim, hatta benden önce annem ve arkadaşlarım fark etti bunu, artık sadece işe giderken değil, sosyal hayatımda da renk kullanmamaya başladım, sanki hakkım yokmuş gibi hissediyorum, istemiyorum...”). Despite the fact that these adverse emotional effects varied in both severity and frequency with respect to each participant’s unique experience, the common point in all their experiences was that most of these adverse and intense emotional effects were evident in the first couple of years of their experience in trauma field.

P2, female clinical psychologist reported that “My naïve world view, that ‘belief in a just world’, ceased. If you do nice things you encounter nice things, yes but, sometimes bad things happening in the world. The belief that the world is a nice and safe place is not valid for me anymore. For instance, I do not believe in a just world anymore, I do not believe in justice or fairness, either. In other words, my world view and belief changed, I wish it did not change, I wish it stayed the same. I feel more angry and more rebellious towards people, towards the system...” (“O naif dünya inancım bitmiş durumda. İyilik yaparsın iyilik bulursun, tamam da, kötü şeyler de oluyor hayatta, hani o dünya iyi bir yer inancı, artık bu yok. Şimdi öyle bir dünya olduğuna inanmıyorum, adaletin olduğuna inanmıyorum mesela. Dünyanın iyi bir yer olduğuna dair inancım kalmadı. Dünyaya hayata inancım değişti yani, keşke öteki türlü kalabilseydi... Daha öfkeli olduğumu hissediyorum, daha isyankar... Sisteme karşı, insanlara karşı…”).

The high majority of the participants, (6 professionals out of the 7 participants) reported feeling of helplessness as a negative feeling of experience while one professional mentioned helplessness with different meaning load.

P1, who is 29-year-old female psychologist who works at child oncology service described how she feels helpless particularly when she works with cancered children as well as with their families, especially with the ones in the terminal term of the illness. She reported that “I think that the hardest thing is not being able to help the patients... While working with the terminal term patients as well as with rape survivors, feeling helpless is really the hardest thing, because you can not do anything to change the past, to change or undo the traumatic reality, you can not heal physically, also it is doubted how much you can heal psychologically... Sometimes I wish to have a magic wand in order to be able to change the whole reality, but the

inability to do this is really hard... Feeling so helpless, staying in that helplessness, unable to stand for that helplessness is still the most difficult point for me... Especially the helplessness afterwards death of a child, death of a child day by day, is very distinctive, it is really hard, really harsh ..." ("En zor geleni sanırım hastalara yardım edememek. Çünkü bazen terminal hastalıkla çalışırken veya tecavüz gibi bir travma ile çalışırken, şey çok zor... Nasıl desem, geriye dönük bir şey yapamazsın, olanları değiştiremezsin, onu fiziksel olarak iyileştiremezsin, ruhsal olarak da ne kadar iyileştirebilirsin tartışılır, en zor gelen şey bu çaresizlik... Bazen keşke elimde bir sihirli değnek olsa da olanları değiştirebilsem diye hissediyorum, bunu yapamamak bana gerçekten en zor geleni. Bu çaresizlikte kalmak, oturmak, o çaresizliği kabullenememek... Yani hala en çok takıldığım nokta burası oluyor... Çocuk ölümünün, hem de adım adım ölümünün yarattığı çaresizlik bir başka belki de... Daha ağır, daha sessiz, daha insanın içine oturan...").

P2, 33-year-old, clinical psychologist defined feeling helplessness as the hardest side of the trauma work, reporting that "You sometimes feel helpless, I think this is the most difficult part of this job..." ("Bazen çaresiz kalıyorsunuz, en zor tarafı bu galiba işin...") She also defined feeling of helplessness about the system; she stated that "It is about the system, it is about the issue of socio-economic classes... Due to the fact that the social state system is underdeveloped in this country, professional help can only be accessed by small number of people although larger numbers of people need this help. So, this reality makes me feel very helpless..." ("Sistemle ilgili bir sorun tabii, yani, biraz sınıfsal bir şey, sosyal devlet sistemi zayıf olduğu için bu ülkede, aslında çok daha fazla insanın yardıma ihtiyacı varken çok daha az insan o yardıma erişebiliyor... O yardımı herkese ulaştıramamak da beni çok çaresiz hissettiriyor...". P2 also reported an increase in her somatic complaints as

well as bad dreams dominated by feelings of helplessness and anxiety. ("Çaresizliğin ve anksiyetenin arttığı rüyalarım oluyor... Somatik ağrılar var...").

P3, 38-year-old, female clinical-forensic psychologist stated feeling helpless after the sessions of the most complicated multiple trauma cases. She also defined her feeling of helplessness in daily life when she witnesses a violation of boundaries signaling a potential sexual abuse, she reported that "It is helplessness... I am trying to sooth myself repeating that "keep your calm, you can not rescue everyone, you can not control everything", because I do not have any other alternative in that feeling of helplessness, the only thing I can do is to be there in order to intervene if s/he wants or needs help. ("Çaresizlik... Orada kendime onu söylüyorum, 'Sakin ol, herkesi kurtaramazsın, herşey, kontrol edemezsin', başka şansım yok o çaresizlikte çünkü. Öyle durumlarda şey yapmaya çalışıyorum, yakınında olup çıkmak istediği anda müdahale etmek...").

P7, the psychologist who works at child and adolescent center reported that "Helplessness, especially which is caused by the inability to help or to do something as much as you wish leads to anger and even rage... Anger and rage towards to the aggressor who caused the trauma, as well as to others who ignored, to the police, to the government, to the system and furthermore to myself... Sometimes when this particular anger and rage increase, it may cost my sleep and hardly ever it may lead to nightmares..." ("Çaresizlik, yani yapmak istediğin kadar bir şey yapamama, bunun yarattığı kızgınlık, konunun etrafındaki diğer insanlara kızgınlık, öfke, işte ne bileyim bunu ona yapana, yapana göz yumana, polise, görevliye, devlete, hatta kendine kızgınlık... Bazen çok arttığında bunlar, uykularıma mal oluyor, kabusum olabiliyor nadir de olsa...").

P4, a 46-year-old female clinical psychologist, defined her feeling of helplessness stating that “To have to scramble against the system makes us feel abundantly helpless...” (“Bir de sisteme karşı mücadele vermek durumunda kalmak, insanı çok çaresiz hissettiren bir şey...”).

P5, a 39-year-old male clinical psychologist who works both as a part-time instructor and as a clinical supervisor in addition to his private clinical practice in trauma field was the one who did not report feeling of helplessness differently from the other participants. He stated that “In general, feeling of helplessness is one of the most prevalent feelings described by the trauma field professionals, but I think it is something that I relatively better cope with. Maybe this is due to my clinicial practice orientation of short-term solution-focused therapies in addition to strategical-systemic therapies from the positive psychology perspective; and maybe partly due to my character and life perspective which is probably my strongest strenght. Instead of dramatizing the negative or traumatic side, I would rather focusing on positive, changable and controllable side of the scene, in terms of both clinical practice and personal style...” (“Travmayla çalışırken insanların en çok tarif ettiği duygulardan birisi de çaresizliktir mesela... Benim daha iyi baş ettiğim bir şey galiba bu çaresizlik. Biraz kısa süreli terapilerin verdiği bir şey belki. Sistemik ve stratejik dışında da hep böyle yöneldiğim çözüm odaklı terapi... Daha çok yapılabilene, değiştirilebilene odaklı olmayı getirir. Çok fazla dramla kendimi de boğmam işin içinde de... Çözüm odaklıyla beraber biraz pozitif psikoloji… Biraz perspektifim de kişi olarak da olumlu tarafa kayabilmeye doğru duran bir tarafım da var. Kişisel olarak belki en güçlü olduğum taraf galiba orası.).

Despite the fact that P5 reported that he generally does not have difficulty in dealing with feeling of helplessness, he stated that the hardest adverse emotional

reaction which is triggered while working with trauma is anger. P5 specifically reported that anger is much more significant and difficult for him to cope with, especially with the cases human-made traumas such as abuse, violence or torture. He particularly defined an anger towards the perpetuator and sometimes towards the system, especially if the system obstructs his intervention and work with the trauma survivors. ("Bir zorlandığım duygu kişisel olarak travmayla çalışırken öfke... Bu insan eliyle olmuşsa, işte mesela taciz, şiddet, işkence, vesaire, uygulayana dair, sisteme dair bir öfke ve bu öfkemi yönetmek belirgin olarak daha zor oluyor… Hele ki sistem mağdurla çalışmamı zorlaştırıyorsa veya engelliyorsa orada öfkem daha da artıyor…").

P6, who is a 40-year-old female clinical psychologist, similarly to P5, reported anger among the intense and adverse emotions which she has difficulty to overcome and which is evoked by trauma work. She explained that she feels angry and she has difficulty to cope with that anger when the trauma survivors with whom she works can not not feel and state anger to the aggressors / perpetuators who traumatized them. She reported that sometimes she feels angry in behalf of them (the trauma surviviors with whom she works), in their stead as well as sometimes much more angry than them; and she added that tryin to cope with that anger makes her feel tired. ("Danışanlarım kendilerini mağdur edene, travmatize edene kızamadıklarında kızıyoum ve bununla çok zorlanıyorum... Onların adına, onların yerine, hatta onlardan fazla öfkeleniyorum bazen... Çok yoğun öfke yaratıyor, bu öfkeyle baş etmeye çalışırken de yoruluyorum").

P7, who has no graduate education and no access to professioanl support systems, also stated that "their helplessness sometimes turns to be your helplessness and most of the time it is not so easy to get rid of it...Sometimes it lasts all day and

night, and it affects both my inner world and my daily life…". ("Ee onların çaresizliği sizin de çaresizliğiniz oluyor tabii bazen. Ve bu duygudan kurtulmak her zaman çok da kolay değil... Bazen o gün o gece de devam ediyor... Bu da iç dünyamı da hayatımı da etkiliyor.").

Theme: Dissociation as a defense

Four of the participants out of seven, reported some degree of dissociation as a kind of defensive mechanism in order to cope with intense negative emotions triggered by trauma work.

P6, the clinical psychologist, described how she defensively dissociates, probably to cope with and to be able to distant herself from trauma work. She asserted that working with trauma is an experience which needs to learn to go without thinking. According to P6, at one hand it means going with intuition; on the other hand it means keeping away from thinking in order to defensively protect herself. Furthermore, she described in a very humorous manner how she dissociates or even denies the fact that she is a 'trauma field therapist', she stated that even today, she can not identified herself directly as a trauma field worker even though she is known so in the field… She explained that every time she was asked and requested to give a field training, she was still surprised and asked herself 'hmm, why do they demand this training from me?' She added humorously that 'is it a denial or a dissociation or something?'. ("Travma çalışmak bazen çok düşünmeden gitmeyi öğrenmek gereken, biraz dissosiye bir şey diye düşünüyorum... Düşünmekten uzak durmak, bu bir yandan sezgisel gitmek demek olabilir bir yandan düşünmekten kendimi korumak olabilir... Bir de "travma çalışan bir uzman" olduğumu ben hala da böyle söylemiyorum, her seferinde "allah allah acaba neden

bu eğitimi benden istiyorlar acaba" diye düşünüyorum… İnkar mıdır dissosiasyon mudur nedir...).

P7, 45-year-old male psychologist who works with refugee children and adolescents as a state employer with no access to professional and organizational support systems, defined his experience as a kind of dissociation and explained how he gained an awareness and insight about it. He stated that it was a stange experience for him to realize that at the end of the working days he almost totally forgot his trauma cases -especially the refugees- with whom he worked all day, he described it like an amnesic state exemplifying how he realized that he could not remember what was told, what was shared, what the themes and traumatic stories were about and so on. He expressed how he firstly felt shock, panic and fear worrying about 'what is happening to me?' and then how he gained an insight and felt calm after naming his experience as a kind of distancing and dissociation as a normal defensive mechanism … ("Garip bir şeydi, mülteci çocuklarla çalışmaya başladığımdan beri burada, mesai çıkışında hafızam siliniyormuş gibi oluyor, yani şu kapıdan bir çıkıyorum akşam, ve kendi kendime "ben bugün ne yaptım, ne konuşuldu, ne çalıştım" falan diye bile sorunca, öylece bir boşluk geliyor, hiç ama hiç bir şey hatırlayamıyor gibi oluyorum...Yok, günün sonunda sıfır hafıza gibi, çok acayipti, şaşırdım, korktum, panik oldum ne oluyor bana diye... Daha sonra bir yerlerde duydum öğrendim ki normal bir savunma biçimi olabiliyormuş, o mesafe koyma, kopma hali…").

Theme: Adverse physical/somatic effects

All of the participant professionals who are working in the trauma field described adverse physical effects reporting that more or less they are suffering from somatic symptoms, such as sickness, aches, nausea, headaches, physical numbness,

sleeplessness and appetite problems as well as feeling tiredness, muscle tension and feeling as if crushed/stumped by a truck.

More specifically, P1, the psychologist who works with chronically and terminally ill children in the oncology service reported a significant physical impact on her due to the workload which is composed of almost totally trauma cases. She reported that "At the end of the day, after working those children in the oncology service, I always feel as if crushed or stumped by a truck" ("Öncelikle fiziksel olarak çok etkileniyorum, üzerimden kamyon geçmiş gibi hissederim, hep böyle tanımlarım o hissi. Günün sonunda, bütün gün kanser ünitesinde o çocuklarla ve aileleri ile çalıştıktan sonra...").

P2, the 33-year-old, female clinical psychologist who predominantly works with the survivors of torture, rape, abuse and physical violence as well as multiple losses and immigration, defined a significant physical tiredness which metaphorically makes her feel like having carryed a heavy burden on her shoulders. She also added that she felt somatic pains after the sessionas with the difficult trauma cases. ("Bedensel olarak yorgunluk hissi çok oluyor, omuzlarımda ağır bir yük taşımışım gibi... Bazen somatik ağrılar oluyor, travması ağır vakalarla çalışığım seansların ardından...").

Theme: Preoccupation with the case

Six out of seven participant trauma field professionals described mental preoccupation with their traumatized patients with warying degrees sometimes with intrusive imageries. More specifically, most of the participants reported and exemplified that they can not stand constantly thinking about the case, sometimes they found themselves in an effort to remote follow trying to protect. They

additionally defined the preoccupation in terms of the fact that they can easily remember some of the case out of the sessions and their stories can be easily triggered through flashbacks, rehearsing the session, ruminating the dreams and nightmares. With an overidentification with the case, most of the participants stated that they sometimes had hard times to stop themselves trying to find solutions as well as separating the cases' stories and experiences from own life.

P2, explained that "You start constantly to think about and preoccupy with your traumatized cases; 'What will s/he do?, Will s/he be able to protect him/herself? Will anybody else hurt him/her again? May there be any other thing that I can do to help him/her more efficiently?' And this preoccupation is quite exhausting." ("Hep aklınızda taşımaya, kafa olarak onunla meşgul olmaya başlıyorsunuz o travmatize danışanlarınızı. Şimdi o ne yapacak? Kendini koruyabilecek mi? Başka birileri daha ona zarar verecek mi? Onun için yapabileceğim başka bir şey var mı? Ve bu meşguliyet oldukça yorucu haliyle…").

P7, explained how preoccupation with his cases makes him feel tired. He exemplified that he has two children, and he is more interested in and preoccupied with children living on the streets. He told that when he comes across those children on the streets, he follows them around trying to do something to help either through their families or through institution. He also added that sometimes he mentally preoccupied with those children who had to leave the institution, he exemplified that he could not stand to think about whether they could get a job, where they lived and so on. He defined the natural result of this preoccupation stating that "all this means that work never ends in your mind". (İki çocuğum var benim... Sokakta yürürken etrafta böyle bir çocuk görünce ilgileniyorum, bazen peşine düşüyorum, ailesi veya kurum üstünden ne yapabileceğim düşünüyorum, ulaşmaya çalışıyorum... Ya da

kurumdan ayrıldıktan sonra aklım kalır çoğu çocukta mesela, ‘ne yaptı, iş buldu mu, nerde yaşıyor’ düşünürüm… Bu da ne demek, iş kafada hiç bitmiyor demek”).

3.2.2 Major Theme 2: Vicarious posttraumatic growth

Theme: Being a trauma therapist as a double-edged sword

All participants in a way described the experience of working with trauma as a double-edged sword which is both rewarding as well as challenging. At one hand, the participants spoke of negative effects of engaging in trauma work, such as grief, adverse emotional and physical effects, mental preoccupation with the cases, feeling helpless within the system and feeling angry; but on the other hand all of them in a way described the positive effects, such as taste of witnessing to the progress, admiration to human resilience as well as life and struggle instinct hidden inside human beings. All of the participants emphasized the unprecedented taste of special interaction and working relationship between the trauma survivor and the trauma therapist. From this perspective, P3, the clinical-forensic psychologist, explained the positive and rewarding sides of working in trauma field stating that working in trauma field was a special and different experience within the clinical field, because the observed difference and progress in the client is much more significant, meaningful and vital. This kind of witnessing and accompanying this special experience by itself makes the therapist feel significantly more useful and efficient despite all the hard times of trauma work. (“Travmayla çalışmak klinik alanın içinde daha farklı ve özel bir deneyim alanı, çünkü şahit olduğunuz ve eşlik ettiğiniz değişim ve gelişim daha canlı, daha belirgin, daha özel ve daha hayati… Tüm o yaşattığı zor zamanlara rağmen, terapist olarak kendinizi daha bir işe yarar ve etkin hissediyorsunuz…”).

