

# Research & Advocacy Digest

Linking Advocates & Researchers

## *Vicarious Trauma and Its Impact on Advocates, Therapists and Friends*

### Letter From The Editor

Janet Anderson, Advocacy Education Director

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**I**n our work as sexual assault advocates, therapists and prevention specialists, we bear witness to the emotional pain of survivors of sexual assault on a daily basis. Although we may experience affirmative, life-changing and positive impacts due to the nature of our work, we are also vulnerable to being exposed to both direct and vicarious sources of traumatic stress. Extensive literature reviews of vicarious trauma recognize this issue as a serious challenge faced by those in the helping profession. They identify compassion fatigue, intrusive imagery, distressing emotions, burnout, somatic complaints, changes in identity, changes in worldview and other functional impairments as potential consequences of vicarious trauma if not dealt with in a systematic way. On the other hand, the literature also cites concrete strategies individuals and organizations can employ to ameliorate its effects.

Vicarious trauma (McCann & Pearlman, 1990) is described as “pervasive changes that occur within clinicians over time as a result of working with clients who have experiences sexual trauma”.

This edition of the Research & Advocacy Digest explores how the special nature of sexual assault work impacts the emotional well-being, health, perceptions of the world through the lens of vicarious trauma, compassion fatigue, countertransference and burnout. This edition also explores risk factors for vicarious trauma and solutions that can be implemented on the personal, professional and organizational level to diminish the negative effects of this phenomenon.

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# Vicarious Trauma: An Interview with Golie Jansen, Associate Professor, Department of Social Work, Eastern Washington University

**WCSAP:** Golie, can you tell me what you were attempting to study in your research?

**G:** The research I am in the process of finalizing is examining the relationship between perceived organizational support and the levels of vicarious trauma in sexual assault workers. It's still being analyzed and will be formally published but I can discuss some of our initial findings and recommendations.

**WCSAP:** What originally led you to do this research project?

**G:** During my conversations with therapists who worked with sexual assault survivors, I noticed that they made statements and discussed some behaviors that made me question how the work was affecting them. For instance, I heard about instances of therapists saying they were shopping during every lunch break, needed drinks to relax when they got home or just stated that they were not involved in much of anything. So, I started wondering if they were experiencing vicarious trauma because of their work.

I also started to question whether the organization had a responsibility to address some of those negative aspects of sexual assault work with their workers. In reading the literature pertaining to vicarious trauma I wanted to determine whether organizational support made a difference in how it mitigates vicarious trauma. Although there is much literature pertaining to vicarious trauma, there is very little literature on the relationship between organizational support and vicarious trauma, so I set out to conduct a research project on the topic.

**WCSAP:** Can you describe how you designed your research project?

**G:** We used two standardized instruments: 1) the Traumatic Stress Institute's (TSI) Belief Scale and 2) the Measure of Perceived Organizational Support,

which measures how satisfied workers are with their organization and their perceptions of support they receive from them. These two measures give us a good idea about the relationship between perceptions of support and whether that support has any influence over how vicariously traumatized they are. We distributed the surveys at WCSAP's annual conference to a variety of participants, including advocates, educational specialists, managers, community outreach specialists and therapists and had a 40% return rate, which is pretty high.

“Preliminary findings indicate that participants were definitely experiencing vicarious trauma as a result of this work, but we also are finding that when people perceive their organizations to be supportive, they experience lower levels of vicarious trauma.”

**WCSAP:** We know your study is still being analyzed and refined, and will be submitted for formal publication in the near future, but can you tell us what your preliminary findings are?

**G:** Preliminary findings indicate that participants were definitely experiencing vicarious trauma as a result of this work, but we also are finding that when people perceive their organizations to be supportive, they experience lower levels of vicarious trauma. At this point in the analysis, our hypothesis has been strongly confirmed; this study is leading us to believe in the relationship between organizational support and how much this support can mitigate the severity of vicarious trauma. This information is very much

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needed because it provides recommendations for organizations on how to manage their programs to mitigate or even prevent the effects of vicarious trauma.

**WCSAP: Based on your preliminary findings, what are some recommendations that you would give to sexual assault organizations, their workers and management? What is crucial for them to understand?**

**G:** My recommendations are as follows:

- It is important for organizations to understand their role as the managers of all this and to not place the burden of dealing with it on the individual therapists and advocates.
- Younger, less experienced workers may need more training since we're finding that they tend to be more vicariously traumatized than more experienced workers.
- Organizations have an obligation to inform and a duty to warn those coming into the field of the potential occupational hazards of the work. This can be done as part of the hiring process so they can make informed choices about whether to continue. Organizations can also set this practice up in their personnel protocols. They should, however, not only stress the hazards, but ways advocates can protect themselves and discuss what the organization will do to help minimize the most negative effects.
- Provide more training on trauma in general to students and sexual assault workers so they are aware of its impact. Universities often don't emphasize this, which ultimately does a great disservice to those going into the work. Consequently the workers have limited exposure regarding the nature of trauma but then find themselves dealing with extremely traumatized people. This also speaks to the need for more intensive staff development.

**WCSAP: Those are great recommendations. Is there anything else you would like to add about this topic?**

**G:** One of the ways that vicarious trauma impacts people is that it affects their worldview, spirituality and sense of identity. Someone may initially be an

idealistic person who sees the world as a place where things are fair or where people are basically good. But by doing this work you only work with the atrocities that people tell you. Consequently, you may begin to shift the notion of what your worldview looks like and find yourself becoming more cynical, and the whole idea of hope becomes lost. The question then arises, if I as a therapist or sexual assault advocate lose hope, how can I instill it in people who are most vulnerable? How can I demonstrate that there are ways to address it; that there are antidotes? Also, if we don't see great success in the work, we may think "I'm a bad therapist" or "I'm a bad advocate." These are issues that agencies can help workers address. Staff meetings and consultation can help people begin to identify ways they are being affected and develop strategies to deal with them, like fostering self-care routines.

I also want to remind people that even though we hear and see atrocities, it is important to remember that people are doing incredible, beautiful and heroic things out there in the world, every day. You can embrace both the atrocities and the goodness. It's important to keep a balanced perspective.

I have completed another research project by interviewing 15 sexual assault workers from all over the state. It was amazing to see how those workers who have stayed in this field for ten or more years talked about the joy and satisfaction this work gives them. Many of them said that spirituality now had a big place in their life as a result. In doing this work they gained a deeper understanding of what life is like, what relationships really are and how beautiful the world is. So we also need to begin to talk about post-traumatic growth and how resilient we are. This work can deepen our sense of connection in the world because we can overcome trauma and suffering. However, one won't come to this place if they don't address the harmful and hurtful aspects of the work, which ultimately can be damaging to our clients.

**WCSAP: Golie, thank you for taking the time to discuss your new study and we look forward to its upcoming publication.**

For more information on Golie Jansen's research, you may contact her at Eastern Washington University at (509) 359-6487 or email her at [golie.jansen@mailserver.ewu.edu](mailto:golie.jansen@mailserver.ewu.edu). ■

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# Emotional Reactions of Rape Victim Advocates: A Multiple Case Study of Anger and Fear

WASCO, SHARON, CAMPBELL, REBECCA.

PSYCHOLOGY OF WOMEN QUARTERLY, 26 (2002) 120-130

The goal of the study was to identify situations that are associated with feelings of anger and fear when doing rape victim advocacy work. In addition, the authors sought out to explore how these emotions related to advocates' choices to continue in their work. The researchers collected qualitative data by interviewing eight experienced advocates from different organizations to understand their emotional responses to repeated exposure to rape. After the interviews, each example of anger or fear was coded by using an "I" for individual (if the anger or fear was a response to an individual or characteristic of a specific person) or "E" for extra-individual or environmental cues (if the participant spoke in general or plural terms, or if the participant focused on the description of a place, structure, setting, system, or institution or larger societal issue).

## Responses of Anger

The results indicated that on the individual level, 49% of the anger responses were associated with reactions to attitudes, actions or statements from criminal justice personnel, including police officers, judges, detectives, defense attorneys, and prosecutors, while 11.3% of the advocates had anger responses directed toward the perpetrators of the assault. The results on the extra-individual level indicated that 38.7% of the participants were angry at the inefficiency and insensitivity of the court system, and 18.3% were angry at other systems like the hospitals. Furthermore, 15% of the extra-individual anger focused on societal attitudes toward women and rape and 14% were angry at the brutality of rape in general.

