Vicarious Traumatization: An Examination of the Effects of Exposure to Traumatic Material in Child Abuse Counselors

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VICARIOUS TRAUMATIZATION: AN EXAMINATION OF THE EFFECTS OF EXPOSURE TO TRAUMATIC MATERIAL IN CHILD ABUSE COUNSELORS

by

Stacey A. Waller

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Stacey A. Waller
Counselors who deliver services to children who have suffered maltreatment confront on a daily basis horrific examples of human suffering inflicted on society’s most vulnerable members. Such repeated exposure may put these professionals at risk for adverse psychological consequences, including vicarious traumatization (VT), which can include symptoms similar to posttraumatic stress disorder (PTSD). The present study examined the unique effects of providing trauma services to children on 34 counselors who work primarily with child survivors of maltreatment. While the prevalence of PTSD symptoms in this sample was low, respondents reported higher levels of depression and emotional exhaustion than found in the general population. Further, this sample reported better than average spiritual and environmental quality of life and lower than average physical and psychological quality of life. Factors that predicted VT, burnout, anxiety, and depression included level of training and utilization of coping resources. PTSD and coping were significant predictors of perceived quality of life. Implications of these results for current conceptualizations of VT and future research are discussed.
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CHAPTER I

INTRODUCTION

The American Psychiatric Association (APA, 1994) defines post-traumatic stress disorder as:

...the development of characteristic symptoms following exposure to an extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one's physical integrity; or witnessing an event that involves death, injury, or threat of the physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate... (p. 424)

The characteristic symptoms are outlined in the diagnostic criteria for the disorder (see Appendix A), and include re-experiencing of the traumatic event, avoidance of events or situations associated with the traumatic event, numbing of responsiveness, and increased arousal (APA, 1994).

This disorder is thought to affect 1 to 14 percent of the general population at some point in time, and affects between 3 and 58 percent of individuals who have experienced a traumatic life event (APA, 1994). Recent studies suggest that between 39 and 45 percent of non-veteran men and women have experienced a traumatic stressor at some point in their lives (Breslau, et al., 1991; Kulka, et al., 1990). Annual exposure rates are estimated at 6 to 7 percent of the population (Fletcher, 1996).
A number of individuals included in these estimates are children. A survey of urban adults suggests that as many as 39 percent of children living in urban areas will experience at least one traumatic incident during childhood or adolescence (Breslau, et al., 1991). Among the traumatic stressors to which children may be exposed are childhood physical and sexual abuse.

Each year, approximately 4.7 percent of children in the United States are reported to child protective service agencies as victims of maltreatment (Wang & Daro, 1998). The most recently available government statistics indicate that in 1998 approximately 2,806,000 children were referred to child protective service agencies in the United States as suspected victims of abuse or neglect (U.S. Department of Health and Human Services, 2000). Approximately two-thirds of these referrals were investigated and assessed by Child Protective Service workers, with 42.8 percent of these investigated cases resulting in a determination of substantiated or indicated maltreatment. Consequently, these reports estimate 903,000 victims of child maltreatment in the United States for 1998. These prevalence rates represent reported incidents of abuse and likely underestimate actual rates.

Approximately 409,000 children representing substantiated reports and 211,000 children representing unsubstantiated reports receive post-investigative services (U.S. Department of Health and Human Services, 2000). Counselors participate in post-investigative services in a variety of capacities, including foster care or adoption counseling and assessment, family preservation counseling, family reunification, and services directed at treatment. In addition, the high rate of
childhood exposure to maltreatment suggests that all professionals who specialize in work with children are likely to come into contact with children who are survivors of trauma during the course of their careers.

Counselors who work with child survivors will witness narrative descriptions of children's traumatic experiences through the reports of the children themselves, the children's family members, or other professionals. Exposure to their clients' narratives may indirectly put counselors at risk for stress reactions, including the development of symptoms similar to those described for PTSD (Figley, 1995; McCann & Pearlman, 1990; Pearlman & Saakvtine, 1995; Sexton, 1999). The third category of traumatic stressors outlined in the DSM-IV criteria for PTSD include stressors experienced indirectly by learning about trauma experienced by a loved one. Figley (1983, 1985, 1995) coined the term "secondary traumatization" to refer to post-traumatic stress disorder which follows exposure to reports of traumatic events experienced by family members. The term "secondary" is applied in these cases to distinguish this type of indirect exposure from that experienced directly by virtue of being a victim or witness.