All the participants reported a kind of growth and transformation in their world views and self perception as well as in their both professional and personal lives. In other words, it was discovered that engagement with trauma work may bring a vicarious posttraumatic growth or a vicarious resilience especially through the effective presence of protective factors such as awareness, education, ongoing field trainings, supervision, support as well as sense of spirituality. These particular factors which were described as protective factors by the researcher were suggested and identified by the participant professionals not only as a kind of buffer for the potential negative impacts of trauma work but also as a mean of growth and an acquired resilience.

One of the examples which described trauma work as a double-edged sword which is both rewarding as well as challenging, P6, the 40-year-old female clinical psychologist, defined her experience in that "both the hardest sides as well as the most rewarding sides, both challenges and rewards of working with trauma are back to back and go hand in hand; if it wasn't so, it would probably be impossible to work with trauma for us". ("Travmayla çalışmanın en zorlayan tarafı, aslında en besleyen tarafla bağlanıyor... Besleyen tarafla zorlayan taraf hep yan yana, hep sırt sırta; zaten öyle olmasa belki de bizim için travma ile çalışmak imkansız olurdu..."). More specifically P6 described that "at one hand there is the feeling of 'how a human being can be so cruel and evil', on the oher hand there is the feeling of how a human being can be so resilient and can cope with and move on with their life'… Disappointment and anger as well as hope and confidence present themselves at the same time, together leading to both damage and burnout as well as empowerment and growth. ("Hem bir yanda "ya bir insan nasıl bu kadar kötü olabilir" boyutu var, insanlığa dair çok öfkelendiren, can yakan bir taraf o; ama aynı anda diğer yanda "bir insan nasıl

bu kadar güçlü olabilir, nasıl böyle baş edebilir, ayakta kalıp hayata devam edebilir" de var... Hayal kırıklığı ve kızgınlık ile umut ile inanç aynı anda, hem yıpratıyor, tüketiyor, hem de güçlendiriyor, büyütüyor...").

P2, 33-year-old, female clinical psychologist, described her experience very similarly reporting that "Probably the hardest and most challenging part of working with trauma is the feeling of deep helplessness, especially the times when you are encountered by the fact that unfortunatelly you can not change what happened to them, furthermore you can not rescue them and you will not be able to protect them from everything in the future, either. Sitting in that room with that helplessness is probably the hardest and most challenging part of this work... But at the same time, in the other side of the coin, being able to sit in that room all with their grief as well as flashbacks, pieces of bitter memories of traumattic life experiences, and being able to accompany and having chance to witness how they come through and move forward with their lives, how they heal and progress, probably contitute the most rewarding and empowering side of trauma work...". (Travma ile çalışmanın dayanması en zor olan, en zorlayıcı tarafı, onun geçmişinde başına gelenleri değiştireyeceğin, onu çekip kurtaramayacağın ve gelecekte de onu herşeyden koruyamayacağın gerçekliği ile karşılaştığın anlardaki o derin çaresizlik, ve de o çaresizlikle o odada onunla oturmak. Ama madalyonun öbür yüzünde, o odada onun acısıyla, yasıyla tüm o flashbackleriyle oturabilmek ve ona eşlik edebilmek, ve hatta onun gelişimine ve iyileşmesine, hayatına nasıl devam edebildiğine tanıklık edebilme şansına erişmek bu işin en besleyen ve bir yandan büyüten yanı aynı zamanda...").

P5, a 39-year-old male clinical psychologist, used human nature as a kind of metaphor for describing the experience of working with trauma. More specifically, He defined that similarly to the human nature which is composed of both good and

evil sides, working with trauma composing of both rewarding and empowering as well as challenging sides, has a kind of balance by itself. Seeing and accepting everything as a part of this particular natural balance and wholeness result in a growth bringing a power and tolerance to cope with life as well as working with trauma...". ("İnsanın doğası iyi ve kötü, insanın yapıcı ve yıkıcı tarafları var, benzer şekilde travma ile çalışmanın da besleyen, güçlendiren ve zorlayan tarafları çok benzer biçimde bence birbirini dengeliyor. Herşeyi hayatın ve dengenin bir parçası görmek ve kabul etmek, bunun etkisi ya da sonucu olarak da büyümek, daha rahat göğüslemeyi getiriyor hayatta birçok şeyi ve de paralel olarak travma ile çalışmayı…

Theme: Change in life philosophy, empowerment and growth through increase in belief and admiration to human resilience

All the participants defined how they were affected and empowered by their clients' resilience and coping as well as overcoming and making sense of their traumatic experiences. The participant trauma therapists reported that they gained not only a significant insight but also a vicarious resilience through their clients about how to overcome adversities. Witnessing and accompanying human beings' immense capacity to survive, to heal and tıo progress were described among the major means of vicarious growth. Additionally, all of the participants reported that their definitions of problem changed after working with trauma in years; they reported that they started to tend to redefine the dimensions of their own problems as well as reassess their priority and importance. Six out of seven participants described a significant clarification and deepening in their spiritual perspective.

P3, definitely stated that "In a word, I grew up, that's it, and it is quite clear". She explained metaphorically stating that she got away that fishbowl, and

started to see beyond the scene and she asserted that was not the same person anymore, also asserting that “I became different; this change and transformation is a positive change which make grow me up”. (“Büyüdüm. Tek kelimeyle bu, evet, büyüdüm, çok net. Yani o fanustan çıktım, artık farklıyım, değiştim, dönüştüm, görünenin arkaplanını da görüyorum. Bu da artı bir şey. Beni büyüten bir şey”).

P6, defined how significantly she changed with the words of “I grew up, very much, and how!”, then she specifically exemplified that “It was my sixth month in trauma field, and exactly at that point I realized that I started to grow up because I did not get angry to something which I would normally do… Just with that experience I apparently realized that the important and unimportant things as well as meaningful and meaningless things were started to be clarified in my life”. Besides she stated that this change and growth increased her tolerance and flexibility. (“Büyüdüm, hem de çok büyüdüm... Travmayla çalışmaya başladığımın altıncı ayıyıdı galiba, daha orada anladım büyümeye başladığımı... Normalde çok kızacağım bir şey olmuştu, ve kızmadım. Anladım ki o noktada işte, önemli ile önemsiz, anlamlı ile anlamsız daha bir ayrışıyor, daha bir netleşiyor hayatımda... Toleransımı ve esnekliğimi arttırdı bu aynı zamanda...”).

Specifically in terms of growth through increase in belief and admiration to human resilience, P2, described how fascinating is the richness of internal resources of trauma survivors as well as witnessing their capacity to get use of them. (“İnsanın iç kaynaklarının zenginliğine ve bunu kullanabilme kapasitelerine şahit olmak çok etkileyici…”). She also added that her belief in human resilience and struggle potential were significantly strengthened. She explained that one of the basic focuses of trauma work was thinking and discovering how the trauma survivor managed to survive, what s/he did to survive, cope and move on. Particulary this point by itself

was quite improving and empowering experience; their internal object as well as attachment capacity helped me to discover my own internal resources in time". ("İnsanın mücadeleci potansiyeline olan inancım bin kat arttı bir kere... Travmayla çalışırken 'bu insan ne yaptı da hayatta kaldı' sorusu odak noktalarından biri oluyor, 'nasıl baş etti ve hayatta kaldı' diye kafa yoruyorsunuz. Bu benim için başlı başına öğretici ve geliştirici bir deneyim oldu... Onların o iç nesnesi ve bağ kurma becerisi, benim de kendi iç kaynaklarımı keşfetmeme yardımcı oldu").

P4, a 46-year-old female clinical psychologist who works with survivors of violence and abuse in a non-governmental organization, talked about how having worked with trauma survivors for years increased her credit and belief in human resilience and vitality. She reported that "Maybe the most important point that I realized is that human beings are very resilient entities who can cope with and survive from everything. I observed that the women who applied to me for counseling are as clever at least as me, in fact they do not need to lean on neither me nor anybody else. Noticing the human vitality and resilience helps to protect the necessary frame while working with trauma, otherwise there is a risk of rescuer fantasy which is hard to manage. It is meaningful to realize that nobody needs a rescuer…" ("Belki de en önemlisi, şunu gördüm, insan çok güçlü bir varlık. Her şeyle baş edebiliyor… Bana danışmaya gelen kadınlar en az benim kadar akıllılar, aslında bana ya da başkasına muhtaç değiller. İnsanın dayanma gücünü görmek sınırları koruyabilmeyi kolaylaştırıyor; yoksa o kurtarıcı role girmek de insanı zorluyor… Kimsenin aslında kurtarılmaya ihtiyacı olmadığını görmek anlamlı…" P4 also pointed out the mutual interaction as well as mutual growth revealed through therapeutic work with trauma survivors, reporting that "Feeling that you are touching one's life and catalyzing/creating a difference, is a reasonably satisfying

experience. Of course working with trauma in therapy is a mutually interactive process. Especially the women whom I worked/counseled were so strong that they all managed to cope with life and survived despite their traumas. And I learned a lot from them and I considerably gained strength. Time to time, especially during the hard instants and occasions in my life, observing these women's traumatic stories together with remembering the way how they coped and survived made me gain a considerable strength while also halped me to find my way..." ("Birisinin hayatına dokunduğunuzu, bir fark yaratabildiğinizi hissettiğinizde o çok doyurucu bir şey. Tabii terapide travma çalışmak karşılıklı etkileşimli bir şey. Özellikle benim görüştüğüm kadınlar o kadar güçlü kadınlar ki, o kadar hayatıyla iyi baş edebilmiş kadınlar ki travmalarına rağmen... Ben de onlardan çok şey öğrendim. Çok güçlendim. Benim hayatımın zor dönemlerinde bu kadınların hikayelerini ve baş edişlerini görmek, hatırlamak beni çok güçlendirdi, bana yol gösterdi…")

Theme: Increase in belief and confidence about self-resilience

In parallel to vicarious growth in terms of increase in belief and admiration to human resilience, all of the the participant professionals also emphasized an increase in their belief and confidence about their self-resilience. They described that working with trauma survivors catalyzed to evolve into greater self-awareness and self-integrity.

P2, the clinical psychologist said that "Deepness of internal resources of human beings as well as their capacity to get use of those resources helped me to discover my own internal resources. At least it increased my hope and energy to find a solution, a cure. I learned not to give up easily, I realized that I am stonger and thougher than I had assumed. And I learned all these, from my clients with whom traumatic histories I work". ("İnsanın iç kaynaklarının derinliği ve bunu kullanabilme

kapasitesi… bu benim kişisel düzeyde de kendi iç kaynaklarımı keşfetmemi sağladı… En azından bir çare, bir çözüm bulma için gücümü, ümidimi arttırdı. Hemen bırakmamayı öğrendim, düşündüğümden daha güçlü olduğumu öğrendim, ve bunu travmasıyla çalıştığım danışanlarımdan öğrendim").

P3, 38-year-old, clinical-forensic psychologist, also described a kind of growth, improvement and enrichment through trauma work; he reported that "I learned something about life, about human beings, and interestingly about myself". ("Çok şey katıyor bana, büyüme, zenginleşme, gelişme... Her çalışmada, her hikayede yeni bir şey öğreniyorum, hem hayata dair, insana dair, hem de ilginçtir, kendime dair...")

Theme: More satisfying interpersonal relationships

Six participants out of seven talked about better interpersonal relationships. They reported a significant increase in tolerance, acceptance, respect and understanding of others. Five of them emphasized that in years, parallel to trauma work experiences, they learned selective investment of personal energy and time into relationships with better protected boundaries while indirectly developing their overall interpersonal skills through these particular experiences and gains.

P2, the 33-year-old, female clinical psychologist stated that "as I listened to others' life stories, especially traumatic ones, I learned to make an effort to understand the other, and to respect to others' pain; I also learned to avoid prejudice as much as possible as well as not to criticize others. I learned to become more tolerant as a human. All these gains enriched me, bared/opened me, improved me in my personal life; they contributed to my interpersonal relationships in my personal life. ("Başka insanların hayat hikayesini dinledikçe, özellikle de travmatik olanları,

başka insanların acılarına saygı duymayı öğrendim, ötekini anlamak için çaba sarf etmeyi öğrendim. Eleştirmemeyi, önyargılardan mümkün olduğunca arınmayı öğrendim... İnsan olarak daha toleranslı olmayı öğrendim... Bu da açtı beni, kişisel hayatımda da beni açtı, aştı ve geliştirdi diye düşünüyordum... Benim kendi hayatımdaki ilişkilere de katkı sağladı...").

P6, the 40-year-old clinical psychologist who works as both a pert time instructor and as a clinician, shared that "working with trauma confronted me both individual and social faces of human beings, and then, with wholeness and awareness it helped me to sustain my life and my relationships. Seeing and understanding the individual human beings in the middle of those traumatic stories helped me to make sense of my contact with hıman. In turn, it bedecked and enriched my belief system as well as my spirituality". ("Travma ile çalışmak beni insanın hem bireysel hem de toplumsal yüzü ile yüzleyip, bütünlük ve farkındalıkla varlığımı ve ilişkilerimi sürdürebilecek gücü ve toleransı verdi bana... O travma hikayelerinin tam ortasında hep insanı, bireyi görmek ve anlamak insanlarla temasımı daha da anlamlandırdı... Dolaylı olarak, maneviyat ve inanç sistemimi de bezedi, zenginleştirdi...").

Theme: Deeper sense of spirituality

Six out of seven participants talked about spirituality. Four participants solely described spirituality as a sense of unity and connectedness as well as sense of gratitude, harmony, balance and meaning; while two participants blended spirituality to religion at some degree. Two participants specifically reported that working with trauma and being confronted by human brutality through trauma work challenged their faith system and spiritual perpective especially related to the God, but then it was reframed and redefined into a wider and deeper sense of spirituality. Three of the

participants reported that they are using regular spiritual rituals and practices such as prayer, breathing or meditation as a self-care habit and as a coping.

P7, 45-year-old male psychologist who works at child and adolescent center as state employer specifically explained that “dealing with traumatic stories challenged my faith in God, especially in the firt couple of years in trauma field because when I see and listen so much bad things which happened to innocent people, I could not stop myself to question and challenge my faith system, I started to think, ‘Is there really a God out there? Is there any meaning to all of this?’ But then, pieced came together and shaped the whole picture, at the end, today, my spiritual beliefs were strengthened”. (“Travma hikayeleriyle haşır neşir olurken Allah inancım sarsıldı önceleri, ne yalan söyleyeyim, o kadar hikayeyi görünce ve dinleyince, o masum insanların başına gelen kötü şeylerle yüzleşince, sorgulamaya başladım haliyle; ‘Orda gerçekten bir tanrı var mı?, Tüm bunların bir anlamı olabilir mi?’ Ama sonra parçalar daha bir birleşti sanki, hatta bugün artık inanç sistemim daha güçlendi”).

P1, 29-year-old female psychologist who works in the oncology service, told how her spirituality evolved in time through trauma field work. She stated that “I always thought and believed like that, but after I had started to work in trauma field my spiritual perspective were strenghtened and evolved. Faith makes me feel better, it helps me to make sense of all the things. I believe that everything has a meaning, everything is a mean of something”. She also added that “Thanks to this belief system, I do not go mad, it supoorts/vitalizes me”. (“Zaten hep böyle düşünürdüm, ama bu sahada çalışmaya başladıktan sonra bu yaklaşımım daha da kuvvetlendi, evrildi... İnanç bana iyi geliyor, inanç sayesinde bir cevap bulabiliyorum, herşey bir

şeylerin aracı ve herşeyin bir nedeni, bir anlamı var diye düşünüyorum. Bu sayede delirmiyorum.. İnanç bana dayanma gücü bana veriyor...")

3.2.3 Major Theme 3: Risk factors

Theme: Nature of the trauma and age of the survivor

With no exception, all participants reported that the most difficult trauma type for them was child sexual abuse and incest. Working with complex trauma involving sexual abuse, sadistic violence and torture as well as neglect and systematic emotional abuse was also described by all the participants among difficult cases, especially in which their victims were the children.

