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What is This?

Shared Resilience in a Traumatic Reality: A New Concept for Trauma Workers Exposed Personally and Professionally to Collective Disaster

Orit Nuttman-Shwartz[1]

Abstract

This article proposes a new concept, shared resilience in a traumatic reality (SRTR), which refers to trauma workers in shared reality situations. Based on the literature that emphasizes the positive effects of exposure to traumatic events for workers in this field, this article expands the perception of shared traumatic situations and examines the ability of trauma workers to cope, to show resilience, and to grow as a result of the mutual relationship with their clients. The literature review presents a variety of terms referring to the positive effects of working with trauma survivors on therapists as a basis for the new concept proposed here. These terms highlight the importance of empathic mutual aid relationships, which are a basic component for promoting resilience in a shared traumatic reality. The relative nature of shared resilience is discussed, bearing in mind that resilience can be manifested as emotions, behaviors, and conceptions. Various findings relating to shared resilience in traumatic situations are reviewed, and recommendations for research, practice, and policy are offered.

In recent years, a growing body of research has shed light on the positive consequences of trauma work. Several models have explained posttraumatic growth (PTG) following direct trauma exposure (e.g., Tedeschi, Park, & Calhoun, 1998) and have been applied to situations where therapists have experienced positive changes as a result of vicarious exposure to trauma experienced by their clients (e.g., Arnold, Calhoun, Tedeschi, & Cann, 2005; Brady, Guy, Poelstra, & Brokaw, 1999; Pearlman & Saakvitne, 1995; Schauben & Frazier, 1995). Most of the existing studies on the positive effects of treating trauma survivors have related to the concept of PTG (Tedeschi et al., 1998) or to resilience responses (Ungar, 2008) among helping professionals (e.g., Itzhaky & Dekel, 2005; Shamai & Ron, 2009). For example, Arnold, Calhoun, Tedeschi, and Cann (2005) found that clinicians working with trauma survivors have reported positive consequences such as increased self-confidence, independence, resilience, emotional expressiveness, sensitivity, compassion, and deepened spirituality.

Parallel to common pathological terms and definitions such as vicarious traumatization (VT; McCann & Pearlman, 1990; Pearlman & MacIan, 1995; Pearlman & Saakvitne, 1995), compassion fatigue (Figley, 1995, 2002), secondary traumatic stress (Stamm, 2002), and burnout (Leiter & Maslach, 1988),

which relate to adverse responses among trauma workers, there have been several attempts to conceptualize possible positive effects. These terms include compassion satisfaction (Figley, 2002), vicarious PTG (VPTG; Arnold et al., 2005), adversarial growth (Linley, Joseph, & Loumidis, 2005), and, most recently, vicarious resilience (VR; Hernández, Gangsei, & Engstrom, 2007). Against this background, we will begin by describing the variety of concepts relating to the positive effects of indirect exposure to traumatic events among therapists.

Vicarious adversarial growth is a general concept based on adversarial growth, which Linley and Joseph (2004) developed to describe a process of struggling with adversity, where changes may arise that help individuals reach a higher level of functioning than that which existed prior to the event. These positive changes have been labeled PTG, stress-related growth, perceived benefits, thriving, blessings, positive by-products,

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positive adjustment, and positive adaptation with reference to people who have worked with trauma survivors (Linley et al., 2005).

The second concept is *VPTG*, which describes positive outcomes resulting from work with trauma victims. For example, research has found that clinicians whose work is trauma related reported positive consequences such as increased self-confidence, independence, resilience, emotional expressiveness, sensitivity, compassion, and deepened spirituality (Arnold et al., 2005). In a later study, Splevins, Cohen, Joseph, Murray, and Bowley (2010) explored the concept of VPTG among a sample of interpreters working in a therapeutic setting with asylum seekers and refugees. The participants in that study reported both negative and positive consequences of their work. Negative responses included rage, hopelessness, helplessness, fear, anxiety, and deep sadness, whereas positive responses included feelings of joy, hope, admiration, inspiration, witnessing client recovery, and a desire to live a deeper and more purposeful life. In both of these studies, perceptions of growth for trauma workers were consistent with the three domains of growth identified by Tedeschi and Calhoun (1996).