Secondary traumatization resulting from indirect exposure is well-documented. For example, reports of family members' traumatic experiences have been linked to the development of significant psychological symptoms among spouses and children of Holocaust survivors (see Baranowsky, et al., 1998 for a review) and combat veterans (Maloney, 1988; Nelson & Wright, 1996; Rosenheck &
Conceptualization of the syndrome has been expanded to include individuals exposed indirectly to trauma by virtue of their professional roles. Figley (1995) developed the term “Compassion Fatigue” to refer specifically to the situation in which helping professionals are indirectly traumatized. While both terms are used interchangeably, Figley claims that the term “Compassion Fatigue” tends to be more readily accepted and preferred by individuals affected by the syndrome.

McCann and Pearlman (1990) have further refined this conceptualization to refer specifically to therapists and to broaden the scope of the syndrome. They use the term “vicarious traumatization” to describe “the enduring psychological consequences for therapists of exposure to the traumatic experiences of victim clients” (p. 133). This condition includes the development of symptoms similar to PTSD (i.e., intrusive imagery, avoidance of trauma-associated cues, hyperarousal) but is broader in that it also includes a number of other effects. Specifically, therapists may experience significant disruptions in their sense of self and their world view, their ability to connect with other people, their spirituality, and their core beliefs about themselves, others, and the world around them (Pearlman & Saakvtine, 1995).

McCann & Pearlman (1990) have proposed a theoretical model to explain the disruptions experienced by therapists based upon the constructivist self development theory (see also Pearlman & Saakvtine, 1995). According to this model, experiences with victim clients influence the development of basic cognitive schemas, memories,
and imagery within the therapist. Particularly, the therapists' basic beliefs and assumptions about themselves and the world around them may be altered in important ways. For example, confronting examples of victimization may challenge the therapist's belief in personal invulnerability to trauma. Such disruptions in turn impact the therapist's emotional reactions and thoughts. For example, when invulnerability assumptions are challenged, the therapist may react by becoming fearful and avoiding situations perceived as risky, or the therapist may react by blaming the victim. In addition, therapists may experience intrusive imagery and memories related to their clients' traumas.

Vicarious traumatization (VT) differs from compassion fatigue. While compassion fatigue tends to focus primarily on the effects indirect critical incident exposure, vicarious traumatization takes into account features of the therapeutic relationship that are unique to working with trauma survivors. Such features include clients' highly demanding emotional needs, the realization and daily reminders of the existence of trauma in the world, reminders of the therapist's own trauma history, and attempts by clients to relate to therapists in ways that are in contrast to the therapist's sense of identity (Pearlman & Saakvtine, 1995). In addition, vicarious traumatization differs from post-traumatic stress disorder in that the traumatic incident is experienced during the course of a professional relationship rather than a familial or close personal relationship, and the symptoms tend to be milder than those experienced within the course of PTSD (Figley, 1995).
Vicarious traumatization is also distinct from burnout, another condition that mental health professionals may develop. Burnout is defined as a condition of exhaustion or frustration that results when a cause in which an individual is strongly invested fails to meet his or her expectations (Freudenberger, 1975). This may be particularly true when individuals set high goals for themselves or their work, are unable to accomplish them, and fail to adjust their goals accordingly (McCann & Pearlman, 1990).

Burnout has been conceptualized as a syndrome comprised of three factors: (1) emotional exhaustion, (2) depersonalization, and (3) reduced feelings of personal accomplishment (Maslach & Jackson, 1981). Emotional exhaustion refers to the experience of feeling overextended by one's job. Depersonalization is the tendency to become emotionally detached or distanced from one's clients. Personal accomplishment is the extent to which workers experience a sense of achievement in their work. While this is the most widely accepted model of burnout, critics have questioned the utility of the three-factor structure (e.g., Garden, 1987; Evans & Fischer, 1993). Alternative models of burnout include a one-factor model including only the emotional exhaustion component (Garden, 1987, 1989, 1991) and a two-factor model comprised of emotional exhaustion and depersonalization (Evans & Fischer, 1993).