More specifically, three of the participants suggested that the theme, direction and degree of a probable vicarious traumatization may depend on the type of trauma with which the professional works. P1, 29-year-old female psychologist who is working with chronically and terminally ill children and their families at oncology service, specifically stated that "probably due to the fact that I work with chronical and terminal illnesses while I do not work with human made traumas such as violence, sexual abuse or torture, my beliefs and assupmtions related to safety and trust did not change. But I observed that my schemas related to health and illness changed and got sensitized due to my trauma field work". ("Belki de ben, insan saldırısına dayalı travmalarla çalışmadığım için, ne bileyim şiddet gibi, taciz, tecavüz, işkence gibi, düşünüyorum da sanırım bu yüzden, güvenle ve güvenlikle ilgili pek değişmedi inanç ve algılarım... Ama benim çalıştığım şey, hastalık-sağlıkla, ölüm-kalımla ilgili travmalar olduğu için ben bu konularda hassaslaştım ve değiştim bence daha çok...").

All of the participants reported that traumas in the professionals' personal life, -both actual ones and the traumatic life experiences in the past-, may constitute a risk factor for the professional for complex countertransferential reactions and for vicarious traumatization.

P2, stated that "if you have a traumatic history, the risks of boundary violation as well as overidentification may increase". ("Sizin de bir travmanız varsa o vakayla çalışırken sınır ihlalini yapma veya fazlasıyla özdeşleşme ihtimaliniz çok yüksek olabilir.").

Furthermore, it was also reported by all participants that as the resemblance between the clients'traumatic stories and the professionals' traumatic histories increases, the risks of burnout and secondary traumatization may increase, too. For instance, being divorced or separated, having a children, having a loss or an illness or being a woman may among these triggering resemblance points for the professionals that they exemplified. More specifically, P4, 46-year-old female clinical psychologist who is married with two children reported that the most significant weakness she had was neglected and abandoned children. She stated that "as a mother, I really have difficulty in listening child abuse and neglect stories from the adult survivors who were sexually abused and physically tortured by their fathers and mothers when they were children… This is my biggest weakness… Working with those stories may sometimes trigger bad dreams and nightmares as well as mental and emotional preoccupation with the case…Above all, I never worked with children, I especially keep myself away from working with children". ("Özellikle bir anne olarak, annesinden babasından işkence gören, tecavüze uğrayan çocuklar... Onların geçmişe yönelik anlattıklarını dinlerken çok zorlanıyorum... Bu en büyük zaafiyetim bu... Bu tür vakalarla çalışmak kötü kötü rüyaları, kabusları ve durdurması zor bir zihinsel ve

duygusal meşguliyet yaratabiliyor…Çocuklarla hiç çalışmadım, özellikle kendimi uzak tutmayı seçtiğim bir alan…").

P2, the female clinical psychologist, reported that "one of the most difficult cases was the woman who had been raped and tortured everday for two years, it was quite hard for me because my empathic engagement and identification were extensively intense, I was affected too much…". ("İki yıl boyunca her gün işkence gören ve tecavüz edilen o kadınla çalışırken benim için en zor şeylerden biri benim de bir kadın olmamdı… Özdeşimim ve empatim fazlasıyla yoğundu… Çok etkilendim…"). She also added another example "I have difficulty while working with the clients who lost their mother when they were children, because I lost my mother when I was a child, too…". ("Bir de çocukken annesini kaybetmiş kişilerle çalışırken hala zorlanıyorum, çünkü ben de annemi o yaşlarda kaybetmiştim...").

Theme: Personal life story and trauma history of the professional

Four participants out of seven reported that they have significant difficulties and sensitiveness in working with ceratin trauma stories to which they have similar traumatic life events, either in their past or in their present lives.

P3, 38-year-old, female clinical-forensic psychologist, reported that "It is quite clear that working with grief and loss is always difficult for me, because I lost my mother as a result of cancer… I do not work with cancer, either…I have a precise boundary at that point...". (Çok net, kayıp ve yasla çalışmak benim için çok zor, ben de annemi kanserden dolayı kaybettiğim için oraya dokunuyor... Kanser hastası almıyorum, kanserle de çalışmıyorum… O noktada keskin bir sınırım var...").

P5, 39-year-old male clinical psychologist exemplified that "I had not work with couples for a period of time when I divorced. Besides, I had not accepted grief

and loss cases for a period when I lost my grandmother…". ("Boşandığım dönemde bir süre çiftlerle çalışmadım, o dönem zorladı. Bir de, benzer şekilde, anneannemi kaybettiğimde de kayıplar, kayıp ve yas vakaları zorlamıştı, bir süre kayıp ve yas temalı başvuları kabul etmemiştim...").

3.2.4 Major Theme 4: Protective factors

Theme: Formal education and special training

Six participants out of seven strongly emphasized the cruciality of postgraduate education as well as special trauma field trainings. They described formal education and field trainings apparently as protective buffers against probable vicarious traumatization. On the basis of the participants' expressions, the results revealed that the psychologists who were more experienced and who had postgraduate degree on clinical psychology as well as special training in trauma field, reported less disruptive changes in their schemas, even if they had personal trauma histories in their past. Six participants out of seven clearly reported that both formal education and special trainings in trauma field helped to increase their sense of groundedness, to reduce their anxiety, to enrich their therapeutic and practical repertoire as well as to help meaning making and protecting frame and boundaries.

P6, the 40-year-old female clinical psychologist who works as a part-time instructor and a clinical supervisor in addition to her private clinical practice in trauma field, pointed out the importance of both formal education and field training stating that "It is clear that it really makes a difference; it reduces the professionals' anxiety and makes the professional feel safe and grounded. Theoretical background and orientation as well as the tools and techniques which are known and used are definitely among the protective resources…". ("En başta, eğitim gerçekten çok fark

ediyor, hem okul hem saha eğitimi... Eğitim kesinlikle rahatlatıyor ve kolaylaştırıyor, güvende hissettiriyor, ayağı yere bastırıyor, anksiyeteyi azaltıyor, o çok net... Teorik altyapın, oryantasyonun ve bildiğin, kullandığın teknikler önemli farklar yaratan, koruyan güç kaynakları…")

Theme: Theoretical and practical flexibility and integration

Emphasizing the necessity of education and field trainings, five participants out of seven pointed out the cruciality of flexibility and integration both theoretically and practically. Most of the participants suggested that trauma work needs and integrative and flexible approach which should be enriched by various therapeutic techniques and integration of different theoretical perspectives.

P1, 29-year-old female psychologist who uses art therapy techniques working with chronically and terminally ill children and their families, suggested that "I think working with trauma requires a wide, flexible and integrative approach far beyod of the standard protocols of trauma trainings… Because having an integrative approach constitutes your tools as well as your resources and strength, may bring flexibility, and in turn, protects both the professional and the patient…". (Çünkü bunlar çalışırkenki araçlarınız, kaynaklarınızı oluşturuyor, güç ve güven veriyor, bir anlamda uzmanı da hastayı da koruyor aslında…". ("Travmalarla çalışma bence bütün o teknik eğitimlerin verebileceği protokollerden çok daha fazlasını, daha geniş, böyle esnek ve kapsayıcı ele almayı gerektiriyor...").

P2, the 33-year-old, female clinical psychologist, put forward that she had an integrative perspective and pointed out its necessity and cruciality. She specifically exemplified that she had a psychanalytic theoretical background which she made use of grasping the macrosystem, besides, she told that she benefited from

various techniques for interventions and psychosocial support processes. She thought that working with an integrative and flexible approach was a necessity, a must; because it protects the therapist. ("Travmayla çalışırken çok daha entegratif bir bakış açım var. Temel olarak teorik perspektif, vakanın formülasyonu, gibi şeylerde psikanalitik eğitimim ve altyapım var, çok yararlanıyorum, makro sistemi anlamak için yararlanıyorum, ama onun dışında daha entegratif çalışma anlayışı ve uygulamalardan yararlanıyorum, müdahalelerde ve psikososyal destek süreçlerinde… Öyle de olmak zorunda, entegratif ve esnek olmak bir ihtiyaçi gereklilik, zorunluluk hatta…Çünkü tam da bu, terapisti de korur, o yüzden de bir must'tır bizim için…").

P5, the clinical psychologist who works both as a part-time instructor, exemplified how he integrated systemic perspective and solution-focused approach as well as how he got use of EMDR and CBT while working with trauma. He stated that "I have a toolbox which contains all my tools and gadgetries which I use depending on the needs of the cases, which also constitutes a resource or a repertoire for me. The richer and wider that repertoire, the more protective it would be for the trauma therapist… ". ("Sistemik perspektif ve çözüm odaklı yaklaşım entegre biçimde çok işe yarar travma ile çalışırken… BDT altyapım ve EMDR eğitimlerinin de her zaman faydasını görüyorum… Esnek ve entegratif bir süreç yönetimi gerektiriyor travma ile çalışmak, benim de bir alet çantam var, ihtiyacım olanı, vakanın gerektirdiğini bulup kullandığım bir kaynak, bir repertuar… O repertuar ne kadar zenginse, genişse, o kadar koruyucu tabii travma terapisti için…").

Theme: Experience and age

All of the participants pointed out the significance of experience, not only in clinical field but also specifically in the field of trauma. Furthermore, they all emphasized the significant protective and empowering effect of age and life experience, from a lifespan developmental perspective. All of the participants agreed that both experience and age are among the determinants of the professionals' risk of experiencing vicarious traumatization; they suggested that the younger and less experienced the trauma therapist, the higher the risk of vicarious traumatization and burnout. They perceived and defined age and experience in terms of number of different ways, ranging from formal education and special training on trauma field to professional and personal life experiences in order to avoid or overcome a probable vicarious traumatization and burnout. They reported that with maturity and experience they started to have an increased awareness and deepened insight towards themselves, while be more flexible and more integrative in their clinical practice and therapeutic relationship. They also added that as their maturity and experience rised, they started to define more clearly as well as understand and accept their roles more proficiently. The participants also stated that as therapists they started to manage to keep work-life balance better now in comparion to their first couple of years of experience in the trauma field. Six out of seven participants indicatively expressed that in years through experience in their both professional and personal lives, their points of view evolved agreeing on the significance of "the relationship itself" as a mean for healing, especially working with trauma.

P4, 46-year-old clinical psychologist, stated that "I think professional experience is one of the most critical and distinctive factors which significantly help the professional to cope with the adverse effects and intense countertransference effects of trauma work…". ("Meslekteki deneyim yılının çok önemli bir koruyucu ve

çok fark yaratan bir faktör olduğunu düşünüyorum uzman için, deneyim yıllar içinde uzmanın, travma alanı çalışmalarının yarattığı olumsuz etkilerle ve o yoğun karşıaktarımla baş edebilmeyi öğrenmesine yardımcı oluyor ciddi şekilde…").

P2, 33-year-old clinical psychologist, empahized the significance of age and experience as a whole, adding a perspective she stated that "Compared to my 20's, I think it is better to work with trauma in 30's of age, because now I know myself better, my knowledge and skills were firmed and maturated by the help of not only field trainings and experience but also life experience and age, my anxiety decreased while my confidence increased, I can protect both my boundaries and the the clients' processes better. Experience in trauma field field may be seen as a risk factor from a different perspective due to the cumulative burden it may create but I think its protective function is more effective, at least my personal experience were so." ("Yaşın ve travma alan deneyiminin, birlikte önemli bir faktör olduğunu düşünüyorum ben... Yirmili yaşlarıma kıyasla şimdi otuzlu yaşlarda travma ile çalışmak daha iyi, kendimi daha iyi tanıyorum, hem deneyimle, hem eğitimlerle hem de yaşla bilgi ve becerilerim pekişti, oturdu, anksiyetem azaldı, daha güvenli hissediyorum, kendimi de vakanın sürecini de daha iyi koruyabiliyorum…Aynı faktör bazen kümülatif etkiden dolayı olumsuz ve risk faktörü olarak da görülebilir ama ben bunun koruyucu tarafının ağır bastığını düşünürüm hep, benim deneyimim de o yönde…").

P5, a 39-year-old clinical psychologist who works both as a part-time instructor and as a clinical supervisor in addition to his private clinical practice in trauma field, differentiated age and experience despite the fact that he emphasized importance of both. He stated that "experience and knowledge have primary protective functions, especially in trauma field". He specifically added that

“experience is much more critical than age, because you can get older but if there is no adequate/significant experience, it means nothing by itself. I think experience makes the trauma therapist more genuine, more sincere and tough”. (“Travmaya çalışmaya dair, deneyim ve birikim bence çok birincil koruyucu işlevde, özellikle de bizim alanda… Yaştan çok hayat deneyiminin olması önemli bence, yaşın olabilir ama deneyimin yoksa alanda ve hayatta, yaş tek başına bir şey ifade etmez. Deneyim, travma terapistini daha bir gerçek, daha bir samimi ve daha bir sağlam kılıyor sanki...”).

Theme: Significance of diversity of professional roles

Five participants out of seven stated that balancing trauma caseload with non-trauma field cases as well as balancing overall trauma work with other professional engagements such as research and academic field, teaching and supervising, or administrative responsibilities were indicative protective factors.

P3, clinical-forensic psychologist who works as a part-time lecturer and also as a part-time clinician reported that lecturing, supervision, researches, projects and trainings were all sources of vitality and energy for her. She definitely reported that she liked to distribute her time and energy among different activities and suggested that “I think diversity of roles and activities has a protective function as a part of self-care habits”. (“Üniversitede dersler, süpervizyon, araştırmalar, projeler, eğitimler bunların hepsini seviyorum, gözümü parlatan şeyler var, canlandıran, yaparken anlam bulduğum… Zamanı ve enejiyi bölüştürmeyi seviyorum, iyi geliyor, özellikle de bu saha da çalışırken, self-care’in bir parçası olarak çok koruyucu görüyorum…”).

P6, the clinical psychologist who works as a part-time instructor and a clinical supervisor in addition to her private clinical practice in trauma field

described how diversity of her roles and activities protects her staing that “Being active both in academic and clinical fields feeds eachother. Supervision, lectures, theses, projects are all source of a fresh breath for me. This diversity protects me against burnout. And I think there should be a limit, it is an absolute necessary, otherwise it drags both the consultant and the consultee to burnout or breakdown…”. (“Hem akademik hem klinik tarafta aktif olmak, bunlar birbirini besliyor... Süpervizyon, tezler, projeler, ders vermek, klinik alan ve travma sahasındaki uygulamanın yanında nefes kaynağı olarak önemli koruyucular diye düşünüyorum benim için… Böyle olunca kendimi tükenmiş hissetmiyorum. Bence mutlaka bir limit olmalı, salt travma ile çalışarak verimli ve sağlıklı olmaz bu iş. Biraz seyretltmek lazım... Yoksa tükenmişliğe götürür, danışanı da danışmanı da dağıtır.”).

Theme: Significance of professional and organizational support

All of the participants underlined the crucial contributions as well as necessity of professional support in terms of supervision, peervision, consultation and regular case presentation meetings. While six out of seven participants get regular professional support and clearly state its benefits, one participant, P7, the psychologist who works at child and adolescent center as state employer, complained about having dificulties in access to regular supervision and working ina kind of isolation. P7 stated that “I can get neither supervision nor peervision although I need it, and I am annoyed about this fact, because I need that kind of a professional support, it is both a must and a lack of our field. I noted this point while I was completing your inventories, supervisions and trainings are so expensive that they are nor affordable for everybody, particularly for state employers like us. Maybe Turkish Psychological Association may do something to slove this problem, and it

should do so. It is part of a labor safety…". ("Çok ihtiyacım oluyor ama ne süpervizyon alabiliyorum ne de bir meslektaşla konuşacak bir durumum oluyor, ki bu beni çok da rahatsız ediyor, çünkü böyle bir mesleki desteğe ihtiyaç duyuyorum, ben bunu sizin formlarınızı o ölçeklerinizi doldururken de düşünmüştüm ve yazmıştım oraya da, mesleki destek ve süpervizyon alanımızın önemli bir ihtiyacı ve eksiği, süpervizyonlar da eğitimler de pahalı. Bizim gibi devlet memurları için mümkün değil... Dernek bir şey yapabilir bu sorunu çözmek için, yapmalı da, zira bu iş güvenliğinin de bir parçasıdır bence..."). P7 defined how helpless and lonely he felt himself, pointing out the risk of burnout due to the intensive burden of trauma caseloads and lack of supportive systems. He also stated that "I sometimes question myself about how efficient I can do my job. Sometimes I feel myself very incompetent or insufficient as well as exhausted. Working with trauma may bring burnout and fatique". ("Bazen çok yalnız, çaresiz hissediyorum... Yaptığım işi ne kadar iyi yapıp yapamadığımı sorguluyorum, bazen çok gücüm tükenmiş gibi, bazen bilgim becerim kifayetsiz gibi hissediyorum vallahi... Bu iş, çok yorgunluk, tükenme, yılgınlık biriktirebiliyor insanda...").