## Responses of Fear

At the individual level, 39.5% of fear was based on reactions to threat or perceived threat from alleged perpetrators or their family members. The results also demonstrated the differences of threat for advocates based upon their geographic location. For example, advocates in urban settings described threatening encounters during work hours and in social settings while advocates in rural settings described encounters in local parks, stores and other

situations in their daily lives. In addition, 29% of fear reactions occurred when advocates personally self-identified with a particular characteristic or story of a client while 15% reported fear for their family. At the extra-individual level, advocates described fear as being associated with, and inherent within, their job duties as advocates. Twenty-six percent (26%) identified being alone in the community as fearful, many times in the darkness of night, while the second most common fear was going to the criminal justice system (20%). Finally, the respondents identified fear from their heightened sense of their own risk of being assaulted (12%) and awareness of the prevalence of violence against women (10%).

The highest percentage of responses (both anger and fear within the individual and extra-individual level combined) was directed at the criminal justice system (49%). Furthermore, the study revealed that participants expressed more instances of anger (146 responses) than fear (88 responses) suggesting that fear may not be as common as advocates gain more training and experience. On the other hand, anger reactions did not seem to dissipate with experience.

The study also demonstrated that participants experienced more reactions of anger and fear toward the extra-individual level vs. the individual level. They suggest two possibilities: 1) that the advocates may have been trained to understand rape from a feminist perspective, thus viewing the issue from a societal framework as opposed to an individual framework, and 2) that to be effective in their role, advocates must interact with community systems more often than other helping professionals. These results may suggest that emotional reactions to rape victims advocacy work may be different than the vicarious traumatization research documented among other types of helping professionals.

A secondary goal was to examine what role these emotions have on advocates' decisions to remain in advocacy work. Although no single conclusion was drawn, the majority did indicate that anger and fear, did, in fact, have a positive impact on their ability to grow, be compassionate and empathetic. ■

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# A Multiple Case Study of Rape Victim Advocates' Self Care Routines:

THE INFLUENCE OF ORGANIZATIONAL CONTEXT WASCO, SHARON, CAMPBELL, REBECCA.  
AMERICAN JOURNAL OF COMMUNITY PSYCHOLOGY, VOL. 30, #3, OCTOBER 2002

The purpose of this research study is twofold: 1) to explore the use of self-care routines among rape victim advocates who are repeatedly exposed to traumatic rape material and 2) to examine the relationship between organizational support and the use of self-care. Paramount to this study was the assumption that rape advocacy work requires the use of self-care in order to carry out their roles effectively and that organizations can be influential in facilitating these routines. Self-care is defined as "the proactive strategies that professionals use to offset the negative aspects of working with trauma victims and promote their own well-being."

"Findings indicated that all of the experienced advocates used some form of proactive self-care to regulate their work related pain and these self-care strategies were more likely to be integrative rather than cathartic."

"Experienced female rape victim advocates (n=8) were recruited for an extensive interview on four topics: 1) description of their advocacy program, 2) self-care routines, 3) emotional reactions to their work, and 4) perceived role of advocates and factors that influence their decision to stay in the field. This analysis focuses solely on the self-care routines. All interviews were recorded verbatim and coded as either "organizational support," or "self-care routines."

Self-care routines utilized by the advocates served two functions: 1) as a cathartic release and, 2) as a way to integrate the material into their lives and fell into five categories: spiritual (faith, guidance for living), physical (music, exercise, relaxation), social (hobbies, traveling, TV, movies), cognitive (changing beliefs, attitudes, internal cheers), and verbal (talking, therapy, naming feelings). The coding process also

yielded a list of 27 perceived supportive organizational characteristics and the advocates' organizations were classified as either "high support," "medium support," or "low support" organizations. Amongst many others, perceived supportive organizational characteristics included:

- Volunteers involved in sexual assault service delivery
- Paging system/relationship with community
- Advocate encouraged to call backup
- Flexible hours
- Training, conferences, workshops
- Weekly case meetings
- Individual clinical supervision
- Sexual assault is main priority

Findings indicated that all of the experienced advocates used some form of proactive self-care to regulate their work related pain and these self-care strategies were more likely to be integrative rather than cathartic. For example, 76.5% of all social, 74% of cognitive and 76% of spiritual self-care routines were integrative, while physical routines (39%) and verbal (12.5%) were significantly less likely to serve integrative functions. A second objective of this study was to examine the relationship between organizational support and self-care routines. As assumed, self-care strategies used by advocates in "high support" organizations were more likely to be integrative (71.4%), than strategies in medium (58.3% or low support (48.7%)) organizational settings. ■

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# Submerged Voices: Coordinators of Sexual Assault Services Speak of Their Experiences

CARMODY, MOIRA. AFFILIATED JOURNAL OF WOMEN AND SOCIAL WORK, 1997, VOL. 12, NO. 4, PGS 452-462

This article uses a qualitative, anecdotal approach to report on the experiences of nine health-based sexual assault coordinators in New South Wales, Australia and discusses the impact this work had on both their professional and personal lives. Although this research does not specifically address the topic of vicarious trauma, some of the responses about this work and its impact on their personal lives may be of benefit. The participants worked within the sexual assault arena for an average of three years; four worked in hospital-based centers, three in community center-based services and two in services in rural hospitals and community health centers. All participants were white middle class women and had completed 4-year undergraduate programs in social work.

“Throughout the course of their work, the sexual assault workers identified struggling with anger, personal safety, awareness of their own vulnerability to rape, particularly since they confronted it on a daily basis, and internalizing client’s pain as key variables impacting their personal lives.”

Although these coordinators offered no singular or consistent perspective and assigned different meanings to their work, they did emphasize the notion that working within the sexual assault arena generally gave them more opportunities for professional development and opened more doors than other forms of social work they engaged in. They cite the increased skills in training, staff supervision, working within

different community systems and most notably, their ability to influence public policy as particularly rewarding. Central to these positive experiences was the focus on working with women and advocating and lobbying on their behalf.

“Some indicated that they encountered some of the same stigma that victims experience because of the highly conflicting values surrounding rape and sexual assault and due to the confronting nature of the work itself, such as their continued efforts to challenge beliefs and systems.”

On a personal level the responses were as varied as the participants themselves however, some general themes emerge. Throughout the course of their work, the sexual assault workers identified struggling with anger, personal safety, awareness of their own vulnerability to rape, particularly since they confronted it on a daily basis, and internalizing client’s pain as key variables impacting their personal lives.

In addition, many were aware that sexual assault work challenged their relationships with friends, family members, partners, children, colleagues and particularly, their alliances with men. Some indicated that they encountered some of the same stigma that victims experience because of the highly conflicting values surrounding rape and sexual assault and due to the confronting nature of the work itself, such as their continued efforts to challenge beliefs and systems. And finally, a sense of loneliness, isolation and being cut off from people with whom they mix socially were also issues that arose for some participants. ■

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# Secondary Traumatic Stress and Burnout in Sexual Assault and Domestic Violence Staff

BAIRD, STEPHANIE, & JENKINS, SHARON RAE, VIOLENCE AND VICTIMS, FEBRUARY 2003, VOL.18, NO.1, PP.71-86

The article focuses on a study that was conducted to examine the effects of secondary traumatic stress, vicarious trauma, burnout and general distress by comparing volunteers and paid staff at dual domestic violence and sexual assault agencies. It involved eight agencies and 101 participants from the Fort Worth area of Texas. The participants were primarily heterosexual, white, Christian women with at least a college education. The study addresses two hypotheses:

**Hypothesis One** – less experienced and younger personnel will report more secondary traumatic stress, vicarious trauma, burnout and general distress compared to more experienced and older personnel. Basically the study found that experience and age are not related to how one experiences vicarious trauma and secondary trauma. It did find however that younger persons experience a little more burnout.