Moreover, the results revealed by Splevins et al. (2010) are consistent with the way that people attempt to reduce pre- and posttrauma cognitive dissonance by accommodating new trauma-related material. Therefore, if trauma workers experience processes similar to those experienced by trauma survivors, they might also successfully integrate and transform their vicarious trauma and maximize the possibility of growth (McCann & Pearlman, 1990). An increased understanding of how trauma workers can foster such positive outcomes has important clinical implications (e.g., enhanced clinician well-being, role retention, and improved therapeutic outcomes). Like VT theory, VPTG theory postulates that distress is inevitable because trauma challenges fundamental beliefs, whether it is experienced directly or vicariously. However, VPTG theory expands on this notion and argues that trauma acts as an impetus for effortful meaning-making processes and subsequent positive outcomes (Joseph, 2011; Joseph & Linley, 2005; Tedeschi & Calhoun, 2004). It is through the accommodation of new trauma-related material that clinicians can experience growth (Park, 2010; Park & Ai, 2006). As Splevins et al. (2010) argued, a theory of VPTG better accounts for the experiences of trauma workers, bearing in mind that VPTG does not discount enduring distress.

Vicarious resilience (*VR*) is a term coined by Hernández, Gangsei, and Engstrom (2007), which refers to resilience processes occurring in therapists as a result of their work with trauma survivors. They speculated that VR may be a unique consequence of trauma work and that this process might be a "common and natural phenomenon illuminating further the complex potential of therapeutic work both to fatigue and to heal" (p. 237). VR posits that trauma therapists may be positively affected by bearing witness to the trauma of their clients. It is a term that refers to positive meaning making, growth, and transformations in the therapist's experience, which result from exposure to clients' resilience in the course of therapeutic

processes that deal with trauma recovery. VR is highlighted as an important dimension, which counteracts the fatiguing processes that trauma therapists normally experience, strengthens the therapists' motivation, and helps them find new meanings and discover ways of taking care of themselves (Hernández et al., 2007).

Research findings indicate that therapists have reported how witnessing their clients overcome adversity has affected or changed their own attitudes, emotions, and behavior in ways that the authors conceptualized as manifesting VR. These responses include (1) reflecting on human beings' capacity to heal, (2) reaffirming the value of therapy, (3) regaining hope, (4) reassessing the dimensions of one's own problems, (5) understanding and valuing spiritual dimensions of healing, (6) discovering the power of community healing, and (7) making the professional and lay public aware of the impact and multiple dimensions of violence by writing and speaking in public forums (Engstrom, Hernandez, & Gangsei, 2008).

Another way of relating to positive responses is reflected in *compassion satisfaction*, a term coined by Figley (2002), which is the opposite of compassion fatigue. Compassion satisfaction is regarded as contentment, pleasure, or professional satisfaction that results from helping others in one's capacity as a professional (Stamm, 2005).

The potential for compassion satisfaction is based on the fulfillment from helping others and positive collegial relationships as part of trauma work (DePanfilis, 2006). According to Figley and Stamm (1996), compassion satisfaction is affected by internal motivational factors such as self-efficacy perceptions as well as by external factors such as environmental factors (various demands of administrators) and by direct feedback from role models (supervisors and colleagues). As such, it might play a protective role by strengthening the clinicians' sense of worthiness and may paradoxically contribute to optimism and a profound belief in the good of humanity (Craig & Sprang, 2010).

These two types of responses simultaneously exist and have been found to be suitable for understanding the variety of effects of working with war and terror victims as well as victims of torture (Barrington & Shakespeare-Finch, 2013), sexual assault victims, survivors of car accidents, refugees, and asylum seekers (Guhan & Liebling-Kalifani, 2011). Those responses are mainly based on trauma work that takes place when the helping professionals are outside of the danger zone, that is, when they are not actually part of the traumatic events.

In addition to the above situations, however, there is growing research evidence that professionals may be exposed to the same threatening experiences as their clients. Thus, the new interrelated concepts of "shared traumatic reality" (STR) and "shared trauma" have been developed to describe situations in which the client and the therapist are "in the same boat."