Six participants out of seven described supervision and/or peervision as a very helpful tool to reduce and to manage the anxiety evoked by trauma work. Also, they reported that both supervision and peer consultation help them to enhance their self awareness about their feelings, beliefs, assumptions, expectations as well as probable vicarious traumatization reactions. Additionally, they all reported that both professional and organization support sources help and guide them implementing the necessary self-care strategies.

P6, the clinical psychologist, stated that "I got supervision regularly in the past, and now I get when I need. I benefit from participating professional support and

consultation groups, also I do my best in order to participate case presentation groups. I had attended my personal psychotherapy for a long time, I still apply for when I need, it always feels good... So, in essence, it should not be worked in trauma field without these support systems, in other words, 'It is dangerous and forbidden to enter into the construction without helmet'…". ("Geçmişte düzenli süpervizyon aldım ve ara ara hala ihtiyacım oldukça alıyorum destek paylaşım gruplarının katılımcısı olmaktan faydalanıyorum. Akran desteği ve vaka paylaşımı gruplarına da katılmak için elimden geleni yapıyorum ve faydalanıyorum... Bireysel terapi aldım uzun süre. Hala ihtiyaç duyunca başvururum, daima iyi hissettirir…Ezcümle, bu destekler olmadan travma sahasında çalışılmamalı, 'inşaata kasksız girmek tehlikeli ve yasaktır!' yani…")

To a certain extent parallel to professional support systems, six participants emphasized importance of organizational support in terms of work settings as well as systemic and organizational characteristics including working as a part of a multidisciplinary team, feeling protected and looked after by a system, having sufficient recognition and reward, having right and flexibility to set limits for both for the trauma caseload as well as for overall workload. Additionally, having adequate and regular breaks and vacations when needed were other indicative points reported by the participants as a part of organizational support, in turn as a part of self-care.

P3, clinical-forensic psychologist, pointed out the cruciality of working in a well-functioning team and working with a harmonious team stating that "this means holding and containing together… and this is so protective that no more burden remains to take home…". ("İyi işleyen bir sistemde, uyumlu bir ekiple çalışmak çok

kritiktir; iyi ekiplerle çalışmak birlikte tutabilmek, taşıyabilmek demektir…Bu o kadar koruyucu olur ki eve götürecek yükün kalmaz…").

P5, 39-year-old male clinical psychologist, clearly suggested that in trauma field working alone can not be efficient or useful for the trauma survivor, also it may be quite risky and harmful for the trauma therapist for vicarious traumatization and burnout. He exemplified his experience stating that "sometimes you don't realize how much you burnout or broken down, but your collegues in the team hold you, stop you if necessary and support you. Being a team means not only taking care of you but also it means taking care of eachother…". ("Ekiple çalışmak çok koruyucudur. Sen ne kadar dağıldığını ve tükendiğini fark etmediğinde, ekipteki arkadaşların seni tutar, gerektiğinde seni durdurur, seni destekkler… Ekip olmak hem kendine hem de birbirine iyi bakmak gibidir, o da çok hayat kurtaran bir şeydir. Travma sahasında yalnız çalışmak bence uygun değil, ikincil travmatizasyona da tükenmişliğe de davetiye çıkarmaktır, ayrıca da o travma vakası için de verimli, faydalı olamaz…").

P2, 33-year-old clinical psychologist similarly pointed out that working as part of a team which mirror, confront and criticize the professional when needed was one of the protective components while working with trauma. ("Travma ile çalışırken ekibin çok önemli bir koruyucu bileşen olduğunu düşünüyorum; gerektiğinde ayna tutan ve kritik eden bir ekip olmalı…").

Theme: Activism

Four paricipants out of seven mentioned activism as a protective factor against bunout and vicarious traumatization. They described function of activism as a mean,

a social and political expression of anger, rebellion and struggle which contains not only support and solidarity but also confrontation and opposition.

P4, a 46-year-old female clinical psychologist who works for women rights movement as well as women protection from violence and abuse, emphasized the protective effect of activism and sense of solidarity denoting that "My activistism is absolutely a significant protective factor. I feel as if I was in solidarity with the women whom I counseled, and in turn this sense of solidarity vitalizes me..." ("Aktivist tarafım çok büyük bir koruyucu kesinlikle. Kendimi bana gelen kadınlarla dayanışıyor gibi hissediyorum ve bu da güç veriyor …") She also elaborated her perspective on the protective effect of activisim integrating with the protective effect of working as a part of a well-functioning system. She reported that "Honestly I feel lucky because I am working at this Women Protection and Shelter Association. Beside my identity as a clinician I am also an activist and a feminist. I have a theoretical background as well as a world view which help me to be aware as well as to make sense of, explain and interpret the meaning of the ongoing processes together with the hidden systemic background factors related to the survivors' traumatic experiences. Besides, I am part of a foundation which works to change these particular background factors in the current system. Thus, by courtesy of these factors, I never listen to the traumatic materials of the survivors helplessly, rather, I feel myself as a part of the process which invests on systemic and solution-focused change steps in the system. I have a chance to share the process and follow the case with a lawyer as well as a social worker. So, I can protect the boundaries more clearly and more easily. There is an interdisciplinary and well-functioning team which is significantly important and protective for the professionals working in the trauma field…" ("Burada çalıştığım için çok şanslıyım aslında. Klinisyenliğimle

birlikte aktivistliğim ve feministliğim de var. Bu insanların yaşadıkları travmaların farkında olabilen, bunun sistemdeki arka planını anlayabilen, duyduklarımı anlamlandırabilen bir dünya görüşüm, ve de teorik altyapım var. Ve aynı zamanda var olan sistemde, bunu da değiştirmek için uğraşan bir kurumun bir parçasıyım. Yani bu sayede, bu alanda çalışırken sadece çaresizce dinlemiyorum, sistemik çözüme ilişkin adımların, yatırımların bir parçası olabildiğimi hissediyorum… Korkunç bir travmatik hikayeyi ve sürecin takibini o sistemdeki bir avukatla, bir sosyal hizmet uzmanıyla paylaşabiliyorum... Biliyorum ki orada ortaklaşabiliyoruz, bu şekilde ben de sınırlarımı daha net çizebiliyorum… Ekip olarak işbirliği içinde akan bir çalışma var, o da çok önemli ve çok koruyucu travma çalışanları için…")

P5, the male clinical psychologist, similarly defined activism as a kind of buffer which functions as a protection against the traps of feeling helplessness, powerlessness, rage or frustration. He also added that activism is quite compatible with his theoretical and practical orientation which focuses on solution and empowerment instead of problem and helplessness. ("Aktivizm bir çeşit tampon vazifesi görüyor diyebilirim, böylelikle o güçsüzlük hissine, çaresizlik, hayalkırıklığı ve öfke tuzağına düşmekten koruyor. Aynı zamanda benim teorik ve pratik yönelimimle de uyumlu, çözüm ve güçlenme odaklı bir yaklaşımım var. Ekip olarak da bizim böyle aktivist bir ruhumuz var, bu da ayrı bir sinerji yaratıyor bu alanda çalışırken tabii…")

P2, 33-year-old, female clinical psychologist defined her activism as a way of coping emphasizing the protective function of activism. She reported that "Activism may be protective, I am trying to transform anger into an activist act, otherwise anger may be quite destructive and it may lead to intolerance. So, I think that professionals who particularly work with trauma have to be activist. I think that all the traumas,

especially the human-made ones, have a political component. Furthermore, I also think that the existing world order by itself creates these traumas, therefore activism is quite important. Of course I do not have a belief or expectation that great things would happen suddenly and then all the world order would change, because working with trauma constantly confronts you with reality as well as revises your expectations, which is nice, at least adaptive. Due to the fact that it would contribute to change of the world, I think that activism should be supported and encouraged not only for mental health professionals working in the trauma field but also for everybody. My activist nature helps me to cope and transform.". ("Öfkeyi daha aktivist bir şeye dönüştürmeye çalışıyorum, bu koruyucu olabiliyor. Dönüştüremezseniz sorun olur, bu öfke çok yıkıcı olabilir, daha tahammülsüz olabilirsiniz. Bu sebeple özellikle travmayla çalışan insanların aktivist olması gerektiğini düşünüyorum. Travmaların hepsinin politik bir bileşeni olduğunu düşünüyorum, özellikle de insan eliyle olanlar, ve de öte yandan bu dünya düzeninin bu travmaları yarattığını düşünüyorum. O yüzden aktivizm çok önemli. Tabii ki birden çok büyük şeyler olacak ve dünya değişecek gibi bir inancım da yok çünkü travma ile çalışmak sizi sürekli gerçeklikle yüzleştiriyor ve beklentilerinizi revize ettiriyor, ki bu da iyi bir şey, en azından adaptif bir şey. Dünyanın değişimine katkıda bulunacağı için aktivizmin desteklenmesi gerektiğini düşünüyorum, hem herkes için hem de özellikle travma sahası çalışanları için. Aktivist tarafım bana baş etmemde ve dönüştürmemde yardım ediyor...")

Theme: Self-care and coping strategies

It is important to begin with the fact that all of the participants were aware about the significant impact of working with traumatic materials on themselves, in addition,

they all recognised and pointed out the cruciality of self-care while working with trauma. All of the participants reported that they developed a repertoire of coping and self-care strategies in order to be able to alleviate the negative impacts of trauma work. One of the most prevalent strategies which were described by all participants were the strategies related to physical self-care habits through regular sleep, balanced nutrition and regular exercise such as walking, jogging, swimming or dancing. Two of the professionals reported that doing something especially using their hands made them feel better either through washing dishes or sculpturing. Additionally, all the participants reported some kind of intellectual self-care habits such as writing and reading, learning and teaching as well as contemplating about meaning making. Social and relational support systems were described as another channel of self-care by the participants. All participant professionals reported significant value of their personal communities and social networks referring their family members, romantic partners, friends as well as their colleagues, feeling as source of trust, shared intimacy, warmth and joy.

P1, 29-year-old female psychologist who uses art therapy techniques working with chronically and terminally ill children and their families, exemplified that talking about daily things with her mother and her friends, doing something totally out of psychology makes her feel good and relaxed, especially in the end of the days she intensely engaged with the children in terminal period…". ("Annemle veya arkadaşlarımla, havadan sudan, günlük şeylerden konuşmak ya da genel olarak psikoloji dışında bir leyler yapmak iyi gelir, rahatlatır, özellikle de terminal dönemdeki çocuklarla yoğun çalıştığım günlerin sonunda..."). P1 also reported that "In general, doing something physical such as sportive activities makes me feel good. I am trying to go to gym regularly, twice or three times a week and it works

well, I feel as if I was refreshed after exercise…". ("Spor yapmak, genel olarak hareket etmek, fiziksel bir şey yapmak iyi geliyor genelde... Haftada iki-üç spora düzenli salona gitmeye çalışıyorum, iyi geliyor, spordan çıktıktan sonra aklımda bir şey kalmamış oluyor, tazelenmiş oluyorum…").

P3, 38-year-old, female clinical-forensic psychologist, reported that playing and walking around with her dog always makes her feel good. In addition, she said that she benefits from breathing, relaxation and meditation. ("Köpeğimle gezmek, oynamak, yürümek daima iyi geliyor... Nefes egzersizi, gevşeme tekniği ve meditasyon iyi geliyor, beni sakinleştiriyor...")

P5, 39-year-old male clinical psychologist, described his self-care habits basically as a life style as well as a professional responsibility. He stated that "exercise and music are a kind of therapy or rehabilitation for me. Also, I try to do my best to take care my body and physical health, taking care of regular sleep, nutrition and break… Particularly I try to protect my boundaries and life-work balance. I think this is one of the most crucial components of self-care…". ("Spor ve müzik benim için bir terapi, bir rehabilitasyon gibi... Bedenimi ve sağlığımı da korumaya dikkat ederim. Düzenli yemek, uyku, mola... Özel hayat ile iş hayatımın arasındaki sınırı ve dengeyi titizlikle korurum. Öz bakımın en önemli parçalarından biri bence budur...").

Protecting boundaries and life-work balance was described among the self-care habits by all participants. P2, 33-year-old, female clinical psychologist reported that "I protect my boundaries, for instance I have a different telephone line for work, and switch it off when I am home… Also, I try not to think and talk about work and cases after I come home…". ("Sınırlar koyuyorum, mesela bir iş telefonum var, onu

kapatıyorum akşamları, eve gelince işle ya da vakalarla ilgili düşünmemeye, konuşmamaya çalışıyorum...").

P7, 45-year-old male psychologist, told that "I have a social life and friends who listen, comfort and encourage me when my mood is down; they are always there when I need... Spending time with my family, particularly with my children is priceless…". ("Sosyal hayatım, beni dinleyen, anlayan, destekleyen, cesaret veren arkadaşlarım var, her zaman iyi gelir onlarla olmak, ruh halim düşük olduğunda, ihtiyaç duyduğumda oradadırlar…Ailemle, hele ki çocuklarımla olmak dünyaya bedel…").

All participant professionals described how spiritual perspective in terms of sense of interconnectedness helps them as a self-care strategy. Five of the participants specifically described spiritual and religious habits as part of their self-care; they explained how they benefits from the approach of feeling as a part of a whole like a macro-system in which everyone is connected to eachother and everything has a meaning and mission. P1 exemplifyed budism, sufism and shamanism while P3 described Islamic rituals among self-care habits.

Arts, hobbies and leisure activities, artistic and creative expressions such as music, playing an instrument, dance, drawing, painting, drama, sculpture, handcraft and creative writing or playing games were described and exemplifyed by all participants as examples of self-care strategies. P3 reported that she liked making puzzles and watching films at home in the evenings while dancing at weekends. P5 reported that he preferred to play reed while P2 exemplifyed that she was dealing with marbling in spare times. P6 told that she was engaged in modern art as both an artistic and an activist expression.

Theme: Special solidarity among trauma field professionals

Six participants out of seven described a special solidarity among the professionals who work in trauma field. Five of them defined some common characteristics which they attribute to the trauma field professionals, such as, sensitivity, responsibility, some degree of sociopolitical activism, sense of fairness and morally uprightness.

P4, the clinical psychologist, described working in trauma field as a part of the trauma network as feeling as a part of a big family with all its protectiveness, containment and warmth. ("Travma sahasında çalışmak, travma networkünün bir parçası olmak, insana kocaman bir ailenin bir parçası gibi hissettirir; tüm o sıcaklığı, kapsayıcılığı ve koruyuculuğu ile…").

P6, 40-year-old female clinical psychologist, stated that "I feel a special fondness with a priceless attachment to the collegues who work with trauma. It is priceless for me to talk to and share something with them". ("Travma ile çalışan insanlarla başka bir yakınlık, çok özel, eşsiz başka bir bağ hissediyorum... Bende bir şeyi onlarla paylaşmamın hali emsalsizdir...").

CHAPTER 5

DISCUSSION

One of the major aims of the present study was to investigate the prevalence of vicarious traumatization among the mental health professionals working in the trauma field in Turkey, and in turn, to attract attention to the probable effects of trauma work on trauma field professionals. In essence, the primary aim of the study was to attract attention as well as to identify protective factors and risk factors which predict vicarious traumatization. More specifically, it was aimed to explore the probable predictor values of demographic variables, level of exposure to trauma work in terms of workload, caseload and experience years in the field as well as burnout, ways of coping, perceived social support and personal trauma history in vicarious traumatization. On the basis of the findings, the significant mission of the study was to generate projects and psychoeducation programs which would invest in and implement on protective factors, especially on self-awareness and self-care in order to be able to prevent probable burnout and vicarious traumatization in mental health professionals as well as candidates in Turkey. Additionally, taking necessary lessons from not only the findings but also the limitations of the study, it was also aimed to think about and propose a future research agenda for more specific dimensions of the topic which in turn would be intended to utilize for application in the field. For the present study, qualitative and quantitative methods were used in combination to get more detailed data in order to be able to explore the effects of trauma work on professionals as well as to grasp the whole picture.

It was revealed that the overall prevalence of vicarious traumatization among the mental health professionals working in the trauma field in Turkey was

predominantly high. When have a short look at the distribution of vicarious traumatization levels, in order just to have a general idea about the prevalence and - more or less- the severity of vicarious traumatization of the professionals, it was observed that 60 % of the mental health professionals in the country were found to exhibit severe levels of vicarious traumatization. Statistical analyses on the quantitative data of the present study revealed a significant difference between the different groups of professions in terms of level of vicarious traumatization. As hypothesized, social workers were found to have the highest level of vicarious traumatization among the four groups of professionals while psychological counselors showed the lowest level. When thinking together with the results of the regression analyses which revealed education, training, support, workload and caseload among the predictors of vicarious traumatization in varying degrees, it was not surprising to find that social workers showed the highest level of vicarious traumatization, because social workers were the group of professionals who had the least level of education and the least amount of field training, almost no access to supervision, peervision or case consultation (Maslach & Leiter, 1997; Maslach, Schaufeli & Leiter, 2001; Bride, 2007), and more importantly, both their workloads and caseloads were overloaded, which made them more vulnerable to both burnout and in turn vicarious traumatization (Lerias & Byrne, 2003). Social workers were predominantly engaged with providing psychosocial support services to vulnerable populations specifically consisting of the neglected or abused children and adolescents as well as disadvantaged and elderly people who generally had multiple traumas (Newel & MacNeil, 2010).