**Hypothesis Two** – greater exposure to sexual assault/domestic violence survivors will correlate with higher rates of secondary traumatic stress, vicarious trauma, burnout and general distress. The study found, in contrast to other studies, that workers who saw more clients had fewer symptoms of vicarious trauma; for volunteers only, burnout was unexpectedly related to seeing fewer clients and seeing more clients for more hours related to greater self-rated personal accomplishment.

Overall this was an interesting article that looks at how other factors such as agency structural support, communication and supervision impact burnout which is unrelated to working with trauma clients. It also provides helpful definitions of the differences between vicarious trauma and secondary traumatic stress, also called compassion fatigue. Symptomatically both show signs of PTSD, but vicarious trauma involves cognitive shifts in the counselor that may be characterized as intrusive imagery rather than developing the full spectrum of PTSD symptoms. ■

## An Empirical Study of the Effects of Trauma on Work With Trauma Therapists

PEARLMAN, LAURIE ANN & MAC IAN, PAULA S.  
PROFESSIONAL PSYCHOLOGY: RESEARCH AND PRACTICE, 1995, VOL. 26, NO. 6, PP. 558-565

This article is about the effects of vicarious trauma on white female trauma therapists. Researchers sought to develop dependent variables that might indicate the existence of vicarious trauma and independent variables which could be used to predict it. It is the first study which attempts to operationalize and measure vicarious trauma – presumably within this socio-economic class of white women. The study did not provide a definition of “trauma therapist.” It relied on self identification of participants with a 32% response rate. It also provided an overview of the research literature relevant to the impact of vicarious trauma and burnout.

Using a variety of scales and methods, dependent variables included measures of safety, trust, intimacy, esteem and power. Independent variables included measures of age, income, education, work setting, use of personal therapy, and the receipt of general or trauma-related supervision. Outcomes from the study indicated that therapists who had a personal trauma history had more negative effects from the work than those who didn't have such a history and those newer to providing trauma therapy experienced the most psychological difficulties. ■

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# A Comparison of Clinicians Who Treat Survivors of Sexual Abuse and Sexual Offenders

WAY, INEKE, VANDEUSEN, KAREN, MARTIN, GAIL, APPLGATE BROOKS & JANDLE, DEBORAH  
JOURNAL OF INTERPERSONAL VIOLENCE, VOL. 19, #1, JANUARY 2004 49-71.

As the first study of its kind, this research compared the coping strategies that help minimize traumatic effects on therapists who treat survivors of sexual abuse (n=95) and those who treat sex offenders (n=252).

Using the standardized Impact of Event Scale, the authors sought to examine five hypotheses:

1. *Clinicians would report avoidance and intrusions resulting from vicarious trauma within the clinical range.* This was supported. Levels of vicarious trauma for the majority of the sample fell within the clinical range.
2. *Childhood maltreatment history and longer time providing sexual abuse treatment would be associated with higher levels of vicarious trauma.* This was not supported. Clinicians with a shorter time providing sexual abuse treatment reported higher levels of vicarious trauma. Furthermore, a history of maltreatment alone was not significantly associated with vicarious trauma.
3. *Greater use of positive personal (i.e. exercise, support seeking, therapy) and positive professional coping strategies (i.e. consultation, supervision, clinical support) would be associated with less vicarious trauma.* This was not supported. The authors found that greater trauma effects were associated with greater use of positive coping strategies. They caution however, that using a cross-sectional model does not allow a test of cause and effect. The second part of this hypothesis revealed that higher usage of professional supports was not correlated with lower traumatic effects.
4. *Greater use of negative personal coping strategies would be associated with greater vicarious trauma.*
5. *Clinicians who treat offenders would report levels of avoidance and intrusions similar to those reported by clinicians who treat survivors.* This was supported. Clinician groups did not differ significantly in levels of vicarious trauma. They postulate that these two subgroups may be too similar in content or share overlapping features to make a clearer distinction.

This was supported. Greater trauma effects were positively associated with greater use of negative coping strategies (use of pornography, alcohol, illegal drugs) again citing the inherent implications of using a cross-sectional model which doesn't allow for a test for causation.

“Educational programs should emphasize awareness of the symptoms; the need for greater use of self-care and acknowledging that vicarious trauma is a natural response to trauma work and not an indication of clinician deficiency.”

Because this study found that those with lesser experience reported higher levels of vicarious trauma, the authors suggest that those who are new to the field may require more specialized training on the risks of trauma work. Educational programs should emphasize awareness of the symptoms; the need for greater use of self-care and acknowledging that vicarious trauma is a natural response to trauma work and not an indication of clinician deficiency. ■

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# Treating Therapists with Vicarious Traumatization and Secondary Traumatic Stress Disorders in “Treating Compassion Fatigue.”

PEARLMAN, L.A., AND SAAKVITNE, K.W. (1995) IN C. FIGLEY (ED.) , COMPASSION FATIGUE: COPING WITH SECONDARY TRAUMATIC STRESS DISORDER IN THOSE WHO TREAT THE TRAUMATIZED, PP. 150-177. NEW YORK: BRUNNER/MAZEL

Authors Pearlman and Saakvitne explore the relationships between the concepts of vicarious trauma and secondary traumatic stress and the treatment of clients who have experienced childhood sexual abuse.

Pearlman and Saakvitne base their article on several different studies that examined the prevalence of vicarious trauma and secondary traumatic stress in the lives of therapists. They identify the scope of the problem, analyze the differences between the phenomena, recognize the effects of each, and make recommendations about how to best treat vicarious trauma.

Though there are similarities between them, vicarious trauma and secondary traumatic stress are different; vicarious trauma is identified by these authors as a transformation in the therapist’s inner experience resulting from empathic engagement with the clients’ traumatic material. Secondary traumatic stress instead focuses on the symptoms of traumatic stress, but does not examine the impact on one’s self-concept or conceptualization of the world. The authors explain that the notion of vicarious trauma is based on Constructivist Self Development Theory.

“Because of the unique impact of treating trauma survivors, vicarious trauma is common only in trauma work. Though many different types of therapists are deeply impacted by sadness or the demanding nature of their work, these authors explain that therapists who treat trauma survivors inevitably become aware of the potential for trauma in their own lives and may be coping with their own traumatic experiences.”

The authors recognize factors that can contribute to vicarious trauma, such as the special characteristics of the therapy and its context, the therapist’s past experience with childhood sexual abuse, the therapist’s high ideals or lack of self-care, and insufficient supervision by experienced trauma-therapy supervisors.

Because of the unique impact of treating trauma survivors, vicarious trauma is common only in trauma work. Though many different types of therapists are deeply impacted by sadness or the demanding nature of their work, these authors explain that therapists who treat trauma survivors inevitably become aware of the potential for trauma in their own lives and may be coping with their own traumatic experiences.

The authors encourage therapists to assess their own experiences to examine the impact of trauma treatment on their own lives. They provide strategies for treatment, encouraging therapists to practice self-care, seek support through therapy or support groups, maintain a full personal life, and identify other healing activities. Furthermore, the authors challenge organizations to reduce the potential of vicarious trauma for their employees by providing a comfortable physical setting, an atmosphere of respect, and access to mental health benefits. ■

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# Assisting Rape Victims as They Recover From Rape: The Impact on Friends

AHRENS, COURTNEY, E. & CAMPBELL, REBECCA.

JOURNAL OF INTERPERSONAL VIOLENCE, 15 #9, SEPT. 2002, 959-986.

This study examined the impact of rape disclosure on 60 friends of rape survivors through questionnaires. The authors note that the literature has virtually neglected the impact of rape disclosure on friends and sought to remedy this gap since research indicates that most rape victims turn to friends and family for support more often than other formal avenues.

“the majority of participants believed their efforts were needed, that the survivor was thankful, that they did not feel particularly distressed and felt good about providing assistance.”

In this study friends were asked to describe their: 1) friendship with the survivor and the type of assault; 2) perceptions about the assault; 3) beliefs about the impact of the assault on the survivor; 4) experience of their assistance; and 5) impact the disclosure had on their relationship.

Gender differences, personal history of assault and length of friendship were also examined to determine if experiences differed along these variables.

Most of the friendships were described as either a “good friend” or “somewhat close” and averaged eight years in length. Survivors were mostly female (98%) and came from diverse racial backgrounds. An average of 7 months elapsed between assault and disclosure, most were acquaintance rapes (83%) and most did not involve injuries (19%), weapons (7%) or alcohol (29%).