Double Exposure

In recent years, the professional literature has begun to acknowledge that indirect exposure through intervention is not

the only way in which mental health professionals are exposed to or threatened by trauma. When the whole community is exposed to traumatic events and helping professionals live and work in the same community as the people they serve, they are exposed to and threatened by the same circumstances as their clients. Thus, they not only help survivors cope with the trauma but also cope with the same traumatic experiences as their clients. This experience has typically been referred to in the professional literature from a negative perspective, as reflected in the terms STR (Nuttman-Shwartz & Dekel, 2008), shared trauma (Saakvitne, 2002), shared tragedy (Eidelson, D'Alessio, & Eidelson, 2003), and shared traumatic stress (SdTS), which has been increasingly used to reflect the distinct impact of trauma that is simultaneously personal and professional (Tosone, 2012).

In essence, the phenomenon of shared trauma has become increasingly prevalent and typifies large-scale events such as terror attacks, wars, and natural disasters, that is, events that have increased in number and magnitude over the last decade (NCTC, 2007). In most of these instances, trauma workers have experienced both primary and secondary trauma, both as members of the traumatized community and as mental health professionals serving that community (Ostodic, 1999; Saakvitne, 2002; Tosone et al., 2003).

Several studies have focused on the impact of war on trauma workers who, as citizens, had been living through the same war reality as their patients (Baum, 2013; Cohen, Gagin, & Peled-Avram, 2006; Eidelson et al., 2003; Lev-Wiesel, Goldblatt, Eisikovits, & Admi, 2009). Their findings showed that the effects of STR on therapists produced a clinical situation in which workers were shaken, threatened, or hurt by the same catastrophic events that had befallen the clients they were treating. On the personal level, they described feelings of sorrow, loss, fear, pain and grief, threat, uncertainty, and sometimes even helplessness. In addition, Shamai and Ron (2009) conducted a study among trauma workers who reported feeling dirty, craving sweets, or feeling a physical need to touch their children. In a similar vein, Dekel and Nuttman-Shwartz (2014) conducted a study among trauma workers in STR and found that the therapists reported difficulties in their parenting role. On the professional level, research findings have shown that trauma workers were unprepared, felt less effective, lost confidence, got tired of hearing about traumatic events, and experienced feelings of guilt or shame about being more oriented to their own needs than to the needs of their clients (Batten & Orsillo, 2002; Dekel & Baum, 2010; Eidelson et al., 2003; Saakvitne, 2002; Seeley, 2003). Based on social workers' descriptions of their exposure to the Gaza War, Baum (2013) termed the unique characteristics of professional double exposure in the context of STR as intrusive anxiety, lapses of empathy, immersion in the professional role, role expansion, and changes in the place and time of work. The first three characteristics refer to emotional and behavioral responses to the danger faced by family members while the therapists are working and the last two reflect expanded or changing demands on professionals. Those

responses reflect the dual role of the trauma workers as professionals on the one hand and as family members and residents of the exposed area on the other.

Despite the above responses, findings have shown a low level of secondary traumatization among workers who provided emergency treatment to victims or their families in the wake of terror attacks and war in Israel as well as following the 9/11 attacks in the United States (Adams, Boscarino, & Figley, 2006; Adams, Figley, & Boscarino, 2008; Baum & Ramon, 2010; Dekel, Hantman, Ginzburg, & Solomon, 2007; Lev-Wiesel et al., 2009; Shamai & Ron, 2009). These findings provide support for the idea of double exposure, as well as for the differential effects of direct and indirect exposure among trauma workers in the context of STR. In the same vein, the effects of exposure to trauma victims may not only be pathological but also be salutogenic. Moreover, studies conducted among workers in these contexts have found that the negative impact of trauma can be accompanied by positive effects on professional performance in an STR and that PTG coexisted with symptoms of distress following these experiences (Bauwens & Tosone, 2010; Dekel & Baum, 2010; Lev-Wiesel et al., 2009; Shamai & Ron, 2009). Moreover, Bell and Robinson (2013) claimed that PTG and VR can serve as protective factors for trauma workers in STR situations.