The present study emphasized the important roles of formal education and field trainings. On the basis of the statistical analyses of the quantitative data, it was

revealed that as education and trauma field training level increased, the severity of vicarious traumatization significantly decreased. In parallel, qualitative data of the study indicated the protective function of education and training against vicarious traumatization, too. A definite consensus among all the participant professionals was evident about the need for and necessity of graduate courses and regular field trainings regarding trauma work, vicarious traumatization and self-care strategies. Consistently with the results of the present study, throughout the literature, formal education, field trainings and supervision were found to be among the major factors which have been always recommended for prevention of vicarious traumatization. Pearlman and MacIan (1995), in their research on 188 trauma field professionals, clearly revealed that the professionals who had higher formal education significantly showed less vicarious traumatization. Their finding is also consistent with the literature (Meyer & Ponton, 2006; Schoener, 2007; Barnet, 2007; Courtois, 2009; Harrison & Westwood, 2009). Among these studies, Harrison and Westwood (2009) particularly pointed out that vicarious traumatization could be preventable by the help of psychoeducation and training of the trauma field mental health professionals.

Through the initial correlation analyses on the quantitative data, vicarious traumatization, was found to be positively and significantly correlated with experience years in the clinical field as well as experience years in the trauma field. Additionally, workload (referring to total working hours per week) and caseload (referring to total working hours engaged with trauma cases per week) were also found to be positively and significantly correlated with vicarious traumatization. Therefore, correlation analyses on the quantitative data revealed that as the exposure to trauma work increased, the severity of vicarious traumatization also increased. Despite the fact that the quantitative and qualitative results of the present study

converged at numerous points indicating the same direction, the results from the two parts diverged in terms of the effect of experience years in trauma field. In spite of the fact that a significant positive correlation was found between trauma field experience years and vicarious traumatization in the initial analyses, it is important to note that, in the hierarchical regression analyses it has not been found as a predictor for vicarious traumatization when all the other research variables (workload, caseload, education, training, support, coping style, burnout etc) were controlled. Furthermore, in the qualitative part of the study, all participants reported that they experienced the significant protective and empowering effect of experience years in the trauma field indirectly in parallel to age and life experience. The participant professionals agreed that the younger and less experienced the trauma therapist, the higher the risk of vicarious traumatization and burnout. They perceived and defined age and experience in terms of a number of different ways, ranging from formal education and special training on trauma field to professional and personal life experiences in order to avoid or overcome a probable vicarious traumatization and burnout. They also reported that with maturity and experience they started to have an increased awareness and deepened insight about themselves, while being more flexible and more integrative in their clinical practice and therapeutic relationship. They also added that with experience, they started to set their boundaries more clearly as well as to understand and accept their roles more proficiently. The participants also stated that as therapists they started to manage to keep a work-life balance absolutely better in experienced years in comparison to their first couple of years of experience in the trauma field. Smith et al (2007) similarly opposed the view that experience years in trauma field negatively influenced the professionals' well-being or effectiveness of therapeutic processes with the trauma cases. Their study,

similar to the qualitative part of the present study, found no differences between experienced trauma therapists and younger and less experienced ones. Furthermore, their results pointed out that with experience they managed to find a balance in coping with the adverse effects of clients' traumatic experiences, better than the younger and less experienced professionals.

The results also indicated that the interaction between gender and age has a significant effect on both active and passive coping styles of the professionals. However, the interaction between age and education had a significant effect only on a passive coping style. More specifically, the results indicated that female professionals -both younger and older- showed similar levels of active and passive coping style, while younger males were found to use more active coping style than older males as well as exhibiting less use of a passive coping style than older male professionals. In parallel, in terms of interaction between age, education and coping, it was revealed that a passive coping style was more predominant for younger mental health professionals who have a BA degree, MA degree and PhD degree. But, for older professionals, use of a passive coping style was observed to decrease as their education level increased. More specifically, mental health professionals who had a BA degree exhibited the highest level of use of a passive coping style while the professionals who had PhD degrees were found to use the lowest level of a passive coping style. These findings obtained on the basis of quantitative data analyses of the present study were also consistent with the qualitative data of the study.

Correlation analysis on the quantitative data also revealed that vicarious traumatization was significantly correlated with burnout. More specifically, vicarious traumatization was significantly and positively correlated with emotional burnout as well as desensitization and depersonalization while it was negatively associated with

a sense of personal accomplishment Although vicarious traumatization was significantly correlated with all the three subscales of the burnout scale, the strongest association -both statistically and theoretically- was with the emotional burnout subscale; so, in the further regression analyses burnout was defined and represented as well as entered in the regression and mediation analyses only in terms of emotional burnout.

The key finding of the present study was the mediator role of emotional burnout predicting vicarious traumatization. It was revealed that emotional burnout fully mediated the relationship between caseload and vicarious traumatization. Initial regression analyses revealed that, education, profession, access to any support, active coping style and perceived social support were found as significant predictors of vicarious traumatization, but further regression analyses in the last model pointed out that, level of education, profession, active coping style and emotional burnout were found as statistically significant predictors. Especially, emotional burnout was found to be the most effective predictor of vicarious traumatization.

In order to be able to understand the overall picture more clearly, an additional analysis was conducted to describe potential factors which predict emotional burnout, and, vicarious traumatization was found to be the most effective predictor. It was revealed that emotional burnout was predicted by vicarious traumatization as well as caseload, workload and passive coping style of the professionals. Therefore, it seemed that vicarious traumatization and emotional burnout may be triggering each other and it was hard to differentiate these two phenomena.

The second important finding of the present study was the moderator role of coping style. It was found that the association between emotional burnout and

vicarious traumatization was moderated by the coping style of the professionals. More specifically, the effect of emotional burnout on vicarious traumatization depended on the amount of the use of passive coping style; a positive relationship between emotional burnout and vicarious traumatization was significant for both a high level of passive coping style and low level of passive coping style. But the results indicated that a low level of emotional burnout lead to more vicarious traumatization in a high level of passive coping style while a high level of emotional burnout lead to less vicarious traumatization in a high level of passive coping style.

The results pointed out that active coping style may be suggested among one of the probable protective factors against vicarious traumatization of the mental health professionals who work in the field of trauma. More specifically, in terms of a repertoire of ways of coping of the professionals, vicarious traumatization was found to be negatively correlated with active coping strategies such as optimism, self-confidence and social support seeking; while it was positively correlated with a passive coping style such as helplessness and submissiveness. But there was a nuance here. This was one of the critical and important findings of the present study which integrative interpretation of both quantitative and qualitative results pointed out; that a passive coping style was more effective specifically in the cases when the emotional burnout as well as a feeling of helplessness was exceedingly intense. Participants in the qualitative part defined the times they felt helpless and angry as well as overidentified and preoccupied with the cases, and they reported that in those times they tried to calm themselves and coped with this oversensitivity by distancing themselves from the cases reminding themselves that they can not rescue everyone, they can not control everything and also everything had some meaning and a function in the whole system. So, despite the fact that, in the overall, active coping

style was to be more protective; a submissive and passive coping style was found to be more effective as a protective factor against vicarious traumatization specifically in times of intense emotional burnout and feeling of helplessness (Schauben & Frazier, 1995; Johnson & Hunter, 1997; Farrell & Turpin, 2003; Dunkley & Whelan, 2006; Chouliara et al, 2009). One of the characteristic examples regarding the effectiveness of a passive coping style was clearly mentioned by a participant professional who works with terminal-cancer children and their families. She exemplified that in the face of the disturbing reality of death of a child and grief of the family, she tried to cope by the help of submissive and passive coping style through spiritual beliefs which helped her to perceive all these bitterness as a part of a connected and a meaningful system. At this point it is also important to note that during the sample recruitment process it was not possible to match the professional who works with chronic and terminally ill children in oncology services with another professional who has been working in the same area for a longer period of time, and it was learned that the turnover of the psychologists in the child oncology services is quite high due to its wearing effects on the professional. So, this area may be worthy of special focus in future studies as well as being implemented specially on protective systems such as professional and organizational support as well as self-care.

On the basis of initial analyses of the quantitative data it was found that as the number of traumatic events in the past life history of the mental health professionals increased, severity of their vicarious traumatization decreased.Despite the fact that correlation analyses revealed that the trauma history of the professionals was negatively and significantly correlated with vicarious traumatization, the results of the further analyses of the present study indicated that when all other research

variables (workload, caseload, trauma training, support, burnout etc) were controlled, personal trauma history of the professionals was not significantly effective on vicarious traumatization of the trauma field professionals. While the results of the quantitative part of the research revealed that personal trauma history of the professional was not among the predictors of vicarious traumatization, in the results of the qualitative part, the participant professionals described their personal life story, personal trauma history and actual life events among the risk factors in catalyzing probable adverse emotional, physical and cognitive effects of trauma work. The qualitative results of the study revealed that traumatic life events in the professionals' personal lives, involving both actual and past ones, constituted a risk factor for the professionals for complex countertransferential reactions and for vicarious traumatization. Furthermore, it was also reported that as the resemblance between the clients' traumatic stories and the professionals' traumatic histories increases, the risks of burnout and secondary traumatization as well as boundary violation and overidentification may increase, too. More specifically, they exemplified that being divorced or separated, having children, having a loss, having a chronic or terminal illness or just being a woman or a man may be among these triggering resemblance points for the professionals. But, integrating the qualitative and the quantitative results, it was important to note that the participant professionals also described how they manage this particular risk and how they actively cope with this difficulty and sensitization. They reported that they set their boundaries quite clearly, and they do not accept those clients who have similar traumatic life stories with which the professionals have difficulties in coping. They described these strategies both as a protective strategy as well as a part of self-care. So, as the results of the quantitative part indicated, results of the qualitative part also pointed out the crucial role of an

active coping style and self-care as protective factors against vicarious traumatization.

The integrated results of the present study revealed theoretically consistent findings with Pearlman and Saakvitne's (1995) Constructivist Self Development Theory (CSDT). The participant professionals stated that their basic beliefs and assumptions about their selves as well as about others, life and the world changed after they had started to work with trauma; so, they no longer believed that anyone could be trusted or the world was basically a safe place. They reported an indicative change and transformation in some of their behaviors as well as their basic assumptions and beliefs in terms of self and others regarding safety, trust, justice, esteem and control, in alignment with the CSDT (Pearlman and Saakvitne, 1995). More specifically, a decrease in a feeling of safety as well as trust in others; an increase in alertness, anxiety and fear; from time to time feeling incompetence, helplessness and anger; mental preoccupation with the cases; sometimes having difficulties in protecting the boundaries in terms of work-life balance, all described a change in the participant professionals' worldview.

On the basis of the results of the qualitative data it was revealed that the participants reported an increase in their alertness and decrease in their trust in other people and safety in the world. On the other hand, most of the participant professionals reported deepening their spirituality in terms of feeling a connectedness as a part of a system in which everything has a certain meaning and function. Additionally, almost all participants pointed out an enhancement in their interpersonal relationships in terms of selectiveness, better boundaries and awareness about the preciousness of the present. All of the participants reported some degree of adverse cognitive, emotional and physical effects as well as sometimes mental

preoccupation due to working with trauma cases, especially complex and difficult trauma cases. The adverse emotional and physical effects such as alertness, hypervigillance, anger, grief, nightmares, tiredness or somatic complaints which are evoked while working with trauma is not only consistent with the literature (Baird & Kracen, 2006; Courtois, 2009; Pearlman & Saakvitne, 1995) but also with the conceptual framework of the present study, namely the Constructivist Self Development Theory (CSDT), particularly in terms of safety and trust (Pearlman & Saakvitne, 1995).

Describing trauma work as a double-edged sword was a shared experience among the participants. Both challenges and difficulties as well as gained experiences and rewards were defined as the two sides of the same coin. Throughout the literature being a trauma therapist was commonly described in similar statements (Baker, 2012). Meyer and Ponton (2006) indicated that counseling in the trauma field is both risky and rewarding experience which on the one hand invites mental health professional to participate, witness and accompany all the overwhelming journey of the human growth and healing process, on the other hand, threatens the professionals' well being due to the intense exposure to the traumatic and painful materials as well as empathic engagement with the trauma survivor.

In terms of a deepened sense of spirituality, the literature indicates inconsistent findings. Some of the researches revealed how working with trauma catalyzes an enrichment and deepening in the sense of spirituality while others found that trauma work and in turn vicarious traumatization disrupted and broke down the professionals' sense of spirituality (Pearlman & Saakvitne, 1995). The inconsistencies may be explained with different alternative explanations. One probable explanation may be found in the operational definition of spirituality. More

specifically, if it is defined in terms of a justice, rewards and punishments axis which may be stated as "belief in a just world" approach, it is expected to be disrupted by trauma work, due to witnessing the injustice of the world as well as human brutality. But, if it is defined in terms of connectedness, hope, balance, nature, system and meaning making, it may be expected to be enhanced and deepened in parallel to trauma work.

The reported self-care habits as well as coping strategies were commonly shared throughout the literature. Physical self-care habits included physical exercise, regular sleep, well-balanced nutrition and regular breaks; intellectual and artistic expressions such as reading, writing, painting, sculpturing, dancing and playing music were other sources of self-care; professional and organizational support systems such as supervision, peervision, case presentation groups and trainings were revealed as one of the most important self-care habits; and spiritual rituals such as meditation, yoga, breathing and praying were defined among the ways of coping and self-care, were all confirmed by various findings in the literature (Harrison & Westwood, 2009; Meyer & Ponton, 2006; Neumann & Gamble, 1995; Pearlman & Saakvitne, 1995; Rothschild, 2006; Trippany et. al, 2004). One of the findings of the present study was that perceived social support of the professionals was found to be negatively and significantly correlated with vicarious traumatization; with all its components such as family, friends and significant others, perceived social support systems of the professionals were indicated among the protective factors also as an indispensable part of self-care.

Although it was not among the basic questions and hypotheses of the present study, a vicarious posttraumatic growth was described by the participant professionals in the qualitative part of the research. This finding is also supported by

the literature, as positive self-transformation of the professional, referring the growth as a consequence of working with trauma survivors (Benatar, 2000) and also as vicarious posttraumatic growth, describing the positive and adaptive changes in terms self-perceptions, interpersonal relationships, worldviews and sense of spirituality in the mental health professionals who work with trauma survivors (Arnold, Calhoun, Tedechi, & Cann, 2005). The participants of the present study defined how they were positively affected and empowered by witnessing and accompanying their clients' resilience and coping as well as overcoming and making sense of their traumatic experiences. They described a significant growth with an increased awareness and insight, enhanced interpersonal relationships as well as with a deepening spirituality in parallel to their experiences in the trauma field. The critical question should be why some of the professionals suffered from vicarious traumatization or burnout while others experienced vicarious growth. What may the predictors which determine the direction of the effect be? The findings of the present study could give an idea about the probable predictors of vicarious traumatization on the basis of quantitative data analyses and also probable predictors of vicarious growth on the basis of qualitative data analysis. More specifically, the mediator role of emotional burnout on the relationship between caseload and vicarious traumatization as well as the moderator role of coping style on the association between emotional burnout and vicarious traumatization were among the most distinctive findings of the present study which contribute to explaining the probable determinants. Additionally, the importance of education, training, support systems and self-care was emphasized by both quantitative and qualitative data analyses of the study. But, above all, despite the fact that it sounded quite impressive, absolutely genuine and sincere, from a perspective of devil's advocate, may vicarious

posttraumatic growth be questionable? Especially from a psychoanalytic perspective, may it be a defensive mechanism to deny the adverse effects? May it be a part of an effort for meaning making? May it be a part of coping? The research is always based on the reports / declarations as well as subjective realities of the participants, but it should be kept in mind that there may be alternative explanations subtle or hidden in the apparent results. Future studies may try to explore the mutual interaction between the trauma survivor and the trauma field professional from relational and systemic perspectives which suggest that the professional and the client as a system in which there is a continuous mutual interaction (Bronfrenbrener, 1976; Stern, 2004). May growth of the survivor / client be a catalyzer and predictor for growth of the professional? If so, what about the effects of drop-out trauma cases in the professionals' caseloads? So, further studies may also look at other probable determinants of vicarious growth of the professional and search for the probable effects of personal characteristics of the professional, personal therapy as well as supervision and peervision the professional had in parallel to ongoing trauma work.