Ratings indicated that participants expected the rape to have a strong impact on the survivors’ lives and most indicated that participants were not to blame. In addition, measures indicated that participants felt empathetic toward survivors and that an average number indicated that participants believed the survivors’ coping strategies were effective.

Average ratings indicated that participants were not puzzled about how to help, although they were unsure what survivors needed (68%). Additionally, the majority of participants believed their efforts were needed, that the survivor was thankful, that they did not feel particularly distressed and felt good about providing assistance. The participants did, however, experience emotions such as anger at the perpetrator (96.6%), shock (71.7%), and a wanted revenge (68.3%). In terms of their continued friendship, ratings indicated that participants believed the friendship grew closer, felt that they still “treated the survivor the same,” and were able to talk about their own feelings. Almost all of the friendships remained intact (95%). While the majority of responses were extremely positive, there were negative impacts. Five percent indicated that they now care less for the survivor and were no longer able to be themselves around her.

“Contrary to other findings regarding significant others’ reactions to rape disclosure, this study suggests that friends of rape survivors experienced more validating and less distressing reactions.”

Based on gender, male friends (n=23) tended to have more negative responses about their friendship after the disclosure, blamed the survivor more, were more confused, and felt more ineffective than the women in the study (n=36). Friends who personally were survivors understood the significant impact this would have on their friend and blamed the victim less than those who had not been assaulted. Length of friendship had an impact on responses as well. Participants who were friends with the victim for more than five years experienced more positive changes in their views of the relationship than those

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who were friends for less than five years. The authors note however, that although there were significant differences based on these subgroups, none of them strongly blamed the survivor for the assault.

Contrary to other findings regarding significant others' reactions to rape disclosure, this study suggests that friends of rape survivors experienced more validating and less distressing reactions. Although the majority of participants reported positive experiences in helping their friends, a more thorough analysis revealed they also needed support and assistance during this time. These findings have implications for sexual assault service providers in that the authors recommend that they should consider developing training programs aimed at teaching friends and significant others how to be skillful support providers after a disclosure. ■

## Impact of Trauma Work on Social Work Clinicians: Empirical Findings

CUNNINGHAM, MADDY. SOCIAL WORK, OCT 2003, V48 #14, PP. 451-459.

This study attempts to analyze the impact of vicarious trauma on clinicians who work with sexual abuse survivors versus those who work with survivors of other 'naturally caused' traumas, such as cancer. In a sample of 182 social workers, the author discussed three hypotheses concerning the clinicians' caseload and their sense of the following categories that might indicate vicarious trauma: self / other safety, negative world view and other trust.

The authors found that clinicians who worked with sexual abuse survivors experienced more evidence of vicarious trauma than those who worked with clients who had cancer. Additionally, the research found that clinicians with a personal history of sexual abuse were more likely to find working with sexual assault clients stressful.

“Clinicians who worked with sexual abuse survivors experienced more evidence of vicarious trauma than those who worked with clients who had cancer.”

The researchers noted several implications of this study on practice and made the following recommendations:

- Providing special training and support for clinical workers can help buffer the impact of vicarious trauma and ensure quality services for clients
- Vicarious trauma and its implications should be more concretely integrated into social work curricula and training programs
- Clinical support and supervision should include non-judgmental discussions of the implications of vicarious trauma
- Clinicians who had mixed caseloads (sexual assault and non-sexual assault clients) reported less vicarious trauma, therefore agencies should investigate mechanisms to balance caseloads, if possible
- Administrators have a 'duty to inform' trauma workers of the potential implications of their choice to serve sexual assault clients so as to make an educated decision. ■

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# Vicarious Traumatization, Spirituality, and the Treatment of Sexual Abuse Survivors: A National Survey of Women Psychotherapists

BRADY, JOAN LAIDIG, POELSTRA, PAUL L. & BROKAW, BETH FLETCHER

PROFESSIONAL PSYCHOLOGY: RESEARCH AND PRACTICE. VOL. 30 AUGUST 1999, PP. 386-393

This article re-examines various studies on vicarious traumatization (VT) and specifically how it affects survivors' and therapists' spirituality. The authors of this article and Moberg's 1979 research, define spirituality as "having both religious and existential components, indicating a relationship with God or a higher power coupled with a sense of life purpose and meaning beyond oneself." Laidig, Fuller and Brokaw note that research in the area of spirituality as it relates to VT is limited, due to its abstract nature. Although research is scarce, the authors include past studies that support the correlations between vicarious trauma and spirituality and they agree that spirituality is disrupted or altered by trauma.

“In relation to spirituality,  
the Brady, Guy and Brokaw  
study states that the  
practitioners who treated  
a larger number of survivors  
of abuse reported a greater  
satisfaction in their spiritual life”

This article cites Decker's 1993 article which states that "no matter what the psychological condition of the survivor, trauma will influence his or her spiritual development." Decker goes on to state the survivor will be focused on his or her search for meaning and perspective, which has been called into question by trauma. Decker suggests that spirituality might improve after trauma. The core values and beliefs of a survivor are often reexamined as a result of the trauma. Therapists experience similar challenges regarding their spirituality. Vicarious Traumatization is considered a very real and "dangerous" threat to the spirituality of the therapists of trauma survivors.

The Brady, Guy and Brokaw study examined the vicarious trauma of 1,000 randomly sampled women psychotherapists that worked with sexual abuse survivors. Participants completed a questionnaire that requested their demographic information, work-related characteristics, involvement in personal therapy, and personal history with trauma. Out of the 446 usable questionnaires that were returned, the following religious affiliations were reported: Agnostic or Atheist 14%, Catholic 19%, Eastern Religion 2%, Jewish 17%, Protestant 32%, and other unspecified faiths at 16%.

It should be noted that when asked about their personal history with psychotherapy and sexual trauma, 79% responded that they were not currently participating in personal psychotherapy. The figure for those who had been in past personal psychotherapy was 69%, however only 46% of the respondents indicated they had addressed how their work with trauma survivors affected them while in personal psychotherapy. One third of the respondents had a personal history of sexual trauma, and of those that experienced sexual trauma, 19% of them experienced the trauma in childhood, 7% in adulthood and 7% in both childhood and adulthood.

“One explanation for the  
increased spirituality could be  
that increased exposure to trauma  
'enhances spiritual well-being'  
because suffering is implied as a  
part of spiritual growth.”

In relation to spirituality, the Brady, Guy and Brokaw study states that the practitioners who treated a larger number of survivors of abuse reported a

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greater satisfaction in their spiritual life, “The more exposure to trauma material, the higher the respondent’s spiritual well-being.” A similar correlation is reported in Carmil and Breznitz’s 1991 statement that Holocaust survivors and their children reported a greater belief in God in comparison to those who did not directly experience the Holocaust.

This article also suggests that one explanation for the increased spirituality could be that increased exposure to trauma “enhances spiritual well-being” because suffering is implied as a part of spiritual growth. Therapists’ exposure to their client’s trauma is thought to cause a spiritual crisis that can generate a stronger sense of spiritual well being. Another phenomenon related to the increase in spirituality is the theory that therapists may be drawn to work with trauma survivors because of their solid foundation or belief in a higher power, which they see as giving them the necessary strength to do trauma work.

Brady, Guy and Brokaw share their foresight of the need for therapists to critically examine their own spirituality and how it may be influenced by their work with trauma survivors. The authors also state that organizations have a duty to help reduce the risk of vicarious traumatization in the workplace, which can be accomplished by offering an emotionally supportive, physically safe and respectful work environment. ■

## Therapists’ Collusion with the Resistance of Rape Survivors

FOX, RAYMOND, CAREY, LOIS, A. CLINICAL SOCIAL WORK JOURNAL, SUMMER, 1999, PG. 185-201

From the subjective perspective of nine rape survivors, this qualitative study examines the phenomenon known as collusive resistance, a process, conscious or unconscious, where therapists join clients in avoiding painful and traumatic material. The authors sought to explain why this collusion occurs and suggest vicarious trauma, countertransference and compassion fatigue as possible reasons for these failed therapeutic interactions. Although they point out that none of these afford a complete or satisfactory explanation, when taken together, they may provide insight and suggest guidelines for intervention.