Burnout shares a number of features in common with vicarious traumatization. Physical symptoms such as fatigue and sleep disturbances are likely to accompany both. Likewise, emotional symptoms such as (a) irritability, (b) anger,
While it has been suggested that vicarious traumatization can serve as a precursor to burnout (Neumann & Gamble, 1995), the two syndromes constitute distinct phenomena and can occur independently of one another. The most salient distinction between the phenomena is that while a variety of professionals may be subject to the effects of burnout, vicarious traumatization is unique to those who are confronted with horrific images of human suffering as part of their work (McCann & Pearlman, 1990). Further, burnout tends to have a gradual onset and the symptoms become progressively worse with the passage of time. Vicarious traumatization, on the other hand, can develop suddenly and recovery tends to proceed more rapidly (Figley, 1995).

Vicarious traumatization is a syndrome unique to therapists who engage in trauma work. Its core defining features are the development of symptoms analogous to PTSD in response to vicariously witnessed trauma (i.e., client report of horrific examples of suffering). In addition, affected therapists will experience a variety of symptoms, including (a) disruptions of worldview and sense of identity, (b) difficulty tolerating strong affect, (c) trauma-related imagery, (d) distancing from clients, (e) victim blaming, and (f) depression (Figley, 1995; McCann & Pearlman, 1990; Pearlman & Saakvtine, 1995; Neumann & Gamble, 1995). Such symptoms may interfere with therapists’ ability to effectively perform their work and may intrude...
into their personal lives and relationships. While not every trauma therapist will develop vicarious traumatization, the risk is present whenever therapists work with trauma victims. Further, the risk may be amplified by (a) the presence of work environment stressors (e.g., the presence of racial or gender discrimination, inadequate supervision), (b) cultural stressors (e.g., prohibitions against speaking about unusual or unacceptable forms of abuse), (c) society's tolerance of certain forms of abuse), or (d) personal characteristics of the therapist (e.g., history of trauma, inadequate self-care; Pearlman & Saakvtine, 1995).
Although vicarious traumatization has only recently gained recognition in the empirical literature, there is a small body of work that suggests that a variety of professionals may be at risk for experiencing its effects. Professional populations that have been examined include disaster workers, emergency services personnel, law enforcement officers, hospital staff, and mental health workers.

Disaster Workers

Disaster support work typically involves a wide variety of professionals working in diverse professional roles. Such individuals include rescue, medical, and psychological support personnel. Several investigations have examined the impact of providing disaster support services on service providers. These individuals report disproportionate rates of anxiety, depression, sleep and eating disturbances, physical health complaints, job stress or frustration, and re-experiencing of traumatic events (Bartone, et al., 1989; Berah, Jones, & Valent, 1984; Raphael, et al., 1983).

Raphael et al. (1983) surveyed rescue workers one month following a railway disaster. Their sample included police officers, ambulance workers, physicians, Salvation Army personnel, forensic workers, social workers, rescue squad workers, and firefighters. While a majority (70%) of these workers reported temporary stress
or strain, a minority (20%) also reported significant psychological symptoms, including depression, anxiety, and insomnia. Although one-year follow-up data were collected, only a small number of the original respondents provided this information, rendering follow-up analyses ambiguous.

Bartone, et al. (1989) examined the impact on Survivor Assistance Officers of providing assistance to bereaved families following a military air disaster. These individuals serve in a variety of roles such as making funeral arrangements, helping the family secure benefits, and providing emotional support. Surveys were mailed six months following the crash, with a modal response time of two weeks (median = 7 weeks). Respondents reported higher than expected frequencies of physical illness, psychiatric symptoms, and negative feelings of well-being. Overall levels of distress increased between the initial evaluation and the one-year follow-up. The presence of social supports and personal resiliency were associated with lower levels of distress, particularly among those individuals with the highest exposure levels. However, among those individuals obtaining low resiliency scores, social support was associated with greater levels of illness.