One of the strengths of the present research is its rich data base on both quantitative and qualitative data. Qualitative data always presents a richer and deeper understanding through open-ended ways of data collection and data analysis, it widens the researcher's perspective and helps to understand complex human experiences more deeply. So, integrating both qualitative and quantitative methods helps to reach more meaningful and fruitful explanations as well as a deeper and wider insight discovering the essence of the trauma work experiences of the professionals who were at risk of vicarious traumatization regarding work with trauma victims.

Despite the fact that throughout the literature vicarious traumatization has been studied by many researchers, the present study became one of the few pioneer studies in Turkey on this issue, especially with its large sample size and its integrative method. For the quantitative part of the present research, 287 participants who were from 40 different cities constituted the sample involving mental health professionals, namely, psychologists, social workers, psychiatrists and psychological counselors who work with trauma in Turkey, while for the qualitative part of the research the participants who had also completed the research inventories were 7 psychologists who work with trauma in İstanbul, Turkey. One of the methodological limitations of the present study was convenience sampling that was used, so the sampling did not provide a representative sample. Besides, the present study also fell short of providing some of the groups with equal or close numbers of participants, especially in terms of sex and profession. But on the other side of the coin, one of the strengths of the study was that the participant interviewees for the qualitative part were selected through purposive and snowball sampling in order to reach the targeted psychologists who have experience with different trauma types and knowledge about different theoretical orientations. These participants were also meticulously determined so that they represented different but comparable demographic characteristics in terms of their sex, age, marital status, working conditions, clinical practices and theoretical orientations. So, despite the fact that the sample was not representative, it constituted an adequately rich source to grasp the overall picture and trends.

The most important limitation of the study was that the inventory which was used to measure level of vicarious traumatization, the TABS, has not gotten a Turkish standardization yet; so, TABS was used in the back-translation format.

Standardization of TABS for Turkish norms was tested by Gürdil (2014) as the pilot study of her dissertation, but factorial analysis did not reveal a meaningful distribution either on the data of the present research or on Gürdil's (2014) study. TABS is an inventory which was originally developed and widely used within a theoretical and practical framework. Therefore, due to the fact that its subtests were not standardized and its items did not reveal a meaningful distribution to the subtests, TABS Total scores were used for the present study which constitutes a meaningful scene for the purpose of the study.

One of the limitations of the present research was its cross-sectional design. Due to the fact that there was no pretest and control group, it is precluded to infer causal explanations. Future studies may compare the mental health professionals who work and do not work with trauma, or, if possible, before and after they start to work with trauma. In one of the studies in Turkey, it was found that mental health professionals who work with trauma were more prone to show vicarious traumatization in comparison to those who do not work in the trauma field (İçöz, 2010). Furthermore, longitudinal studies may be quite fruitful in order to be able to see and understand developmental process of the effects of working with trauma in years. Additionally, the professionals who had been once working in the trauma field but left working in the field due to its cumbersome adverse effects and vicarious traumatization may be another research focus to investigate through a qualitative research in order to be able to understand their subjective experiences in detail.

Among the minor limitations of the study, an unpredicted problem was observed in the data entrance process in the PhD category of education because it was detected that some of the psychiatrists completed the inventories marking the

Master's degree box while some other psychiatrists marked PhD box. So, there is a categorical confusion in terms of the psychiatrists' education level in the data.

Another limitation of the present study, which may be revised and redesigned in future studies was that the number of participants was limited to seven and all the participants were psychologists in the qualitative part. For the present study as a dissertation thesis, the qualitative part of the present study was planned just to be used as a supportive source of a more-detailed insight about the subjective experiences of psychologists who work in the trauma field; additionally, it was also planned to be used for a comparison and an overall interpretation of the results integrating with the results of the quantitative analyses. So, in future studies, the sample size of the qualitative part may be increased to 20-28 professionals consisting of not only psychologists but also social workers, psychiatrists and psychological counselors, involving at least 5-7 participants for each profession. In turn, this may give the chance to compare the professionals' subjective experiences from different professions, with backgrounds and different practices.

In future studies, the research data may be analyzed through Structural Equation Modeling (SEM) in order to be able to understand the causal relationships between the research variables and constructs more precisely. Despite the fact that it was adequate to grasp the whole picture as well as it was statistically appropriate to use hierarchical multiple regressions for analysis of the present study especially considering the sample size, in order to be able to decrease Type 1 error tolerance more conservatively SEM may be used in future studies. Furthermore, SEM is described as the second generation of multivariate technique which is used for testing and estimating probable casual relationships between the constructs on the basis of casual assumptions and statistical data (Bartholomew, 1999) while hierarchical

multiple regression is defined among the first generation techniques which are used for assessing correlational relations between variables (Tabachnick, 2001). In future studies, SEM would be able to explain the probable relationship between emotional burnout and vicarious traumatization, and in turn their associations with the protective and risk factors more precisely.

Although investigated and tested, the present study did not have any hypothesis about differences in terms of sex. So, sex differences were beyond the scope of the present study, and were not aimed to be investigated thoroughly; but in the final stages of statistical analyses, moderation analysis results indicated a significant difference in coping style in interaction with age and education. Thus, one other interest of future studies may be the investigation of gender differences in vicarious traumatization, burnout and more specifically in terms of coping style and self-care habits, taking into account the influences of age, experience years in trauma field as well.

Quantitative data was based on 287 respondents. The sample size of the research is adequately high in comparison to previous studies on the subject in Turkey. In spite of the fact that the research data were obtained from 40 cities from different regions of Turkey, these cities and geographical regions were neither defined among the demographic variables nor taken into account in analyses. One of the reasons of this was that it was not among the primary questions or interests of the present research. A more important factor was that among the research variables, workload, caseload, education, special training on trauma field, access to professional support systems such as supervision and peervision constituted the construct variables in detail, so city or region difference is a more global categorization in comparison to these research variables which had been already

defined and controlled. As an alternative direction and focus, in the future, a different research may be designed specifically and primarily on the effects of city or region aiming to investigate probable differences regarding cultural factors in terms of collectivist versus individualistic or analytic versus holistic cultural contexts. Additionally, in a future study on this focus, their residing dynamics should be taken into account; they may be staying and working there because they were born there or they may be assigned to work there. This nuance may make a difference in both having an access to and getting use of social support systems, from a cultural differences perspective.

Another alternative approach for future studies may be to investigate the probable relationship between secondary traumatization in terms of symptoms and vicarious traumatization in terms of cognitive-behavioral changes on schemas of the mental health professionals working in the trauma field.

The present study also has important implications regarding not only trauma field practices but more importantly education and field trainings, aiming to increase awareness and insight about probable effects of trauma work as well as to implement protective strategies and self-care. One of the practical values which the present study has is that its findings pointed out important facts about the trauma field professionals and the overall professional system. The indications of the study may be used as a reference to apply for funded projects by the Disaster, Crisis and Trauma Unit of Turkish Psychological Association in order to be able to pervade free supervision and trainings and making these kinds of support systems more easily accessible by potentially all colleagues all over Turkey.

The literature described some common risk factors which catalyze vicarious traumatization. Meyer and Ponton (2006) categorized and explained these risk

factors regarding their sources, as individual (personal) and environmental risk factors. Individual risk factors which increase the professional's vulnerability, and in turn, the risk for the development of vicarious traumatization over time involve personal trauma history of the professional (Pearlman & MacIan, 1995); being less experienced in the field as well as having less trauma training (Pearlman & MacIan, 1995) as well as being female and younger (Weiss, Marmar, Metzler, & Ronfeldt, 1995); history of a psychiatric disorder (Brewin, Andrews & Valentine, 2000); and current life stress (Weiss, Marmar, Metzler, & Ronfeldt, 1995). On the other hand, environmental risk factors which may increase the probability of vicarious traumatization include intense empathic engagement and overidentification with the trauma survivors; brutality and cruelty of the traumatic stories as well as detailed graphic descriptions of traumas during the sessions; successive sessions per day with traumatized patients as well as working with large caseloads per week, and finally working with traumatized children (Brady, Guy, Polestra, & Brokaw, 1999). Additionally, lack of social support and feelings of helpless while working with complex trauma cases were also described among the environmental risk factors for vicarious traumatization (Lerias & Byrne, 2003).

The literature also indicates certain protective factors which constitute kind of a firewall against vicarious traumatization, including self-care strategies, spirituality, (Brady et al., 1999); being an experienced professional in the field (Kramen-Kahn & Hansen, 1998; Pearlman & MacIan, 1995); and having a supportive working environment (Eidelson, D'Alessio, & Eidelson, 2003). Trippany et al. (2004) emphasized that maintaining balance between personal life and professional work is among the protective factors for the trauma field professionals.

Self-care strategies are described in terms of physical activities and exercises such as walking, jogging, swimming or doing housework; sense and use of humor; breaks and vacations when needed; leisure activities and hobbies; social and relational support through socializing with family, friends or significant others . Some of the studies categorize professional support systems such as supervision, peervision, case consultations, field trainings as well as attending personal psychotherapy or psychoanalysis as indispensable parts of self-care (Brady et al., 1999; Kramen-Kahn & Hansen, 1998; Trippany et al., 2004).

Self-care habits are indicated not only solely as protective factors for the professionals against vicarious traumatization fostering health, well-being and resilience, but also as one of the essential components in order to be able to protect the working frame as well as the effectiveness of the therapeutic process from the probable negative effects of vicarious traumatization (Brady et al., 1999).

Witmer and Young (1996) indicated that support systems of the professionals, involving both personal support systems such as family, friends and significant others, and professional networks such as colleagues, peers and supervisors, as a whole constitute a kind of barrier for the professionals against a potential vicarious traumatization, providing also a protection from probable burnout and impairment.

In their review of literature on vicarious traumatization, Lerias and Byrne (2003) indicated that social support was one of the significant protective factors in the professionals' self-regulation of the effects of trauma work. They specifically described the function of social support for the professionals stating that the more social support the professionals had, the less vicarious traumatization they

experienced; so, they emphasized social support among the direct predictors of the change or adjustment of the professional.

Miller (1998) suggests that both the theoretical background and professional support systems of the mental health professional serve as a regulation system which helps the professional to filter, organize, regulate and process the potential effects of trauma, also to create a safe and containing working environment for the trauma survivor.

Besides, the literature agrees that professional support systems should be part of an ideal professional work environment in which colleagues and supervisors discuss and consult on cases from theoretical, practical and ethical perspectives within a containing and well-functioning organizational system. Professional support systems such as supervision, peervision or case consultations not only assist and guide the professional but also indirectly protect the clients and the intervention or therapeutic process (Brady et al., 1999; Trippany et al., 2004). According to Skovholt (2001), well-set professional relationships and a well-functioning organizational system in the work environment enable growth of the professional, also it is crucial in order to be able to create and maintain a work-life balance.

In parallel to the body of literature which emphasized the crucial role of spirituality as a protective factor against the risk of vicarious traumatization, (Brady et al., 1999; Sherwin, Elliot, Frank, Hanson & Hoffman, 1992), Meyer and Ponton (2006) metaphorically suggested that spirituality serves as a root system of a tree, which essentially keeps the professional grounded, raised and empowered especially when confronted with the burdensome adverse effects of trauma work particularly while working with complex trauma cases which involve systematic and multiple

brutal and cruel traumatic experiences as well as cases with grief and loss which bring feeling of helplessness.

To sum up, all the interviewed participants of the present study as well as the colleagues in the field described the experience of working with trauma as a double-edged sword which is both rewarding as well as challenging. At one hand, the participant professionals reported negative effects of engaging in trauma work, such as grief, adverse emotional and physical effects, mental preoccupation with the cases, feeling helpless within the system and feeling angry, but on the other hand they described the positive effects of trauma work, such as priceless experience of witnessing the progress and healing process, admiration for human resilience as well as the hidden instinct for life and striving inside human beings. All of the participants emphasized the uniqueness of the experience of special interaction and working relationship not only between the trauma survivor and the trauma therapist, but also among the trauma field professionals within the network. Pearlman and Saakvitne (1995) described the experience of working with trauma with the words of: "While it is a dark path, it is a spiritual journey, into the darkest recesses of people's private experiences, and one which deepens our humanity in increasing our awareness of all aspects of life. In this way, it is indeed a gift, a reward of doing this work" (p. 406).

On the basis of the findings of the present research, one of the valuable missions of this study is pointing out the necessity of awareness and psychoeduation about trauma, trauma work, vicarious traumatization and self-care. It should be a formal part of education as a required course of graduate clinical programs; it may be in the form of seminars or conferences for undergraduate students. Also, it should be supported and organized by Turkish Psychological Association in order to make possible to get an access to professional support for all trauma field colleagues,

especially for the colleagues in less-developed and divergent cities. These lectures and trainings should be facilitated by appropriately licensed faculty members and experienced trauma field workers.

Integration of all the results of the present study boiled down to the essence of the investment on psychoeducation programs aiming to increase awareness, preparedness regarding vicarious traumatization as well as implementation of preventive programs through self-care strategies. Rather than just emphasizing the importance of work-life balance, the trauma field professionals should be, moreover, supported, guided and trained specifically on self-care habits as well as time and life management. Awareness and psychoeducation on vicarious traumatization and self-care strategies should absolutely be in the form of a life-long continuing education or training programs starting in undergraduate education and going on professional-life-long. This should be far beyond just a resource or curriculum management, rather, it should be admitted as a technical and an ethical requirement for trauma field mental health professionals in accordance with the ethical principles and standards defined by the Turkish Psychological Association's Ethics Code especially in terms of competency and responsibility as well as beneficence and maleficence (TPA, 2004).

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Appendix 1

Mesleğiniz : ..... **Cinsiyetiniz :** ..... **Yaşınız :** .....

Öğrenim durumunuz :
□ Lise ve altı □ Önlisans □ Lisans □ Yüksek Lisans □ Doktora ve üstü

Travma alanında özel bir eğitim aldınız mı ? □ Evet □ Hayır
Cevabınız evet ise; aldığınız eğitim toplam kaç saatlik ? .....

Meslekteki çalışma yılınız : .....
Haftada ortalama kaç saat çalışıyorsunuz ? .....

Hangi yaş gruplarıyla çalışıyorsunuz ?
□ Çocuklar □ Ergenler/Gençler □ Yetişkinler □ Yaşlılar

Hangi kategoride çalışıyorsunuz ?
□ Kamu □ Özel □ Sivil Toplum Kuruluşu
□ Diğer:.....

Şu anda en az 1 tane travma mağduru ile çalışıyor musunuz ? □ Evet □ Hayır
Cevabınız hayır ise ; en son ne zaman travma ile çalıştınız ? .....
Cevabınız evet ise ;
Kaç yıldır travma mağdurları ile çalışıyorsunuz ? .....
Haftada ortalama kaç saat travma mağdurları ile çalışıyorsunuz ? .....

En sık çalıştığınız travma türü/türleri nedir ?
□ Fiziksel şiddet □ Cinsel istismar (cinsel taciz veya tecavüz) □ İhmal
□ Doğal afet (deprem, sel, vb) □ Kaza, yangın □ İşkence, tutsaklık ve/veya hapis
□ Savaş, çatışma ve/veya terör □ Hayatı tehdit eden bir hastalık
□ Yakın ya da sevilen birinin ani ölümü
□ Diğer : .....

Sizi en çok etkilediğini düşündüğünüz, çalışmakta en zorlandığınız travma türü nedir ? (Lütfen bir tane seçiniz)
□ Fiziksel şiddet □ Cinsel istismar (cinsel taciz veya tecavüz) □ İhmal
□ Doğal afet (deprem, sel, vb) □ Kaza, yangın □ İşkence, tutsaklık ve/veya hapis
□ Savaş, çatışma ve/veya terör □ Hayatı tehdit eden bir hastalık
□ Yakın ya da sevilen birinin ani ölümü
□ Diğer : .....

Travma mağdurları ile çalışırken, zorlandığınız durumlarda destek alıyor musunuz ?
□ Evet □ Hayır

Cevabınız evet ise ; aşağıdaki destek sistemlerinden hangilerini kullanıyorsunuz ?
□ Akran meslektaşlar □ Aile
□ Süpervizyon □ Arkadaş, dost
□ Danışmanlık/Psikoterapi/Psikanaliz □ Eş/Partner/Sevgili
□ Diğer : .....

İnancınız var mı ? .....
Eğer varsa nasıl bir inanç taşıdığınızı ve hayatınıza etkilerini kısaca tanımlar mısınız ?
.....
.....

Appendix 2

TABS (Travma ve ve Bağlanma İnanç Ölçeği)

Bu anket bireylerin kendilerini ve başkalarını nasıl gördüklerini anlamak için hazırlanmıştır. Sizden istediğimiz; kendinizi ve dünya hakkındaki inançlarınıza ve düşüncelerinize en uygun düşen cevabı, her ifade yanında verişmiş parantez içindeki numaralardan birini işaretleyerek belirtmenizdir. Lütfen tüm ifadeleri tamamlamaya dikkat ediniz.