Another attempt to shed light on the positive consequences of STR was made in order to identify and measure professional growth resulting from work with traumatic clients and in traumatic situations (Baum, 2013; Bauwens & Tosone, 2010). Baum's (2013) findings highlight the unique contribution of lapses of empathy to the professionals' distress and the contribution of immersion in their role to their growth. In contrast, Bauwens and Tosone (2010) found that together with the negative effects, increased compassion and connectedness with clients were the factors that characterized professional PTG.

Nonetheless, the positive effects were not referred to as a unique or distinct phenomenon which characterized the shared situation. Nor was the client–therapist relationship nor the reciprocal process that occurred in the shared situation considered to be unique. Beyond that, as mentioned, these effects were overshadowed by the negative consequences. Thus, this article aims to conceptualize the opportunities for personal and professional positive responses in a shared reality as part of double exposure situations and as a result of the mutual experiences of therapists and clients

Resilience and PTG in the Context of STR

Most people exposed to trauma retain a stable equilibrium without reactive psychopathology (Bonanno, 2004; Bonanno, Galea, Bucciarelli, & Vlahov, 2006), which is commonly viewed as resilience (Bonanno, 2004; Lepore & Revenson, 2006). Resilience is a dynamic concept, which is linked to emotional regulation and associated with the ability to use internal and external resources in order to flexibly apply various coping strategies and/or emotional expression to meet the needs of a

stressful situation. It involves multiple components such as psychological habituation, changes in mental set in response to stress and adversity (ideas, attributions, self-reflection, and planning), and alterations in self-efficacy (Watson & Neria, 2013; Pulla, Shatte, & Warren, 2013). In addition, Ungar (2013, p. 256) defined resilience as "the capacity of both individuals and their environments to interact in ways that optimize developmental processes." Specifically, research has shown that in situations of adversity, resilience is observed when individuals engage in behaviors that help them navigate their way to the resources they need to flourish. However, Ungar (2013) argues that:

these processes occur . . . only when the individual's social ecology (formal and informal social networks) has the capacity to provide resources in ways that are culturally meaningful . . . and may co-occur despite the presence of disorder resulting from trauma. (p. 256)

This notwithstanding, theoretical approaches to resilience and PTG are often confused in the literature (Levine, Laufer, Stein, Hamama-Raz, & Solomon, 2009; Tedeschi, Calhoun, & Cann, 2007), and there is a debate as to whether or not PTG is a form of resilience. Several researchers have argued that growth is superior to resilience (Lepore & Revenson, 2006; Tedeschi et al., 2007; Westphal & Bonanno, 2007), whereas others (e.g., Levine et al., 2009) have argued that resilience can be conceptualized and measured by a lack of posttraumatic stress disorder following adversity and is inversely associated with PTG.

The same inconsistency is reflected in the research literature on shared trauma. Some researchers have found that psychological growth can occur following vicarious brushes with trauma (e.g. Arnold et al., 2005; Baum, 2013). Thus, the negative effects of STR can be accompanied by direct and indirect positive responses of shared traumatic exposure as a combination of PTG and VPTG. Regarding the competency and resilience of therapists working in STR, other researchers (e.g., Dekel & Nuttman-Shwartz, 2014; Tosone, McTighe & Bauwens, 2014) have found that each client's story reinforces a process of gradual change in therapists through positive accommodation (McCann & Pearlman, 1990) as a combination of resilience and VR (Bell & Robinson, 2013). As mentioned, Ungar (2013) argued that resilience is a phenomenon that goes beyond the individual. Thus, it is possible to consider the process of resilience and manifestations of resilience in terms of the relationship between the therapist and the client. Furthermore, Ungar argued that a resilient environment affects the resilience of individuals and their ability to deal successfully with trauma. Therefore, we assumed that when either the therapist or the client feels resilient and is able to function in a traumatic reality, this can affect the other party. As such, it is possible to refer to "shared resilience" in this reality.