The specific roles and types of involvement of professionals in these studies varied widely. While they document some of the adverse effects of trauma work, they leave unanswered questions regarding the effects of disaster work unique to mental health workers providing mental health services. Hodgkinson & Shepherd (1994) examined the impact of disaster support work on 67 social workers, providing support services to survivors of two major British disasters. These social workers
were assigned the task of counseling survivors and bereaved relatives. Questionnaires were administered at nine months post-disaster for one group and at four months post-disaster for a second group. Follow-up questionnaires were administered at 12-months post-disaster for all. When compared to general population norms, respondents reported higher levels of distress on measures of somatic complaints, obsessive-compulsive symptoms, interpersonal sensitivity, anxiety, and depression. Identification with clients and role ambiguity were the factors contributing most strongly to stress levels. A majority of respondents reported that their work had impacted their personal lives. Low hardiness scores on measures of coping style, less perceived social support, and more experience were related to greater levels of distress. Overall levels of distress were maintained at 12-month follow-up.

Disaster work differs from outpatient psychotherapy work in terms of the proximity of both the client and therapist to the critical incident. In particular, disaster workers are often placed in situations in which they are at risk for personal harm. For example, Raphael et al. (1983) reported that among those workers providing services at the site of the disaster, a majority reported feeling fearful that their lives were in danger. Consequently, it is unclear to what extent reported symptoms were of a primary nature, as opposed to the result of truly vicarious exposure.
Emergency Service Personnel

Weiss, et al. (1995) examined the effects of trauma work on emergency service personnel, including police, firefighters, paramedics, and emergency medical technicians. They included those responding to a freeway collapse, those working in the area of the collapse but not involved, and those working in other areas. Greater exposure to the critical incident was associated with higher levels of symptomatic distress. Lower levels of psychological adjustment were associated with higher levels of distress. Less experience on the job, an external locus of control, lack of social support and more than average dissociative experiences were associated with higher levels of distress.

As with other disaster workers, many of these emergency service personnel were directly exposed to aspects of the critical incident or to similar events during the course of their work. Nevertheless, this study illustrates a number of factors that may mediate the development of symptoms among professionals exposed through more indirect channels. Among them are (a) proximity to the incident, (b) level of exposure, (c) experience on the job, (d) personality traits, (e) availability of coping resources, and (f) pre-exposure psychological functioning.

Hospital Workers

Like disaster workers and emergency services personnel, hospital workers are likely to experience repeated exposure to victims of trauma. Hospital workers differ in that the extent of their personal exposure to the critical incidents will be more
limited. Nevertheless, professionals working in hospital settings may be at risk for developing symptoms as a result of vicarious exposure. Hartman (1995) describes a series of case examples illustrating the ways in which nurses may be exposed to patient traumas and the effects of that exposure. A variety of symptoms were reported by these nurses and may constitute a vicarious traumatization syndrome. Typically reported symptoms include (a) increased autonomic arousal, (b) emotional reactions (e.g., irritability, depression, anxiety, and avoidance), (c) psychological reactions (e.g., denial, rationalization, and projection), and (d) behavioral reactions (e.g., missing appointments, drug or alcohol abuse, and inattention).

A recent empirical investigation of hospital staff reported greater levels of burnout, anxiety, and health disturbances among intensive care unit nurses working 12-hour shifts when compared with nurses working 8-hour shifts (Iskra-Golec, et al., 1996). However, this study did not specifically attempt to measure the effects of indirect exposure to patient trauma on these nurses. While these differences could have been a function of longer periods of exposure to patient trauma, the effects of other job-related stressors cannot be ruled out.

Outpatient Psychotherapists

Psychotherapists are confronted with a number of challenges, unique to their jobs. These unique features of their work may put them at increased risk to develop symptoms of both vicarious traumatization and burnout. Job circumstances that may exacerbate the effects of exposure to their clients’ narratives include (a) isolation and
loneliness, (b) unclear standards for determining treatment progress and outcome, (c) the need to be dependable to people in crisis, (d) social distancing (resulting from confidentiality restrictions; Neumann & Gamble, 1995), (e) overidentification with clients, and (f) challenging client behaviors (e.g., self-mutilation, suicide; Pearlman & Saakvtine, 1995). Consequently, individuals providing psychotherapy services require special attention. In particular, those therapists devoting the majority of their work to trauma therapy may be at special risk.