Nine female rape survivors were interviewed in-depth. Each survivor had completed from 20 to 32 sessions of group therapy and a different therapist facilitated each group. All nine women had been in individual treatment prior to or during their support group work. This study examines their experience in both the individual and group setting. The type of rape (acquaintance, stranger, gang, weapon used) and time passed since the assault varied by survivor.

Although no hard data can be obtained due to the subjective nature of this study, the survivors identified subtle cues they received from their therapists who inhibited successful resolution of their

traumatic experience and provided suggestions for therapists to facilitate recovery and minimize collusive resistance.

“It’s important for therapists to view the client from a strength perspective so as not to give the impression that the survivor is incapable of handling the material of process.”

These suggestions include 1) knowing when to push and when to back off but not responding passively, 2) viewing the client from a strength versus weak perspective so as not to give the impression that the survivor is incapable of handling the material or, 3) understanding proper timing and pacing and 4) possessing personal and professional qualities to engage their clients in the work, such as empathy, understanding, caring, humor and the ability to deal with rage, horror and pain. They also cited that training about rape and trauma should be a prerequisite for those treating rape survivors. ■

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# Implications For Practice: Therapeutic, Personal and Organizational Coping Strategies

THE FOLLOWING RISK FACTORS AND COPING STRATEGIES WERE OUTLINED BY KAREN MCSWAIN, RENEE ROBINSON, AND LAURA PANTELUK AT THE SECOND ANNUAL POSTER SESSION COMPETITION, APRIL 17, 1998 (WWW.DRJONTRY.COM/HANDOUTS)

As the introduction outlined, vicarious trauma, compassion fatigue, countertransference and burnout interact with one another to produce occupational stress for sexual assault advocates, therapists and other helping professionals. Some of the contributing risk factors may include:

- Lack of experience with trauma victims
- Caseloads made up of high percentages of sexual assault victims
- Hearing client stories of trauma and abuse
- Working with clients who reenact pathological relationships in therapy
- Working without adequate supervision and consultation
- Witnessing traumatic incidences such as suicide
- Working with clients in a work context where concrete signs of success are few
- Empathizing with client's experiences of severe pain in their lives and not holding to strong boundaries

Some coping strategies that can be employed at the personal, professional and organizational level include:

## **THERAPEUTIC WORK COPING STRATEGIES**

- Recognize that vicarious trauma is an occupational hazard of trauma work
- Accept your reactions as normal responses to specialized work
- Limit exposure to traumatic material (books, conferences, movies)
- Balance your workload as to type of client problems
- Develop a supportive environment for discussing your own reactions
- Set and maintain clear client limits on therapeutic relationships
- Develop a balance of professional skills (trauma and non-trauma work)

## **PERSONAL COPING STRATEGIES**

- Engage in activities that promote physical health & leisure activities
- Seek both emotional and instrumental support
- Emphasize self-care and self-nurturing activities
- Take mental health breaks purposely
- Seek out experiences which instill hope and comfort
- Set clear boundaries between home and work

## **ORGANIZATIONAL COPING STRATEGIES**

- Recognize that vicarious trauma is an occupational hazard of trauma work & destigmatize
- Create a safe, private and confidential work space
- Provide adequate pay & benefits as resources for dealing with stress
- Provide supervision and consultation
- Create a working environment that is respectful toward staff and clients
- Provide adequate vacation, sick time and personal leave
- Provide professional development
- Provide access to critical stress management teams.<sup>1</sup>

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# Additional Resources

## Websites

National Center for  
Post-Traumatic Stress Disorder  
802-296-6300  
www.ncptsd.org

Sidran Institute  
200 E. Joppa Road, Suite 207  
Towson, MD 21286  
410-825-8888  
www.sidran.org

Traumatic Stress Institute  
22 Morgan Farms Drive  
South Windsor, CT 06074  
860-644-2541  
www.tsicaap.com

International Society for Traumatic Stress Studies  
60 Revere Drive, Suite 500  
Northbrook, IL 60062  
847-480-9028

## Books

Emotionally Involved:  
The Impact of Researching Rape  
by Rebecca Campbell, Routledge Press 2002

This is a powerful book which discusses the impact of researching rape and provides a critique of conducting victimization studies on both the researchers and "subjects."

## Video Tapes

Vicarious Traumatization  
(The Cost of Empathy - Part I) and  
(Transforming the Pain -Part II).  
Cavalcade Productions

These two videos outline the signs and symptoms of vicarious trauma as well as provide practical guidelines that individuals and organizations can take to ameliorate its effects. This is a great resource to show during staff and consultation meetings.

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please call us at 360.754.7583 or by email at [wcsap@wcsap.org](mailto:wcsap@wcsap.org).

During the course of collecting research, the term vicarious trauma was used in conjunction with other terms including compassion fatigue, secondary traumatic stress, burnout, co-victimization, traumatic countertransference and indirect trauma. Although these are considered overlapping concepts, these terms are actually quite distinct in their definition. For the sake of clarity, the definitions of vicarious trauma, compassion fatigue, countertransference and burnout are included.

Vicarious trauma (McCann & Pearlman, 1990) is described as “pervasive changes that occur within clinicians over time as a result of working with clients who have experienced sexual trauma. These include changes in the clinician’s sense of self, spirituality, worldview, interpersonal relationships, and behavior. Vicarious trauma can also have implications for organizations that may include greater use of sick leave, higher turnover, lower morale, and lower productivity.

Compassion fatigue is described by Figley (1995) as “the natural result of emphatic engagement with clients and exposure to their traumatic material and the stress of helping or wanting to help a traumatized or suffering person.”

Countertransference refers to a “clinician’s unconscious and conscious affective, behavioral, and cognitive response

to a particular client’s transference (not specific to trauma clients) within the treatment relationship.” (Pearlman & Saakvitne, 1995). B. Hudnall Stamm, points out that “countertransference applies more to and how our patients affect our work with them, whereas the other issues are about how our patients affect our lives, our relationships with ourselves, and other social networks.”

Burnout refers to a “generalized emotional exhaustion that helping professionals may develop over time related to various work-related stressors” (McCann & Pearlman, 1995). Burnout can occur when helpers struggle to maintain high levels of empathy and caring in work situations where there is likely to be unrealized and unrealistic expectations (Blair & Romoes, 1996).

Although there isn’t a single term used to describe what occurs when sexual assault advocates, therapists or other helping professionals are continuously exposed to traumatic material, the one thing we can predict is that working in this field leaves us vulnerable to this phenomenon and will most likely occur at some point during the course of your career. Therefore, we hope this Digest will provide you with an understanding of the issue and present some helpful tools and strategies to implement so you can continue the work of ending sexual violence. ■

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# Preventing Vicarious Trauma: What Counselors Should Know When Working With Trauma Survivors

Robyn L. Trippany, Victoria E. White Kress, and S. Allen Wilcoxon

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*Counselors in all settings work with clients who are survivors of trauma. Vicarious trauma, or counselors developing trauma reactions secondary to exposure to clients' traumatic experiences, is not uncommon. The purpose of this article is to describe vicarious trauma and summarize the recent research literature related to this construct. The Constructivist Self-Development Theory (CSDT) is applied to vicarious trauma, and the implications CSDT has for counselors in preventing and managing vicarious trauma are explored.*

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Counselors in virtually all settings work with clients who are survivors of trauma. Trauma can generally be defined as an exposure to a situation in which a person is confronted with an event that involves actual or threatened death or serious injury, or a threat to self or others' physical well-being (American Psychiatric Association, 2000). Client traumas frequently encountered in clinical practice include childhood sexual abuse; physical or sexual assault; natural disasters, such as earthquakes or tornadoes; domestic violence; and school and work-related violence (James & Gilliland, 2001). Many American counselors have recently been faced with a new population of traumatized clients secondary to the recent terrorist attacks on the United States. With estimates indicating that 1 in 6 women (Ratna & Mukergee, 1998) and 1 in 10 men will experience sexual abuse during childhood, and FBI estimates indicating that 1 in 4 women will be victims of sexual assault in their lifetime (Heppner et al., 1995), sexual victimization is one of the most commonly presented client traumas. Clients' reactions to traumas are typically intense fear, helplessness, or horror. As a result of the trauma, the person may experience severe anxiety or arousal that was not present prior to the trauma (American Psychiatric Association, 2000).