Therefore, our aim is to shed light on the positive consequences of being exposed to adversity, not as a result of the clients' and therapists' attempt to deal with the traumatic responses that they might develop but as a unique experience

that allows them to continue functioning despite the shared trauma situation that still exists. Against that background, we will first describe and relate to SRTR.

SRTR: A New Concept for Challenging Times

Although many researchers have not addressed the issue of resilience, they in fact have described a process of gaining resilience and have made a connection between resilience and empathic behaviors among therapists and clients as a result of the therapeutic encounter and the shared experience. The importance of mutual help through empathic bonding as reflected in SRTR has been illustrated by Batten and Orsillo (2002) who found that the level of emotional intensity experienced by several therapists in the wake of a terrorist incident actually allowed them to become more connected with their clients' emotions and helped them respond more empathically and effectively to their clients in therapy sessions.

Other researchers have claimed that helpers may feel more empathy and bonding toward their clients because they experience similar emotions. As a result, the therapists might feel more competent and can be more effective in helping their clients as well as themselves (Shamai, 2005; Tosone & Bialkin, 2004). In the same vein, Varcarolis (2006) claimed that empathy promotes mutual aid and enables positive, collaborative, and cooperative relationships. In this way, therapists and their counterparts provide a balance to psychopathology by focusing on promoting resilience. In addition, Cohen and Collens (2012) have argued that an empathic relationship is the basis for secondary positive processes. Yet they also claimed that in order for secondary growth to take place, therapists first need to identify and acknowledge their client's growth. In contrast, Tosone, McTighe, and Bauwens (2014) argued that empathy, compassion, and a sense of competence precede the therapist's resilience in an STR and that resilience mediates enduring SdTS.

Several studies have emphasized that in order for resilience to occur, two partners need to be involved. Trauma workers have indicated that both they and their clients are stronger than they had imagined and that they were inspired by their clients (Benatar, 2000). Therapists have also expressed their amazement at the "human spirit" (Splevins, Cohen, Joseph, Murray, & Bowley, 2010) and at its resilience (Clemans, 2004; Schauben & Frazier, 1995). The dyadic and reciprocal positive process has been reflected most recently in research findings, in which therapists indicated that they were satisfied with their ability to help others but recognized that they were also helping themselves (Dekel & Nuttman-Shwartz, 2014). Moreover, therapists have indicated that they learned simultaneously from their clients and from themselves about what helps in situations of threat and that they developed new methods of intervention that were helpful and effective for their clients and for themselves.

Based on the findings of several studies conducted among trauma workers in different types of shared traumatic situations, Tosone et al. (2014) reported that the reciprocal nature of the shared trauma and the mental health responders'

personal disaster–related experiences can impact the nature of practice, and the interactions with trauma survivors can influence personal responses to the same precipitating traumatic event. The personal and professional aspects of the traumatic experience are interconnected and not readily separated. Thus, the positive consequences of shared trauma experiences include not just the relationship between therapists and clients but also a broad range of positive reciprocal relations, such as relationships with colleagues and managers in the workplace and relationships with family members. All these are the result of the ability for bonding and mutual containment. For example, Seeley (2003) and Eidelson, D'Alessio, and Eidelson (2003) found that besides a renewed commitment to their clients and to the profession, many professionals have reported an increase in positive feelings about their work, which are considered a component of resilience. Additionally, clinicians have reported an increased sense of purpose and commitment to their chosen career and renewed appreciation for the benefits and limitations of the mental health profession (Bauwens & Tosone, 2010) as well as an improvement in their ability to manage their job responsibilities and achieve a more desirable personal–family–work balance (Bauwens & Tosone, 2010; Dekel & Nuttman-Shwartz, 2014) and enhanced involvement in political action and policy advocacy (Iliffe & Steed, 2000; Satkunanayagam, Tunariu, & Tribe, 2010).