		Kesinlikle katılmıyorum	Katılmıyorum	Biraz katılmıyorum	Biraz katılıyorum	Katılıyorum	Kesinlikle katılıyorum
1	Güvende olduğuma inanıyorum.	1	2	3	4	5	6
2	Kimseye güvenilmez.						
3	Çok bir şey hak ettiğimi düşünmüyorum.						
4	En yakınlarım ile birlikteyken bile kendimi oraya ait hissetmiyorum.						
5	İnsanların yanında kendim olamıyorum.						
6	Kimsenin güvende olduğuna inanmıyorum.						
7	Kendi yargılarıma güvenmem.						
8	İnsanlar mükemmel.						
9	Üzgün olduğum durumlarda iyi hissedebilmek için bir şeyler yapabilirim.						
10	Başkası lider konumdayken kendimi rahat hissediyorum.						
11	Çoğu zaman insanların beni incittiğini düşünüyorum.						
12	Kendi yargılarıma güvenirim.						
13	Kendim hakkında kötü hislerim var.						
14	Başka insanlarla geçirdiğim vakitler en mutlu olduğum zamanlardır.						
15	Kendimi kontrol edemeyeceğimi hissediyorum.						
16	Birisine ciddi zarar verebilirim.						
17	Yalnız olduğumda kendimi güvende hissetmiyorum.						
18	Çoğu insan önem verdiği şeyleri mahvediyor.						
19	İçgüdülerime güvenmiyorum.						

		Kesinlikle katılmıyorum	Katılmıyorum	Biraz katılmıyorum	Biraz katılıyorum	Katılıyorum	Kesinlikle katılıyorum
20	Kendimi birçok insana yakın hissediyorum.						
21	Kendimi çoğu günler iyi hissediyorum.						
22	Dostlarım benim fikirlerimi dinlemiyor.						
23	Yalnızken içimde bir boşluk hissediyorum.						
24	Sürekli başkalarınının güvenliğini düşünüyorum.						
25	Keşke duygusuz olabilseydim.						
26	İnsanlara güvenmek pek akıllıca değil.						
27	Kendime hiç zarar vermem.						
28	Genellikle başkalarının kötü yanlarını düşünürüm.						
29	Başkalarına kötülük yapsam da kontrolü elimde tutabilirim.						
30	Fazla bir şeye layık değilim.						
31	İnsanların bana söylediklerine inanmam.						
32	Dünya tehlikeli bir yer.						
33	İnsanlarla çoğu kez uyuşamıyorum.						
34	Karar vermekte zorluk çekiyorum.						
35	İnsanlarla bağımın koptuğunu hissediyorum.						
36	Güçlü olan insanları kıskanıyorum.						
37	Hayatımdaki önemli insanlar tehlikede.						
38	Güvende olduğumu hissedebilirim.						
39	İnsanlar iyi değil.						
40	Duygularımdan kaçmaya devam ediyorum.						
41	İnsanlar kendi arkadaşlarına güvenmemeli.						
42	Başıma iyi şeylerin gelmesini hak ediyorum.						
43	İnsanların bana bir şey yapacağından endişe ediyorum.						
44	İnsanları seviyorum.						
45	Kendimi kontrolde hissetmeliyim.						

		Kesinlikle katılmıyorum	Katılmıyorum	Biraz katılmıyorum	Biraz katılıyorum	Katılıyorum	Kesinlikle katılıyorum
46	Yetişkinlerin yanında kendimi çaresiz hissediyorum.						
47	Kendime zarar vereceğimi düşünsem de, bunu yapmayacağım.						
48	Kimseden yeteri kadar sevgi aldığımı hissetmiyorum.						
49	Yargılarım kuvvetlidir.						
50	Güçlü insanlar yardıma ihtiyaç duymaz.						
51	Ben iyi bir kişiyim.						
52	İnsanlar sözlerini tutmuyor.						
53	Yalnız olmaktan nefret ediyorum.						
54	Başkaları tarafından tehdit edildiğimi hissediyorum.						
55	İnsanlarla birlikteyken kendimi yalnız hissediyorum.						
56	İrademi kontrol etmekte sorunlar yaşıyorum.						
57	Dünya, ruh sağlığı sorunları olan insanlarla dolu.						
58	Karar verme mekanizmam iyidir.						
59	Sık sık insanların beni kontrol etmeye çalıştıklarını hissediyorum.						
60	Kendime kötü bir şey yapabileceğimden endişe ediyorum.						
61	Başkalarına güvenen insanlar aptaldır.						
62	Benim en iyi arkadaşım kendimdir.						
63	Sevdiklerim yanımda değilse tehlikede olduklarına inanıyorum.						
64	Kötü bir insan olduğum için kötü şeyler başıma geliyor.						
65	Yalnızken kendimi güvende hissediyorum.						
66	Kendimi korumak için tetikte olmalıyım.						
67	Çoğu kez kendimden şüphe ediyorum.						
68	Çoğu insan iyi kalplidir.						
69	Yardıma ihtiyaç duyduğumda kendimi kötü hissediyorum.						
70	İhtiyacım olduğunda en iyi arkadaşlarım yanımdadır.						

		Kesinlikle katılmıyorum	Katılmıyorum	Biraz katılmıyorum	Biraz katılıyorum	Katılıyorum	Kesinlikle katılıyorum
71	Birisinin beni inciteceğini düşünüyorum.						
72	Başka insanları tehlikeye atacak şeyler yapıyorum.						
73	İçimde kötü bir güç var.						
74	Kimse gerçekten beni tanımıyor.						
75	Yalnız olduğumda sanki dünyada ben dahil kimse yokmuş gibi geliyor.						
76	Çok iyi tanıdığım insanlara saygı duymam.						
77	Genellikle insalara ne olduğunu anlayabilirim.						
78	Eğer lider konumda değilsem iyi iş çıkaramam.						
79	Kendimi rahatlatamıyorum.						
80	İnsanlara fiziksel zarar veriyorum.						
81	Kendime zarar vereceğimden korkuyorum.						
82	Kendimi her yerde terkedilmiş hissediyorum.						
83	Eğer insanlar gerçekten beni tanısaydı benden hoşlanmazlardı.						
84	Yalnız geçireceğim zamanları iple çekiyorum.						

Appendix 3

Aşağıda bireylerin işleriyle ilgili tutumlarını yansıtan ifadeler yer almaktadır. Her maddede yer alan ifadenin size ne kadar uygun olduğunu 5'li ölçek üzerinden işaretleyiniz.

	Hiçbir zaman	Çok nadir	Bazen	Çoğu zaman	Her zaman
1. İşimden soğuduğumu hissediyorum.	1	2	3	4	5
2. İş dönüşü kendimi ruhen tükenmiş hissediyorum.	1	2	3	4	5
3. Sabah kalktığımda, bir gün daha bu işi kaldıramayacağımı hissediyorum.	1	2	3	4	5
4. İşim gereği karşılaştığım insanların ne hissettiğini anlarım.	1	2	3	4	5
5. İşim gereği karşılaştığım bazı kimselere, sanki insan değillermiş gibi davrandığımı fark ediyorum.	1	2	3	4	5
6. Bugün insanlarla uğraşmak benim için gerçekten çok yıpratıcı.	1	2	3	4	5
7. İşim gereği karşılaştığım insanların sorunlarına en uygun çözüm yollarını bulurum.	1	2	3	4	5
8. Yaptığım işten tükendiğimi hissediyorum.	1	2	3	4	5
9. Yaptığım iş sayesinde insanların yaşamına katkıda bulunduğuma inanıyorum.	1	2	3	4	5
10. Bu işte çalışmaya başladığımdan beri, insanlara karşı sertleştim.	1	2	3	4	5
11. Bu işin beni giderek katılaştırmasından korkuyorum.	1	2	3	4	5
12. Çok şeyler yapabilecek güçteyim.	1	2	3	4	5
13. İşimin beni kısıtladığını hissediyorum.	1	2	3	4	5
14. işimde çok fazla çalıştığımı hissediyorum.	1	2	3	4	5
15. İşim gereği karşılaştığım insanlara ne olduğu umurumda değil.	1	2	3	4	5
16. Doğrudan doğruya insanlarla çalışmak bende çok fazla stres yaratıyor.	1	2	3	4	5
17. İşim gereği karşılaştığım insanlarla aramda rahat bir hava yaratırım.	1	2	3	4	5
18. İnsanlarla yakın bir çalışmadan sonra kendimi canlanmış hissederim.	1	2	3	4	5
19. Bu işte birçok kayda değer bir başarı elde ettim.	1	2	3	4	5
20. Yolun sonuna geldiğimi, her şeyin bittiğini hissediyorum.	1	2	3	4	5
21. İşimdeki duygusal sorunlara serinkanlılıkla yaklaşırım.	1	2	3	4	5
22. İşim gereği karşılaştığım insanların bazen problemlerinin, zaman zaman benden kaynaklandığını düşünüyorum.	1	2	3	4	5

Appendix 4

Bu ölçek, kişilerin sıkıntıları ve stresle başa çıkmak için neler yaptıklarını belirlemek amacıyla geliştirilmiştir. Lütfen sizin için sıkıntı ya da stres oluşturan olayları düşünerek bu sıkıntılarınızla başa çıkmak için genellikle neler yaptığınızı hatırlayın ve aşağıdaki davranışların sizi tanımlama ya da size uygunluk derecesini işaretleyin.Herhangi bir davranış size hiç uygun değilse % 0'ın altındaki kutu içine **X** işaretini koyun. Çok uygun ise % 100'ün altını işaretleyin.

BİR SIKINTIM OLDUĞUNDA	**Sizi ne kadar tanımlıyor/Size ne kadar uygun?**			
	%0	**%30**	**%70**	**%100**
1. Kimsenin bilmesini istemem.				
2. İyimser olmaya çalışırım.				
3. Bir mucize olmasını beklerim.				
4. Olayı/olayları büyütmeyip, üzerinde durmamaya çalışırım.				
5. Başa gelen çekilir diye düşünürüm				
6. Sakin kafayla düşünmeye,öfkelenmemeye çalışırım.				
7. Kendimi kapana sıkışmış gibi hissederim.				
8. Olayın / olayların değerlendirmesini yaparak en iyi karar vermeye çalışırım.				
9. İçinde bulunduğum kötü durumu, kimsenin bilmesini istemem.				
10. Ne olursa olsun direnme ve mücadele etme gücünü kendimde bulurum.				
11. Olanları kafama takıp, sürekli düşünmekten kendimi alamam.				
12. Kendime karşı hoşgörülü olmaya çalışırım.				
13. İş olacağına varır diye düşünürüm.				
14. Mutlaka bir yol bulabileceğime inanır, bunun için uğraşırım.				

Sizi ne kadar tanımlıyor/Size ne kadar uygun?

BİR SIKINTIM OLDUĞUNDA	%0	%30	%70	%100
15. Problemin çözümü için adak adarım.				
16. Her şeye yeniden başlayacak gücü kendimde bulurum.				
17. Elimden hiçbir şeyin gelemeyeceğine inanırım.				
18. Olaydan/olaylardan olumlu bir şey çıkarmaya çalışırım.				
19. Her şeyin istediğim gibi olmayacağına inanırım.				
20. Problem/problemleri adım adım çözmeye çalışırım.				
21. Mücadeleden vazgeçerim.				
22. Sorunun benden kaynaklandığını düşünürüm.				
23. Hakkımı savunabileceğime inanırım.				
24. Olanlar karşısında "kaderim buymuş" derim.				
25. "Keşke daha güçlü bir insan olsaydım" diye düşünürüm.				
26. Bir kişi olarak iyi yönde değiştiğimi ve olgunlaştığımı hissederim.				
27. "Benim suçum ne" diye düşünürüm.				
28. "Hep benim yüzümden oldu" diye düşünürüm.				
29. Sorunun gerçek nedenini anlayabilmek için başkalarına danışırım.				
30. Bana destek olabilecek kişilerin varlığını bilmek beni rahatlatır.				

Appendix 5

Çok Boyutlu Algılanan Sosyal Destek Ölçeği

Asağıda 12 cümle ve her birinde de cevaplarınızı isaretlemeniz için 1'den 7'ye kadar rakamlar verilmistir. Her cümlede söylenenin sizin için ne kadar çok doğru olduğunu veya olmadığını belirtmek için o cümle altındaki rakamlardan yalnız bir tanesini daire içine alarak isaretleyiniz. Bu sekilde 12 cümlenin her birinde bir isaret koyarak cevaplarınızı veriniz.

1. İhtiyacım olduğunda yanımda olan özel bir insan var

Kesinlikle hayır 1 2 3 4 5 6 7 Kesinlikle evet

2.Sevinç ve kederlerimi paylasabileceğim özel bir insan var

Kesinlikle hayır 1 2 3 4 5 6 7 Kesinlikle evet

3. Ailem bana gerçekten yardımcı olmaya çalısır

Kesinlikle hayır 1 2 3 4 5 6 7 Kesinlikle evet

4. Ðhtiyacım olan duygusal yardımı ve desteği ailemden alırım

Kesinlikle hayır 1 2 3 4 5 6 7 Kesinlikle evet

5. Beni gerçekten rahatlatan özel bir insan var

Kesinlikle hayır 1 2 3 4 5 6 7 Kesinlikle evet

6. Arkadaslarım bana gerçekten yardımcı olmaya çalısırlar

Kesinlikle hayır 1 2 3 4 5 6 7 Kesinlikle evet

7.Ðsler kötü gittiğinde arkadaslarıma güvenebilirim

Kesinlikle hayır 1 2 3 4 5 6 7 Kesinlikle evet

8. Sorunlarımı ailemle konusabilirim

Kesinlikle hayır 1 2 3 4 5 6 7 Kesinlikle evet

9.Sevinç ve kederlerimi paylasabileceğim arkadaslarım var

Kesinlikle hayır 1 2 3 4 5 6 7 Kesinlikle evet

10.Yasamımda duygularıma önem veren özel bir insan var

Kesinlikle hayır 1 2 3 4 5 6 7 Kesinlikle evet

11. Kararlarımı vermede ailem bana yardımcı olmaya isteklidir

Kesinlikle hayır 1 2 3 4 5 6 7 Kesinlikle evet

12.Sorunlarımı arkadaslarımla konusabilirim

Kesinlikle hayır 1 2 3 4 5 6 7 Kesinlikle evet

Appendix 6

Travma Sonrası Stres Tanı Ölçeği (TSSTÖ)

1. Bölüm

Birçok kişinin başından, hayatının herhangi bir döneminde, oldukça stresli ve travmatik bir olay geçmiş ya da böyle bir olaya tanık olmuştur. Aşağıda belirtilen olaylar içinde, **başınızdan geçen ya da tanık olduğunuz** olayların hepsini yanındaki kutuyu işaretleyerek belirtiniz, **birden fazla işaretleyebilirsiniz**.

(1)	Ciddi bir kaza, yangın ya da patlama olayı (örneğin, trafik kazası, iş kazası, çiftlik kazası, araba, uçak ya da tekne kazası)	☐
(2)	Doğal afet (örneğin, hortum, kasırga, sel baskını ya da büyük bir deprem)	☐
(3)	Aile üyelerinden biri ya da tanıdığınız bir kişi tarafından cinsel olmayan bir saldırıya maruz kalma (örneğin, saldırıya uğrayıp soyulma, fiziksel bir saldırıya maruz kalma, silahlı saldırı, bıçaklanma ya da silahla rehin alınma)	☐
(4)	Tanımadığınız biri tarafından cinsel olmayan bir saldırıya maruz kalma (örneğin, saldırıya uğrayıp soyulma, fiziksel bir saldırıya maruz kalma, silahlı saldırı, bıçaklanma ya da silahla rehin alınma gibi)	☐
(5)	Aile üyelerinden biri ya da tanıdığınız bir kişi tarafından cinsel bir saldırıya maruz kalma (örneğin, tecavüz ya da tecavüze teşebbüs gibi)	☐
(6)	Tanımadığınız bir kişi tarafından cinsel bir saldırıya maruz kalma (örneğin, tecavüz ya da tecavüze teşebbüs gibi)	☐
(7)	Askeri bir çarpışma ya da savaş alanında bulunma	☐
(8)	18 yaşından daha küçük olduğunuz bir dönemde kendinizden 5 ya da daha büyük yaşta biriyle cinsel temas (örneğin, cinsel organlarla, göğüslerle temas gibi)	☐
(9)	Hapsedilme (örneğin, cezaevine düşme, savaş esiri olma, rehin alınma gibi)	☐
(10)	İşkenceye maruz kalma	☐
(11)	Hayatı tehdit eden bir hastalık	☐
(12)	Sevilen ya da yakın birinin beklenmedik ölümü	☐
(13)	Bunların dışında bir travmatik olay	☐
(14)	13. Maddeyi işaretlediyseniz aşağıda bu travmatik olayı belirtiniz: _____ _____ _____ _____	

YUKARIDAKİ MADDELERDEN HERHANGİ BİRİNİ İŞARETLEDİYSENİZ, SORULARI YANITLAMAYA DEVAM EDİN.