Counselors' reactions to client traumas have historically been characterized as forms of either burnout or countertransference (Figley, 1995). More recently, the term *vicarious trauma* (VT; McCann & Pearlman, 1990) has been used to describe counselors' trauma reactions that are secondary to their exposure to clients' traumatic experiences. The construct of VT provides a more complex and sophisticated explanation of counselors' reactions to client trauma and has implications for preventing counselors' VT reactions.

VT has been referred to as involving "profound changes in the core aspects of the therapist's self" (Pearlman & Saakvitne,

1995b, p. 152). These changes involve disruptions in the cognitive schemas of counselors' identity, memory system, and belief system. VT has been conceptualized as being exacerbated by, and perhaps even rooted in, the open engagement of empathy, or the connection, with the client that is inherent in counseling relationships (Pearlman & Saakvitne, 1995b). VT reflects exposure of counselors to clients' traumatic material and encompasses the subsequent cognitive disruptions experienced by counselors (Figley, 1995; McCann & Pearlman, 1990). These repeated exposures to clients' traumatic experiences could cause a shift in the way that trauma counselors perceive themselves, others, and the world. These shifts in the cognitive schemas of counselors can have devastating effects on their personal and professional lives. By listening to explicit details of clients' traumatic experiences during counseling sessions, counselors become witness to the traumatic realities that many clients experience (Pearlman & Mac Ian, 1995), and this exposure can lead to a transformation within the psychological functioning of counselors.

This article describes VT and how it differs from counselor burnout and countertransference. In addition, this article applies the Constructivist Self-Development Theory (CSDT) to VT, and discusses the implications CSDT has for preventing and managing counselor VT.

## VT, BURNOUT, AND COUNTERTRANSFERENCE

Previously, in the professional literature, the term VT was not used; such trauma was referred to as being either a form of burnout or a countertransference reaction (Figley, 1995; McCann & Pearlman, 1990). Recently, differences among the concepts of burnout, countertransference, and VT have been identified. There are several significant differences between burnout and VT. Burnout is described more as a result of the general psychological stress of working with difficult clients

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(Figley, 1995) versus VT, which is seen as a traumatic reaction to specific client-presented information. Also, vicarious traumatization occurs only among those who work specifically with trauma survivors (e.g., trauma counselors, emergency medical workers, rescue workers, crisis intervention volunteers), whereas burnout may occur in persons in any profession (McCann & Pearlman, 1990). VT and burnout also differ in that burnout is related to a feeling of being overloaded secondary to client problems of chronicity and complexity, whereas VT reactions are related to specific client traumatic experiences. Thus, it is not the difficult population with which the counselor works, but rather the traumatic history of a traumatized population that contributes to VT. Burnout also progresses gradually as a result of emotional exhaustion, whereas VT often has a sudden and abrupt onset of symptoms that may not be detectable at an earlier stage. Finally, on a personal level, burnout does not lead to the changes in trust, feelings of control, issues of intimacy, esteem needs, safety concerns, and intrusive imagery that are foundational to VT (Rosenbloom, Pratt, & Pearlman, 1995). It is important to note that many counselors working with traumatized populations experience general burnout as well as VT.

Despite these contrasts, VT and burnout share similar characteristics. Both VT and burnout may result in physical symptoms, emotional symptoms, behavioral symptoms, work-related issues, and interpersonal problems. In addition, both VT and burnout are responsible for a decrease in concern and esteem for clients, which often leads to a decline in the quality of client care (Raquepaw & Miller, 1989).

Like the construct of burnout, countertransference is also distinct from VT. Countertransference refers to a counselor's emotional reaction to a client as a result of the counselor's personal life experiences (Figley, 1995). VT, however, is a direct reaction to traumatic client material and is not a reaction to past personal life experiences. The differences between countertransference and VT are not always distinct. Although VT may involve countertransference issues (e.g., the counselor being a trauma survivor), VT is not inherent in, nor does it equate to, countertransference (Figley, 1995). An additional difference between countertransference and VT is that countertransference is specific to the counselors' experiences during or around counseling sessions, whereas VT effects transcend the session, thus affecting all aspects of counselors' lives.

Countertransference and VT, although distinct in conceptualization, are related to one another. As a counselor experiences increasing levels of VT, the related disruptions in cognitive schemas become part of the counselor's unconscious personal material that may then result in countertransference reactions toward the client (Saakvitne & Pearlman, 1996). These differences among VT, countertransference, and burnout indicate that VT is a unique construct that is worthy of consideration apart from the concepts of burnout and countertransference. The management and prevention of burnout reactions and countertransference have been addressed in the literature (James & Gilliland, 2001), yet these issues are rarely addressed with regard to VT. De-

spite VT's apparent importance and uniqueness, there is a paucity of research and literature exploring ways in which counselors working with traumatized clients can prevent VT reactions from developing.

## VT AND CSDT

As previously stated, VT has a unique progression. One theory that can be used to explain this progression is the CSDT (McCann & Pearlman, 1992; Pearlman & Saakvitne, 1995a). The premise of this theory is that individuals construct their realities through the development of cognitive schemas or perceptions, which facilitate their understanding of surrounding life experiences. CSDT supports the notion that changes in these cognitive schemas, or the perceived realities of counselors, occur as a result of interactions among clients' stories and counselors' personal characteristics (Saakvitne & Pearlman, 1996). In this self-development process, counselors are active in creating and structuring their individual perceptions and realities. CSDT "emphasizes the adaptive function of individual behavior and beliefs, and the individual's style of affect management" (Pearlman & Saakvitne, 1995a, p. 56), thus indicating that counselors' VT reactions to client-presented traumas are normal and adaptive.

CSDT further purports that human cognitive adaptation occurs in the context of interpersonal, intrapsychic, familial, cultural, and social frameworks. According to CSDT, counselor VT experiences are normal counselor adaptations to recurrent client-presented traumatic material. Essentially, CSDT proposes that irrational perceptions develop as self-protection against these emotionally traumatic experiences. In addition, CSDT suggests that the effects of these changes in counselors' cognitive schemas are pervasive (i.e., have the potential to affect every area of the counselor's life) and cumulative (i.e., potentially permanent because each traumatized client the counselor encounters reinforces these changes in cognitive schemas; McCann & Pearlman, 1990).

According to CSDT, there are five components of the self and how the self and one's perceptions of reality are developed: (a) frame of reference; (b) self-capacities; (c) ego resources; (d) psychological needs; and (e) cognitive schemas, memory, and perception (Pearlman & Saakvitne, 1995a). These CSDT components reflect the areas in which counselors' distorted beliefs and VT reactions occur. Saakvitne and Pearlman (1996) proposed that the interpersonal components of CSDT (i.e., frame of reference, self-capacities, ego resources, psychological needs, and memory system) are the most vulnerable to symptomatic adaptation (e.g., disruptions in previous belief systems as a result of clients' trauma material) in the emergence of VT in counselors.

In discussing the first component of CSDT, frame of reference, McCann and Pearlman (1990) wrote that "a meaningful frame of reference for experience is a fundamental human need" (p. 141). The frame of reference is generally defined as an individual's framework, or context, for understanding and viewing the self and the world (Pearlman & Saakvitne, 1995b).

The frame of reference encompasses one's identity, worldview, and belief system and is the foundation for viewing and understanding the world and self. It also involves cognitive processing of causality and attribution. Any disruptions in an established frame of reference can create disorientation for the counselor and potential difficulties in the therapeutic relationship. For example, in attempting to understand a client's pain, counselors discussing a traumatic event may conclude that the victim was actually to blame, an outcome that will likely revictimize the client. Such an outcome might be the result of the counselor's frame of reference not accommodating the possibility of a blameless victim.