Johnson and Hunter (1997) compared sexual assault counselors with a control group of counselors specializing in work with a variety of other populations. They assessed burnout, beliefs, values, and coping strategies among 41 sexual assault counselors and 32 controls. Results suggest that sexual assault counselors were at greater risk for burnout, particularly the emotional exhaustion component. They were also more likely than their counterparts to make use of escape or avoidance coping strategies. With regard to beliefs and values, increased levels of burnout were correlated with more negative attitudes regarding intimacy and personal relationships, and with negative attitudes toward persons or organizations in authority. This study represents one of the few attempts to directly compare trauma therapists with a group of control therapists. The differences noted between the two groups support the idea that vicarious exposure to client trauma is a key feature of vicarious traumatization. However, while this study assessed the beliefs component of vicarious traumatization, it did not address other aspects of the syndrome. Further, the reliability and validity of the attitudes and beliefs scale used in this study have not been assessed. Finally,
this study did not identify specific characteristics of sexual assault work responsible for the increased risk.

Vicarious exposure to client trauma alone may not account for the differences between these two groups. Pearlman and Saakvtine (1995) have identified a number of factors that distinguish trauma therapy from other forms of psychotherapy. They point out that trauma work forces therapists to face the reality that trauma exists in the world and that the potential exists for trauma within their own lives. Therapists may be forced to confront reminders of personal traumas. Likewise, their clients may present unique challenges such as reenacting traumatic events in session. These factors combine to exacerbate the effects of indirect exposure and place trauma therapists at unique risk for the development of symptoms.

Several investigations have examined the effects of trauma work on trauma therapists. Schauben & Frazier (1995) reported survey data from 148 female sexual violence counselors and psychologists. Participants provided information related to the nature of their work, personal victimization history, cognitive schemas, PTSD symptoms, vicarious trauma, negative affect, burnout, and coping strategies. Overall, the sexual violence counselors had fewer years of formal education, a higher percentage of survivors on their caseloads, and had worked with survivors for fewer years than the psychologists. There were no significant differences between groups with regard to personal victimization histories.

Those counselors and psychologists for whom a higher percentage of their caseload was composed of survivors reported more disturbances in cognitive
schemas, more PTSD symptoms, and more vicarious trauma. Percent of survivor clients on caseload was not related to burnout or negative affect. Personal history of victimization was not significantly correlated with any of the dependent measures; however, the number of participants classified as having no victimization history was disproportionately small (70 percent of psychologists and 83 percent of sexual violence counselors reported prior victimization). Active coping strategies and planning were related to fewer symptoms, while negative coping strategies were either unrelated to symptoms or were associated with more symptoms. Results suggest that because personal history of trauma is unrelated to symptoms, there is greater support for the idea that the symptoms are truly vicarious. This study was limited, however, in that the key dependent measures (i.e., PTSD symptoms and vicarious trauma) were not assessed with standardized measures. To assess vicarious trauma, therapists were asked simply to rate on a 5-point scale the degree to which they felt they had been vicariously traumatized.

Pearlman and Mac Ian (1995) attempted to operationalize vicarious traumatization by evaluating relationships among several dependent measures hypothesized to comprise the vicarious traumatization syndrome. They further attempted to identify independent variables that predict the development of symptoms by surveying 188 trauma therapists. They developed a questionnaire to assess work and personal characteristics of the therapists. Correlations among these factors and measures of cognitive schemas, PTSD symptoms, general psychological functioning, and social desirability were examined. They found that those therapists who had a
history of trauma in their personal lives were most likely to report disruptions in their cognitive schema and elevated psychological symptoms. Newer therapists tended to experience more difficulties than (a) more experienced therapists, (b) those devoting less of their caseloads to trauma work, (c) those working in hospital settings, and (d) those seeking therapy to help cope with the stresses of their work.

Unlike the Schauben & Fraizier (1995) study, a number of standardized measures were used to assess symptoms hypothesized to comprise vicarious traumatization. Further, working from their theoretical conceptualization of the syndrome, they assessed not only PTSD symptoms but also disruptions in respondents' core beliefs. The most significant weakness is that several of the predictor variables were assessed using questions that were vague and open to interpretation. For example, the question used to assess personal trauma simply asked, “Do you have a trauma history?” Differences in the wording of such questions may account for the differences in findings across the two studies. Alternatively, differences in the populations from which the samples were drawn may account for these discrepant findings (e.g., trauma therapists vs. sexual violence counselors).