Like compassion satisfaction resulting from direct or indirect exposure to trauma, the manifestations of SRTR might include a greater capacity for empathy and therapeutic intimacy as a result of being exposed to the same collective trauma as one's clients, a deeper connection with clients and greater compassion for them as well as fuller enjoyment in the work with clients (Bauwens & Tosone, 2010), new theoretical orientation that create more open and flexible boundaries (Tosone, 2014), and development of better self-care habits relating to professional practice as well as a higher level of professional competence (Dekel & Nuttman-Shwartz, 2014). In their latest research in a shared traumatic situation, Dekel and Nuttman-Shwartz found that therapists perceived the flexibility and blurred boundaries in the therapeutic setting as an option to learn more about their clients, themselves, and their relationships. They were able to adopt effective ways of coping with their clients, and the ability to see things from the clients' perspective from time to time made them more aware of the clients' personal and professional needs. Furthermore, they learned to see their supervisors as parent figures who could help them self-regulate, and they derived strength from their colleagues as well as from the social services. Finally, they stressed that their new knowledge about STR and SRTR empowered them and gave them more self-confidence.

In sum, the above findings suggest that positive responses and the ability to articulate resilience under stress might also result from the shared reality that the therapist and the client are exposed to together. Moreover, the shared reality might help therapists understand that these mutual, symmetric relationships, especially empathic bonding, are the basis for positive responses to reality that can help them be aware of shared resilience. In this way, the concept of resilience goes beyond the microlevel of the client–therapist relationship and includes relationships at the mesolevel, such as relationships with colleagues, managers, and family members (Ungar, 2013). This concept relates to a shared reality or what we have proposed to refer to as SRTR.

SRTR and Related Concepts

Shared growth in a traumatic reality and countertransference. Although we tried to conceptualize the above process as SRTR, it is important to relate to a similar, complementary process that might reflect client–therapist relationships in shared reality situations. As mentioned previously, there is a theoretical confusion between PTG and resilience. The debate is also an outcome of the importance of the empathic relationship, which has been found not only to be a risk factor for developing VT but also to be the source of the growth process. For example, Brockhouse, Msetfi, Cohen, and Joseph (2011) found that an empathic connection between the client and therapist may facilitate growth through a process of identification, thus increasing the personal impact of the vicarious experience and the need to accommodate current schemata. The accommodation process can be a negative one (as in the case of vicarious trauma), but it also opens the door for a positive experience which is mainly known as PTG and may reflect resilience as well (Ungar, 2013).

Others relate simultaneously to the ability to develop suitable relations in therapeutic sessions and to the growth process. For example, in a study of therapists after the September 11th attacks in the United States in 2001, Tosone (2006) found that developing connectedness in the therapeutic relationship may be one way of enhancing growth and moderating the effects of vicarious and personal trauma. Later on, Bauwens and Tosone (2010) found that clinicians who were better able to relate to their clients may have experienced more growth and satisfaction from clinical work and even professional growth. It is important to realize that although the majority of studies have examined the consequences of therapeutic connections in shared reality, they have not conceptualized the positive process in an STR as shared growth, which relies on dyadic therapeutic relationships that are necessarily of a reciprocal nature.

The confusion between resilience and growth concepts is also reflected in the existing research on the topic. Although all the researchers have related to the process of growth, some of them used the PostTraumatic Growth Index to measure growth (Lev-Wiesel et al., 2009; Tedeschi & Calhoun, 1996) as a common tool for examining PTG responses as well as VPTG, whereas others have based their studies on qualitative descriptions of growth experiences in general (e.g., Cohen & Collens (2012). Researchers have also emphasized professional growth (Baum, 2013; Bauwens & Tosone, 2010), and a few have measured resilience on the basis of the Resiliency Scale (e.g., Tosone, 2011; Tosone, McTighe, & Bauwens, 2014). Those researchers have focused on the therapeutic relationships among clients and workers in situations of STR and compared

it with SdTS which measures SdTS. The studies have related mainly to the posttrauma period and to the long-term effects of the traumatic experiences. In the same vein, although there are some overlap predictors of resilience and growth in STR, several research findings have shown that the most significant predictors of resilience are attachment style and enduring distress (Tosone et al., 2014), whereas intrusive anxiety, changes in place and time of work, and immersion in role correlated significantly with personal growth (Baum, 2013).