Self-capacities, the second component of CSDT, are "inner capabilities that allow the individual to maintain a consistent, coherent sense of identity, connection, and positive self-esteem" (Pearlman & Saakvitne, 1995a, p. 64). These self-capacities allow individuals to manage emotions, sustain positive feelings about themselves, and maintain relationships with others. Self-capacities are susceptible to disruptions when a counselor experiences VT and may result in counselors experiencing a loss of identity, interpersonal difficulties, difficulty controlling negative emotions or avoiding exposure to media that conveys the suffering of others, or feelings of being unable to meet the needs of significant others in their lives. The inability to tolerate negative emotions could have pronounced implications for counselors attempting to serve trauma survivors.

The third component of CSDT, ego resources, allows individuals to meet their psychological needs and relate to others interpersonally (Pearlman & Saakvitne, 1995a). Some of these resources include (a) ability to conceive consequences, (b) ability to set boundaries, and (c) ability to self-protect. Disruptions affecting these ego resources may promote symptoms such as perfectionism and overextension at work. Counselors may also experience an inability to be empathic with clients, a condition that poses a variety of practical and ethical dilemmas, particularly for services to trauma survivors.

The fourth and fifth components of CSDT are psychological needs and cognitive schemas. These include safety needs, trust needs, esteem needs, intimacy needs, and control needs. These needs reflect basic psychological needs of individuals, as well as how individuals process information related to these needs in developing their cognitive schemas about themselves and others (Pearlman & Saakvitne, 1995a). As discussed in this article, these psychological needs can be very helpful in understanding VT and how to prevent VT in counselors. A discussion of each of these aspects and their relationship to VT is reflected in the following sections.

### **Safety Needs**

A sense of security is basic to safety needs. Counselors experiencing VT may feel there is no safe haven to protect them from real or imagined threats to personal safety. According to Pearlman (1995), higher levels of fearfulness, vulnerability, and concern may be ways in which this disruption in safety needs is manifested. Counselors experiencing

VT may be overly cautious regarding their children or may feel an overwhelming need to take a self-defense course, install a home alarm system, or carry mace or a rape whistle for protection. The following segment of an interview with a counselor experiencing VT, after working with a sexual trauma survivor, illustrates this point with vivid clarity:

I suddenly find myself more critical of the quality of locks in my home and replace them with better ones. The car door is always locked when I am driving. I am more careful with whom I speak in public. I find myself wondering why that guy is walking toward me and clutch my keys ready to strike out if I have to. I question the motives of others much more readily and never assume they mean no harm to me. (Astin, 1997, p. 106)

### **Trust Needs**

According to CSDT, trust needs include self-trust and other trust. Trust needs reflect an individual's ability to trust her or his own perceptions and beliefs, as well as to trust others' ability to meet his or her emotional, psychological, and physical needs; in other words, trust needs refer to a form of attachment or a "healthy dependency" (Pearlman & Saakvitne, 1995a, p. 71). All people, according to CSDT, have a natural need to trust themselves and others.

A counselor's inherent trust needs make him or her vulnerable to VT. In other words, the exposure to repeated client trauma shakes the trusting foundations upon which the counselor's world rests. For example, a counselor may have a caseload of clients who were recently exposed to a terrorist act by a minority group and, hence, may have his or her trusting foundation shaken and may become suspicious of all minority group members. This suspiciousness may even transcend previously trustworthy relationships with minority group members. In addition, counselors experiencing VT are vulnerable to self-doubt and inhibited self-trust, often prompting them to question their ability to judge and intervene effectively with clients. Such trust difficulties frequently promote negative effects in relation to esteem needs.

### **Esteem Needs**

The need for esteem is characterized by value for self and value for others (Pearlman, 1995). Counselors experiencing VT may feel inadequate and question their own abilities to help someone. Esteem for others can be compromised as counselors are faced with the ability of people to be cruel and for the world to be unfair.

### **Intimacy Needs**

Intimacy needs are defined as "the need to feel connected to oneself and others" (Pearlman & Saakvitne, 1995a, p. 62). Pearlman (1995) described consequences of disruptions in this area as feelings of emptiness when alone, difficulty enjoying time alone, an intense need to fill alone time, and avoidance and withdrawal from others. VT may cause a counselor to push away or become increasingly dependent on significant persons in his or her life.

### Control Needs

Control needs are related to self-management; when schemas are disrupted regarding sense of control, the resulting beliefs and behaviors may be helplessness and/or overcontrol in other areas. "These beliefs lead to distress as we [counselors] question our ability to take charge of our lives, to direct our future, to express our feelings, to act freely in the world" (Pearlman & Saakvitne, 1995a, p. 292).

The memory system of each individual is basic to his or her perception of life. Pearlman and Saakvitne (1995a) identified five aspects of the memory system: (a) verbal memory (cognitive narrative), (b) imagery (pictures stored in the mind), (c) affect (emotions experienced), (d) bodily memory (physical sensations), and (e) interpersonal memory (resulting dynamics in current interpersonal relationships). With traumatic experiences, each aspect of memory can represent a fragment of a traumatic event. Without therapeutic integration of these aspects, the fragments interfere with one's awareness and perception. Therefore, through empathic engagement with the client, the counselor is vulnerable to experiencing VT and intrusion from clients' descriptions of memories.

These recollections can remain with the counselor long after the therapy session has ended, even to the point of introducing thoughts and images that involve the counselor having nightmares of being raped. Astin (1997) wrote that she would imagine a rapist coming toward her—much as the rapist had approached the victimized client. The author suggested that intrusive images are associated with normal perceptual processing for traumatic events but, due to the painful emotions involved, resist assimilation into memory as simple events to become actual mental representations. To combat these intrusive thoughts and images, the counselor may turn to numbing, avoidance, and denial. However, avoidance and numbing provide only temporary relief. Astin further suggested that these intrusive images need to be examined, rather than suppressed or overshadowed, to make them less painful and intrusive for the counselor.

### PROFESSIONAL AND PERSONAL CONSEQUENCES OF VT

Constructivist self-development theory and recent research suggest that the experience of VT is significant for counselors on both a personal and professional level. A concern for the personal functioning of trauma counselors is the increased awareness of the reality and occurrence of traumatic events. This reality makes counselors more aware of their vulnerability. Safety and security are threatened when counselors become cognizant of the frequency of trauma, often resulting in a loss of feeling in control as a result of hearing clients' stories in which the control was taken from them. In addition, the helplessness of a counselor to change past trauma can challenge, or even shatter, the counselor's identity (Pearlman & Saakvitne, 1995b).

VT can also affect how counselors relate to their friends and family. Counselors affected by VT may be less emotionally accessible due to a decrease in access to emotions (Saakvitne &

Pearlman, 1996). Intimacy with partners may become difficult as guilt and intrusive thoughts related to a client's abuse become present when engaging in intimacy. Counselors may also experience overwhelming grief, which may create a sense of alienation from others (Herman, 1992). Herman reported that counselors who worked with survivors of the Nazi Holocaust reported feeling "engulfed in anguish" or "sinking into despair" (p. 144). Finally, the counselor may experience changes in esteem for self and others (Saakvitne & Pearlman, 1996).

The impact of VT on counselors, if unacknowledged, can present ethical concerns (Saakvitne & Pearlman, 1996). The potential for clinical error and therapeutic impasse increases as the vulnerability that counselors experience increases. The disruptions in cognitive schemas may lead to counselors compromising therapeutic boundaries (e.g., forgotten appointments, unreturned phone calls, inappropriate contact, abandonment, and sexual or emotional abuse of clients). Counselors may feel anger toward their clients when they have not complied with some idealized response to therapy (Herman, 1992). Counselors may begin doubting their skill and knowledge and potentially lose focus on clients' strengths and resources (Herman, 1992). In addition, counselors may avoid discussion of traumatic material or be intrusive when exploring traumatic memories by probing for specific details of the client's abuse or pushing to identify or confront perpetrators before the client is ready (Munroe, 1995).

Other hazards the client may be subjected to when the counselor is experiencing VT include irritability of the counselor, decreased ability to attend to external stimuli, misdiagnosis, and "rescuing" by the counselor (Munroe, 1995). In addition, the client may attempt to protect the counselor, which may create an ethical bind based on exploitation of the client. Any of these effects can be damaging to the client. Therefore, addressing the occurrence of VT is imperative for counselors.