HİÇBİR MADDEYİ İŞARETLEMEDİYSENİZ, DEVAM ETMEYİN.

2. Bölüm

(15) 1. Bölümde **birden fazla** sayıda travmatik olay işaretlediyseniz, ***canınızı en çok sıkan, sizi en rahatsız eden*** olayın yanındaki kutuyu işaretleyiniz. Eğer, 1. Bölümde **yalnızca bir** travmatik olayı işaretlediyseniz, aşağıda da aynı olayı işaretleyiniz.

(a)	Kaza (araba ya da iş kazası, gibi)	☐
(b)	Doğal afet	☐
(c)	Aile üyelerinden biri ya da tanıdığınız bir kişi tarafından cinsel olmayan bir saldırıya maruz kalma	☐
(d)	Tanımadığınız biri tarafından cinsel olmayan bir saldırıya maruz kalma	☐
(e)	Aile üyelerinden biri ya da tanıdığınız bir kişi tarafından cinsel bir saldırıya maruz kalma	☐
(f)	Tanımadığınız bir kişi tarafından cinsel bir saldırıya maruz kalma	☐
(g)	Savaş	☐
(h)	18 yaşından daha küçük olduğunuz bir dönemde kendinizden 5 ya da daha büyük yaşta biriyle cinsel temas	☐
(i)	Hapsedilme	☐
(j)	İşkenceye maruz kalma	☐
(k)	Hayatı tehdit eden bir hastalık	☐
(l)	Sevilen ya da yakın birinin beklenmedik ölümü	☐
(m)	Bunların dışında bir olay	☐
(n)	Aşağıda boş bırakılan yerde yukarıda işaretlemiş olduğunuz travmatik olayı kısaca anlatınız. _____ _____ _____ _____ _____ _____ _____ _____	

Anlattığınız bu olay hakkında aşağıda birkaç soru verilmiştir. Bu soruları yanıtlayınız:

(16) Bu travmatik olay **ne kadar zaman önce** meydana geldi? (**YALNIZCA BİR TANESİNİ** daire içine alınız)

(a)	1 aydan daha az
(b)	1-3 ay arası
(c)	3-6 ay arası
(d)	6 ay – 3 yıl arası
(e)	3-5 yıl arası
(f)	5 yıldan daha fazla

Aşağıdaki sorularda, **Evet** için E harfini **Hayır** için H harfini daire içine alınız.

Bu travmatik olay sırasında:

(17)	Fiziksel bir yara aldınız mı?	E	H
(18)	Başka bir kişi fiziksel bir yara aldı mı?	E	H
(19)	Hayatınızın tehlikede olduğunu düşündünüz mü?	E	H
(20)	Başka bir kişinin hayatının tehlikede olduğunu düşündünüz mü?	E	H
(21)	Kendinizi çaresiz hissettiniz mi?	E	H
(22)	Büyük bir korku duygusu yaşadınız mı?	E	H

3. Bölüm

Aşağıda, insanların bazen bir travmatik olayın ardından yaşadığı bazı sorunlar belirtilmiştir. Her maddeyi dikkatlice okuyun ve **GEÇTİĞİMİZ AY İÇİNDE** bu sorunun sizi ne sıklıkta rahatsız ettiğini en iyi ifade ettiğini düşündüğünüz sayıyı (0, 1, 2 ya da 3) daire içine alın.

Örneğin, söz ettiğiniz olay geçtiğimiz ay içinde aşağıda verilen sıkıntılar açısından sizi yalnızca bir kez rahatsız ettiyse 0'ı; haftada bir kez rahatsız ettiyse 1 işaretleyin. Aşağıda belirtilen olayla ilgili her sıkıntıyı **15. maddede belirttiğiniz travmatik olay açısından** değerlendiriniz.

0 Hiç ya da yalnızca bir kez
1 Haftada bir ya da daha az/kısa bir süre
2 Haftada 2 – 4 kez / yarım gün
3 Haftada 5 ya da daha fazla / neredeyse bütün gün

(23)	Bu travmatik olay hakkında, istemediğiniz halde aklınıza rahatsız edici düşünceler ya da imgelerin gelmesi	0	1	2	3
(24)	Bu travmatik olayla ilgili kötü rüyalar ya da kabuslar görme	0	1	2	3
(25)	Bu travmatik olayı yeniden yaşama, sanki tekrar oluyormuş gibi hissetme ya da öyle davranma	0	1	2	3
(26)	Bu travmatik olayı hatırladığınızda duygusal olarak altüst olduğunuzu hissetme (örneğin, korku, öfke, üzüntü, suçluluk vb. gibi duygular yaşama)	0	1	2	3
(27)	Bu travmatik olayı hatırladığınızda vücudunuzda fiziksel tepkiler meydana gelmesi (örneğin, ter boşalması, kalbin hızlı çarpması)	0	1	2	3
(28)	Bu travmatik olayı düşünmemeye, hakkında konuşmamaya ya da hissetmemeye çalışma	0	1	2	3
(29)	Size bu travmatik olayı hatırlatan etkinliklerden, kişilerden ya da yerlerden kaçınmaya çalışma	0	1	2	3
(30)	Bu travmatik olayın önem taşıyan bir bölümünü hatırlayamama	0	1	2	3
(31)	Önemli etkinliklere çok daha az sıklıkta katılma ya da bu etkinliklere çok daha az ilgi duyma	0	1	2	3
(32)	Çevrenizdeki insanlarla aranızda bir mesafe hissetme ya da onlardan koptuğunuz duygusuna kapılma	0	1	2	3
(33)	Duygusal açıdan kendinizi donuk, uyuşuk hissetme (örneğin, ağlayamama ya da sevecen duygular yaşayamama)	0	1	2	3

(34)	Gelecekle ilgili planlarınızın ya da umutlarınızın gerçekleşmeyeceği duygusuna kapılma (örneğin, bir meslek hayatınızın olmayacağı, evlenmeyeceğiniz, çocuğunuzun olmayacağı ya da ömrünüzün uzun olmayacağı duygusu)	0	1	2	3
(35)	Uykuya dalma ya da uyumada zorluklar yaşama	0	1	2	3
(36)	Çabuk sinirlenme ya da öfke nöbetleri geçirme	0	1	2	3
(37)	Düşüncenizi ya da dikkatinizi belli bir noktada toplamada sıkıntı yaşama (örneğin, bir konuşma sırasında konuyu kaçırma, televizyondaki bir öyküyü takip edememe, okuduğunuz şeyi unutma)	0	1	2	3
(38)	Aşırı derecede tetikte olma (örneğin, çevrenizde kimin olduğunu kontrol etme, sırtınız bir kapıya dönük olduğunda rahatsız olma,vb.)	0	1	2	3
(39)	Diken üstünde olma ya da kolayca irkilme (örneğin, birisi peşinizden yürüdüğünde)	0	1	2	3
(40)	Yukarıda belirttiğiniz sorunları ne kadar zamandır yaşıyorsunuz? (**YALNIZCA BİR TANESİNİ** daire içine alınız) a. Bir aydan daha az b. 1-3 ay arası c. 3 aydan daha fazla				
(41)	Bu sorunlar söz konusu travmatik olaydan ne kadar sonra başladı? (**YALNIZCA BİR TANESİNİ** daire içine alınız) a. 6 aydan daha az b. 6 ay ya da daha fazla				

4. Bölüm

3. Bölüm'de işaretlediğiniz sorunların **GEÇTİĞİMİZ AY SÜRESİNCE** hayatınızın aşağıda belirtilen alanlarından herhangi birini engelleyip engellemediğini belirtiniz. **Evet** için E harfini, **Hayır** için H harfini daire içine alınız.

(42)	İş hayatı	E	H
(43)	Evin günlük işleri	E	H
(44)	Arkadaşlarınızla ilişkiler	E	H
(45)	Eğlence ve boş zamanlardaki etkinlikler	E	H
(46)	Okulla ilgili işler	E	H
(47)	Ailenizle ilişkiler	E	H
(48)	Cinsel yaşam	E	H
(49)	Genel anlamda hayattan memnuniyet	E	H
(50)	Hayatınızın her alanında genel işleyiş düzeyi	E	H

Appendix 7

Bilgilendirilmiş Olur Formu

Bu araştırma Boğaziçi Üniversitesi, Sosyal Bilimler Enstitüsü, Klinik Psikoloji Doktora Programı öğrencisi Klinik Psk. Serap Altekin'in doktora tezidir. Tez Danışmanı Dr. Nur Yeniçeri olup, tez izleme komitesi Prof. Dr. Falih Köksal, Prof. Dr. Güler Fişek ve Yard. Doç. Dr. Ayten Zara'dan oluşmaktadır.

Araştırma, travma ile çalışmanın, travma ile çalışan profesyöneller (klinik psikolog, psikiyatrist, psikolojik danışman ve sosyal hizmet uzmanı) ve paraprofesyöneller (profesyönellerin süpervizyonunda sahada yardımcı olarak çalışan gönüllüler) üzerindeki etkilerini araştırmak; ve bu zeminde olası etkilerle etkin baş etme yollarını netleştirmek amacını taşımaktadır. Bu amaç doğrultusunda, bilimsel metotlarla elde edilen araştırma verileri, klinik alanda çalışanları geliştirme ve destekleme hedefi taşımaktadır.

Katılımcıların paylaştığı her tür bilginin korunmasında gizlilik esastır. Bu nedenle tüm envanterler anonim olarak (kimlik ve iletişim bilgileri alınmadan) doldurtulacaktır. Katılımcı, istediği an, kendisini rahatsız hissettiren herhangi bir nedenle araştırmadan geri çekilme hakkına sahiptir.

Araştırma verilerinin toplanmasında hem kantitatif (niceliksel) hem de kalitatif (niteliksel) yöntemler kullanılacaktır. Kantitatif veriler, 5 envanterin katılımcılar tarafından doldurulmasıyla elde edilecek olup, kalitatif veriler ise gönüllü katılımcılarla yapılacak ve ses kaydı alınacak olan yüz yüze görüşmeler yoluyla sağlanacaktır. Bu görüşmenin ses kaydının yazılı dökümü, arzu eden katımcılara sunulacaktır. Envanterlerin doldurulması ortalama olarak toplam 20 dk almaktadır. Gönüllü katılımcılarla yapılacak olan yüz yüze görüşme ise ortalama olarak 1-2 saat sürecektir.

Arzu eden tüm katılımcılar, veri toplama aşaması tamamlandıktan ve verilerin istatistiksel analizi yapıldıktan sonra düzenlenecek olan 2 saatlik eğitim, destek ve paylaşım çalışmasından bedelsiz olarak yararlanma hakkına sahip olacaktır. Bu çalışma tüm katılımcılara e-posta yoluyla 3 hafta öncesinden duyurulacak olup, temel olarak araştırma hedef ve verilerinin sunulmasına ve ikincil travmaya karşı koruyucu ve önleyici nitelikte baş etme becerilerinin geliştirilmesine yönelik bilgilendirme mahiyetinde olacaktır.

Bana aktarılan bu bilgileri okudum ve anladım, araştırmaya katılmayı kabul ediyorum. Bu bilgilendirilmiş olur formunun bir nüshasını imzalayarak araştırmacıya teslim ederken, bir nüshasını da imzalı şekilde teslim alıyorum.

Katılımcının Adı ve Soyadı :

Katılımcının İmzası :

Araştırmacı :
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Appendix 8

Yüz yüze görüşmede çerçeve olarak kullanılan sorular:

1. Mesleğiniz nedir ? (Psikolog, psikiyarist, danışman, sosyal hizmet uzmanı, gönüllü paraprofesyonel ?) Bana biraz eğitiminizden ve mesleki özgeçmişinizden söz eder misiniz lütfen ?
2. Nerede çalışıyorsunuz ? Çalışma düzeninizden biraz söz eder misiniz ? (Tam zamanlı, yarı zamanlı, çalışma saatleri ve koşulları vb gibi)
3. Kaç yıldır klinik alanda çalışıyorsunuz ?
4. Klinik alan dışında başka iş ve uğraşlarınız var mı ? (Geçmişte başka işlerde ve başka sektörlerde çalıştınız mı ?)
5. Sizi bu mesleği seçmeye ve icra etmeye yönelten şey nedir ? (Bu mesleğin / hizmetin sizin için anlamı nedir ?)
6. Bu mesleğin / hizmetin sizin için ne gibi zorlukları ve bunun yanında ne gibi iyi gelen, besleyen yanları var ?
7. Travma ile kaç yıldır çalışıyorsunuz ? (Nasıl bir çalışma düzeninde, ne sıklıkta, ne yoğunlukta ? Ne kadarı seçim ve tercih, ne kadarı zorunluluk ve tayin ?)
8. Hangi tür travmalarla çalıştınız / çalışıyorsunuz ? Travmayı nasıl tanımlıyorsunuz ? En sık karşılaştığınız / çalıştığınız travma türleri neler ?
9. Travma ile çalışmak sizi nasıl etkiliyor ?
10. Travma ile çalışmanın sizin için en zor / en ağır yanı nedir ?
11. Sizi daha çok etkilediğini düşündüğünüz bir travma türü var mı ?
12. Sizi en çok etkileyen / sizde en çok iz bırakan / etkileri ile en zor baş ettiğiniz travma vakası hangisi oldu ? Terapi / çalışma süreci nasıldı ? Sizce bu vakanın ya da temanın sizi bu kadar etkilemesinin nedeni nedir ?

13. Geçmişinizde yaşadığınız herhangi bir hayat olayının sizce bu etkinin yönü ya da şiddetinde bir etkisi olabilir mi ?
14. Geçmişinizde doğrudan maruz kaldığınız ya da sizi çok etkileyen bir hayat olayı var mı ?

    ( ) Ciddi bir kaza (trafik kazası, ev kazası, spor kazası, düşme vb) ?

    ( ) Ciddi, hayatı tehdit eden bir hastalık ya da ameliyat ?

    ( ) Afet (deprem, sel, fırtına, yangın vb) ?

    ( ) Fiziksel şiddet ?

    ( ) Cinsel saldırı, cinsel istismar veya tecavüz ?

    ( ) Savaş, askeri bir çarpışma, çatışma, terör ?

    ( ) İşkence ?

    ( ) Başka herhangi bir travmatik hayat olayı ?

15. Travma ile çalışırken / çalıştıktan sonra kendinizde, hayat görüşünüzde, dünyayı, insanları ve kendinizi algılama biçiminizde, yakın ilişkilerinizde nasıl farklar oldu ? (Olumlu farklar ? Olgunlaşma, iyimser bakış açısı ? Olumsuz farklar ? Güvensizlik, korku, şüphe, karamsar bakış açısı ? Semptom ? Akut ya da kronik bir psikopatoloji ?)
16. Travma ile çalışmanın terapist / gönüllü üstündeki etkileri sizce en çok hangi değişkenlerle ilgili ? (Etki kümülatif mi, yoksa kısa süreli ve sadece çalışılan süreyi mi kapsıyor ? Klinik çalışma / deneyim yılları etkili mi ? Deneyim baş etmeyi kolaylaştırıyor mu?Terapistin kendi geçmişi, etkili mi ? Terapistin cinsiyeti, yaşı, ilişki durumu, medeni durumu etkili mi ? Çalışma koşulları fark yaratıyor mu ? Travmanın türü bir faktör mü ? Özel ve sosyal destek

mekanizmalarının, eğitim ve süpervizyon desteğinin varlığı ya da yokluğu bu değişkenler arasında mı

17. Travma ile çalışmanın yarattığı etkilerle baş edebilmek için neler yapıyorsunuz / neler iyi geliyor / neler yatıştırıyor ?
18. İnancınız var mı ? Eğer varsa hayatınızdaki yeri nedir ? İnancınız yaşadığıız bu zorluklarda, size güç veren bir destek olabiliyor mu ?
19. Travma vakalarınızla olan terapi süreçleriniz için süpervizyon alıyor musunuz ? Travma vakalarınızla olan terapi süreçlerinizi akran meslektaşlarınızla paylaşıyor musunuz ?
20. Psikoterapiye / psikanalize gittiniz mi ? (Evet, Hayır ? Ne zaman ? Ne kadar süre ?) Sizde nasıl izler bıraktı ? Bugün yararlandığınız ve size yol gösteren yansımaları var mı ? Psikoterapiye / psikanalize gidiyor musunuz ? (Evet, Hayır ? Ne kadar süredir ?) Yararını görüyor musunuz ?
21. Benim sorularımla değinmediğim ancak sizin önemli ve anlamlı bulduğunuz ve eklemek istediğiniz herhangi bir şey var mı ?