Other trauma-related responses of clinicians have been described under the rubric of countertransference. As commonly defined, countertransference refers to the affective and behavioral reactions of the clinician to the client, whether conscious or unconscious. The contemporary definition of countertransference includes both objective and subjective components; that is, it contains the clinicians' personal, subjective reactions of the clinician to the client as well as diagnostic, objective ones in which the clinician responds in accordance with the client's provocations (Boulanger, 2007). Whereas VT and secondary traumatization and related concepts describe the short- and long-term impact of hearing traumatic material on the entirety of the clinician's life, countertransference is confined to the therapeutic setting. A critical point is that although countertransference is a frequent occurrence in treatment, countertransference reactions may not necessarily be of a traumatic nature. Those are termed traumatic countertransference (Herman, 1992) and traumatic reenactments (Boulanger, 2007; Davies, 1996).

Thus, although the new concept of shared resilience in traumatic situations also applies to the therapeutic setting and derives from empathic bonding, it might go beyond the therapeutic sessions. As such, it sometimes involves others and can relate to the resources of clients and/or therapists, which enable them to create a suitable therapeutic relationship and cope successfully with the traumatic situation together.

Conclusions and Future Thoughts

In this article, we proposed a new concept, "SRTR," as a basis for examining positive effects of working with trauma survivors in situations where therapists and other helping professionals are exposed to the same traumatic reality as their clients. This concept reflects recent developments in research on trauma and its impact on mental health practitioners and helping professionals, which take into account both the negative and positive effects of direct and indirect exposure on therapists in an STR. As mentioned, the theoretical and empirical literature has focused on the negative effects of such exposure and on the ability of therapists to cope with these situations. These studies have revealed low levels of symptoms among helping professionals, although a wide range of other consequences have been found, which affect their functioning and personal life (e.g., Baum, 2013; Dekel, 2010; Tosone, 2012).

Consistent with this approach, attempts have been made to understand individuals and their environment in order to identify the factors that facilitate coping and promote growth

and resilience in situations of shared reality, whether they result from war and terror or from natural disasters (Bauwens & Tosone, 2010; Dekel & Nuttman Shwartz, 2014). However, this concept has not been addressed sufficiently to date. Most of the existing theoretical knowledge examined these situations from a pathological perspective, with emphasis on the individual. In addition, there is a lack of knowledge on double and shared exposure and on the positive dynamics that might develop as a result of the client–therapist encounter in a shared reality. These aspects include resilience, the ability to establish reciprocal relations with clients, the role of the empathic bonding, the role of therapeutic flexibility, and the changing roles of therapists and clients. For example, Tosone (2012) proposed a definition of shared reality in the Encyclopedia of Trauma, which highlighted the positive effects and resiliency of such situations. Nonetheless, Tosone's definition focused on SdTS—the pathological consequences of the shared traumatic situations (Tosone at al., 2014). Simultaneously, Baum (2013) conducted a study that served as a basis for developing a specific measure of professional growth among therapists as a result of "double exposure," which focused on the difficulties involved in functioning in an STR. Thus, it is important to consider a new and separate concept in order to change professional perceptions and engage in a dialogue aimed at enabling them to integrate the positive concept as part of their work in shared trauma situations.

However, a thorough examination of existing studies on the topic as well as those cited in the literature review indicates that even though all of the researchers have related to the negative implications of direct and indirect exposure to trauma, any mention of the positive effects has remained at the level of direct growth and has not dealt with indirect effects resulting from the client's growth. That is, these studies have not examined secondary growth in shared trauma, even when they dealt with secondary traumatization in a shared reality (Boscarino, Figley, & Adams, 2004). Nor have these studies examined "shared growth" in traumatic situations, even when they relate to the empathic relationships, which are the key to growth and resilience in a shared reality.

Moreover, as the results of these studies indicate, there is a theoretical confusion between these positive concepts, including PTG and the concept of SRTR. Notably, little attention has been paid to the important role of resilience in therapeutic interventions as a factor that promotes coping in shared traumatic situations, nor has sufficient attention been paid to shared resilience. Whereas Tosone (2012) argued that empathy, compassion, and a sense of competence precede the therapist's growth in an STR, Baum (2013) found that lack of empathy exacerbates distress more than direct exposure to threat and that it is more prevalent in situations of double exposure. It can also be argued that if therapists are resilient, they can show empathy despite double exposure. Thus, they will be open to secondary growth and shared resilience, which will improve their professional and personal functioning as well as their relationships with their clients.