### IMPLICATIONS FOR COUNSELORS: PREVENTING VT

CSDT as applied to VT has numerous implications for counselors who work with traumatized clients and are thus at risk for VT. Being aware of the risk of VT and applying the CSDT model to one's experiences may prevent VT. More specifically, counselors can apply the CSDT model to their own experiences, thus preventing negative professional and personal consequences and encouraging self-care. The following sections describe ways that counselors can engage in the prevention of VT through self-care.

#### Caseload

Counselors who work primarily with trauma survivors experience a greater measure of VT than counselors with a general caseload who may see only a few trauma survivors (Brady, Guy, Poelstra, & Brokaw, 1997; Chrestman, 1995; Cunningham, 1999; Kassin-Adams, 1995; Pearlman & Mac Ian, 1993; Schauben & Frazier, 1995). Trippany, Wilcoxon, and Satcher (2003) found that sexual trauma counselors who reported

an average of 14 to 15 clients per week did not have statistically significant experiences of VT. This finding suggests that the management of counselors' caseloads through limiting the number of trauma clients per week may minimize the potential vicarious effects of working with traumatized clients. This implication is consistent with the research of Hellman, Morrison, and Abramowitz (1987), who reported that counselors indicated less work-related stress with a moderate number of clients on a weekly caseload than with a higher number of regularly scheduled clients.

### **Peer Supervision**

Peer supervision groups serve as important resources for trauma counselors (Catherall, 1995). Sharing experiences of VT with other trauma counselors offers social support and normalization of VT experiences. This normalization lessens the impact of VT, which in turn amends cognitive distortions and helps counselors maintain objectivity. Other benefits include reconnecting with others and sharing potential coping resources (Catherall, 1995). Pearlman and Mac Ian (1993) found that 85% of trauma counselors reported discussion with colleagues as their most common method of dealing with VT. Peer supervision methods are helpful in providing trauma counselors with validation and support, in providing them with the opportunity to share new information related to therapeutic work, and in allowing them to vent their feelings (Oliveri & Waterman, 1993). Talking to colleagues about their experience in responding to trauma offers trauma workers support in dealing with aftereffects (Dyregrov & Mitchell, 1996). Peer supervision has also been found to decrease feelings of isolation and increase counselor objectivity, empathy, and compassion (Lyon, 1993).

Peer supervision offers several benefits to trauma counselors. First, consultation with colleagues provides an opportunity for counselors to examine their perspective, thus aiding in decreasing cognitive disruptions. Peer supervision also gives counselors an opportunity to debrief and express reactions regarding client stories (Catherall, 1995). Whereas limits of confidentiality prevent counselors from being able to debrief with support systems, peer supervision serves as a medium for counselors to debrief in an ethical manner. Furthermore, supervision helps alleviate issues of countertransference and traumatic reactions (Rosenbloom et al., 1995). "It is important for caregivers to have a variety of peer support resources to allow easy access to share with others the burden of bearing witness to traumatic events" (Yassen, 1995, p. 194). Discussion of therapeutic successes in formal peer supervision helps to reaffirm a counselor's confidence in his or her clinical skills (Pearlman & Saakvitne, 1995b).

### **Agency Responsibility**

Agencies that employ counselors who provide services to clients with traumatic histories have a responsibility to help their clinicians decrease the effects or occurrence of VT (Pearlman & Saakvitne, 1995b). Formal measures of informed

consent regarding risks of providing trauma counseling services can be used as a standard employment procedure when considering new counselors. In addition, professional development resources should be available for trauma counselors, including (a) opportunities for supervision, (b) consultation, (c) staffing, and (d) continuing education. Pearlman and Saakvitne (1995b) further suggested that provision of employee benefits could decrease the impact of VT, including (a) insurance for personal counseling, (b) paid vacations, and (c) limiting the number of trauma survivors on the counselor's caseload. In addition, Chrestman (1995) found empirical evidence suggesting that increased income correlated positively with a decrease in symptoms of psychological distress. Thus, pay raises may help trauma counselors acknowledge success as a counselor.

### **Education and Training**

Training focused on "traumatology" is vital for trauma counselors and can decrease the impact of VT (Pearlman & Saakvitne, 1995b). In a study by Follette, Polusny, and Milbeck (1994), 96% of mental health professionals reported that education regarding sexual abuse was imperative to effective coping with difficult client cases. Chrestman (1995) also found empirical evidence that supported use of additional training to decrease the symptomatology of posttraumatic stress disorder in counselors working with trauma clients. Furthermore, Alpert and Paulson (1990) suggested that graduate programs for mental health professionals need to incorporate training regarding the impact of clients' childhood trauma and its effects on VT.

### **Personal Coping Mechanisms**

The impact of VT can be decreased when counselors maintain a balance of work, play, and rest (Pearlman, 1995). This balance includes socializing with friends and family, being involved in creative activities, and being physically active. Participation in the aforementioned activities may aid in preserving a sense of personal identity. Because of their restorative nature, rest and leisure activities (e.g., taking vacations) are important in decreasing the effects of VT (Pearlman, 1995). Moreover, VT may affect counselors' ability to trust others; therefore, a strong social support network can help to prevent VT and may also help soothe VT reactions. In addition, participation in activities that increase counselors' personal tolerance level, including journaling, personal counseling, meditation, and obtaining emotional support from significant others, allows reconnection to emotions.

### **Spirituality**

The damage of vicarious traumatization is often related to the counselor's sense of spirituality (Pearlman & Saakvitne, 1995a). The VT experience results in a loss of a sense of meaning and often fractures cognitive schemas and counselors' worldview. Without a sense of meaning, counselors may become cynical, nihilistic, withdrawn, emotionally numb,

hopeless, and outraged (Herman, 1992; Pearlman & Saakvitne, 1995a). "The defenses employed to protect oneself from knowledge of people's capacity for cruelty . . . have their own costs" (Pearlman & Saakvitne, 1995a, p. 288). These defenses, produced from changes in cognitive schemas regarding one's view of the world (i.e., the world is good; people are good), create a reorganization in the counselor's spirituality. As a result, the counselor may experience sorrow, confusion, and despair.

Research indicates that counselors with a "larger sense of meaning and connection" (Pearlman & Saakvitne, 1995b, p. 161) are less likely to experience VT. In a survey of trauma counselors, 44% reported that spirituality provided an effective coping mechanism in dealing with the effects of their work (Pearlman & Mac Ian, 1993). Finding meaning can help trauma counselors alleviate the impact of VT. Astin (1997) reported that working with rape victims has made her more aware of the potential for harm, thus making her more prudent. She wrote, "My rape clients have given me a gift without knowing it . . . I don't live in a fantasy world and I take active steps to reduce risk and vulnerability" (Astin, 1997, p. 107). In addition, Wittine (1995) suggested that counselors with a strong sense of spirituality are more likely to accept existential realities and their inability to change the occurrence of these realities. Wittine further suggested that counselors' acceptance of these existential realities allows them to be more present with their clients.

More specifically, counselors who are at risk for developing VT can use whatever source brings them a sense of spirituality. Organized religions, meditation, and volunteer work are just a few examples of activities that may facilitate a sense of spirituality. Ultimately, it is up to the individual counselor to determine how he or she will choose to develop his or her sense of spirituality.

## CONCLUSION

Vicarious traumatization is a significant concern for counselors providing services to traumatized clients. Counselors' cognizance of potential changes in their beliefs about self, others, and the world may have a preventative function regarding VT. This awareness can aid counselors in protecting themselves against the consequential effects of helping those with traumatic histories. An awareness of personal reactions to VT may allow counselors to implement self-care strategies to ameliorate such effects, thus minimizing potential ethical and interpersonal difficulties.

In addition, it is important that supervisors and administrators overseeing counselors working with trauma survivors consider the impact that VT may have on counselors and take an active preventative role. Supervisors have a responsibility to use their knowledge about VT to prevent counselor VT and to facilitate counselor mental health through providing a supportive and VT-preventative environment. Encouraging peer support groups, educating counselors on the impact of client traumas on counselors, diversifying counselor caseloads, encouraging counselor respite and relaxation, and encouraging counselors' sense of spirituality and wellness

are several means of providing support for at-risk counselors. Professional counselors have many strengths and resources that are used to help traumatized clients—applying these resources to themselves, as a means of preventing VT, will surely facilitate their own wellness.

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