Our new theoretical concept—SRTR—is consistent with the perspective of Tosone et al. (2014) who concluded that

the personal and professional aspects of the traumatic experience are interconnected and that shared trauma is reciprocal, such that mental health responders' personal disaster–related experiences can impact the nature of their practice. Similarly, their interactions with trauma survivors can influence their personal responses to the same precipitating traumatic event.

In addition, a unique aspect of shared reality is the ability to move between different domains as well as the flexibility that therapists show in these situations and the extent to which they have a holding environment (Dekel & Nuttman-Shwartz, 2014). As Ungar (2013) puts it, "It also means that clinicians need to be willing to engage with individuals in ways that empower them to share their own perspectives of their hidden patterns of resilience" (p. 263). Although these strategies may not be adaptive in the long term, "exploring how people cope can inform clinical interventions by focusing attention not just on what individuals need to change, but also on aspects of the social ecology that have to change for new coping patterns to be adopted" (Ungar, 2013, p. 263).

These insights support the person in environment approach (Karles & Wandrei, 1994) and Ungar's (2013) resilience approach, which focus on the relationship between individuals and their environment and on the importance of interpersonal relationships and relationships between ecological systems as well as on the ability to maneuver between individual resources and environmental resources. In the context of shared reality, this refers to the microsystem (i.e., the resources of the therapist and client), to the mesosystem (the family resources of the therapist and client, and resources available to the organization in which the intervention takes place) as well as to the macrosystem (i.e., the community of the therapist and client). Moreover, this new concept attributes importance to the mutuality of the therapist's and client's exposure to a shared threat and considers the client and clinician in context which is consistent with a contemporary relational approach (Tosone, 2004). As such, it is consistent with current trends in therapeutic relations which take the clients' competencies and knowledge into consideration. It also relates to mutual learning in the therapeutic encounter and to practice wisdom and highlights the transition to a positive perspective in trauma research in general and in social work research in particular (Joseph & Murphy, 2014).

Theoretical and Practical Recommendations

In light of the blurred definitions of resilience and growth in the theoretical literature, it is important to deepen our understanding and to continue investigating those concepts in general as well as the relevance of the concepts to STR situations. Those studies make it possible to deconstruct this important concept and improve theoretical and methodological standards of practice. In examining resilience, it is necessary to consider which personal characteristics or conditions result in what level of resilience and at what level of exposure to continuous trauma and threat.

In addition, it is important to increase awareness of resilience and growth in the context of providing training and

assistance to therapists in these kinds of situations. Specifically, it is necessary to consider developing concepts that reflect also the positive aspects of double exposure (Baum, 2012; Dekel & Nuttman-Shwartz, 2014; Tosone et al., 2014). It is also necessary to take into account the factors that are associated with shared resilience in the process of planning and providing trauma training, as well as in educating and supervising workers, especially among practitioners living and working in areas that are more susceptible to such potentially traumatic events.

Finally, although resilience is considered a culturally sensitive concept (Ungar, 2013), there is a need for further research on universal and culturally based aspects that might be associated with resilience as well as the effects of the therapeutic relationship and shared resilience in traumatic situations.

To conclude, STR and SRTR coexist in times of war, terror, and natural disaster. In these situations, when trauma workers and their clients are exposed to the same traumatic events, SRTR and STR integrate individual, family, and organizational factors as predictors and mediators of distress responses as well as positive responses. As a result, it is necessary to take protective factors for trauma workers into consideration in situations of STR and double exposure. In that context, helping professionals need to be trained for work in a shared reality. In light of this new conceptualization, there is also a need to conduct further research in an attempt to enhance understanding of these phenomena and identify factors that foster resilience. Moreover, there is a need to develop training programs that focus on promoting resilience in the face of shared trauma and in a therapeutic relationship where the therapists and their clients are exposed to the same dangers.

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