Follette, Polusny, and Milbeck (1994) examined the effects of working with child abuse survivors on mental health professionals and law enforcement officers. Participants were 471 mental health professionals, including licensed psychologists and marriage and family therapists, and 87 trained investigative police officers. Participants completed a number of self-report questionnaires which included questions regarding (a) personal trauma history, (b) general psychological
functioning, (c) work-related behaviors, (d) coping resources, and (e) trauma symptoms. Although both mental health professionals and law enforcement officers reported moderate to high levels of personal stress, the law enforcement officers reported higher levels of trauma symptoms and greater psychological distress. In both groups, those who had personally experienced childhood physical or sexual abuse reported significantly greater levels of trauma-specific symptoms. The most frequently reported coping strategies included (a) education, (b) supervision, (c) consultation, and (d) humor.

The finding that mental health professionals were less affected by exposure to traumatic material than law enforcement officers may have been due to a number of factors. First, Follette et al. (1994) reported that mental health professionals were more likely to make use of personal therapy services. Use of such services may have represented a valuable coping resource for reducing and/or preventing symptoms. Second, there may have been effects related to differences training backgrounds of these two groups. Third, the mode by which these two groups provide services may have put the police officers in more direct contact with the traumatic events.

Finally, these two groups differed with respect to the age of their clients and temporal proximity of the critical incident. The majority of clients served by the mental health professionals were adults (81%). Although similar data were not reported for the law enforcement officers, it is reasonable to suspect that the typical client in a child abuse case under active investigation would be a child. It is possible that exposure to a child’s reports of traumatic incidents may be qualitatively different
from those of adults in terms of both detail and impact on the listener. There may also be qualitative differences as a function of the amount of time that has passed since the traumatic event. For example, when a great deal of time has passed since the critical incident, survivors’ recall and accounts may be altered in important ways.

Brady, Guy, Poelstra, and Brokaw (1999) further examined vicarious traumatization among female therapists working with sexual abuse survivors. They surveyed 446 psychotherapists recruited from the American Society of the Abuse of Children and the American Psychological Association. The majority (76%) held Ph.D. or Psy.D. degrees. Using standardized measures, they assessed PTSD symptoms, beliefs, and spiritual well-being. The results indicated that greater exposure to client trauma was associated with increased PTSD symptoms but not with cognitive disruptions. Contrary to their hypothesis, greater exposure was related to increased spiritual well-being. There were no differences between those therapists reporting more contact with child versus adult clients and those reporting more contact with adult clients. One possible explanation for this finding is that whether the clients were children or adults, all were seeking therapy to deal with issues of childhood sexual abuse.

It has been widely suggested that accounts of childhood abuse may be especially problematic for professionals (Brady et al., 1999; Figley, 1995; Johnson, 1998; Pearlman & Saakvtine, 1995). Part of this may rest in cultural taboos against sexual encounters with children, as well as outrage at the fundamental betrayal of the child’s trust by the perpetrator (Johnson, 1998). Therapists may experience a greater
sense of helplessness when confronted with childhood abuse cases (Brady et al., 1999). Feelings of helplessness may be rooted in society’s tendency to tolerate abuse and knowledge that clients often remain in dangerous situations (Pearlman & Saavktine, 1995). Therapists may also experience different types of emotional reactions to childhood abuse in contrast with other types of trauma. For example, Nader (1994) has suggested that childhood abuse is more likely to elicit rage or a desire to retaliate against the perpetrator. Finally, Brady et al. (1999) suggest that identification with the victim is stronger in these cases, as therapists may imagine their own children placed in similar circumstances or may vividly recall their own childhood fears and vulnerabilities.

To date no empirical investigation has specifically evaluated the circumstances under which vicarious traumatization is likely to develop among counselors who specialize in the assessment and treatment of children. Previous investigations suggest that indirect exposure to trauma via interaction with child victims does occur in parents (Newberger, et al., 1993) and law enforcement officers (Follette, et al., 1994). Likewise, therapists working with adult survivors are at risk (Follette, et al., 1994; Johnson & Hunter, 1997; Schauben & Frazier, 1995). While Brady et al. (1999) demonstrated that sexual abuse counselors working with children are at similar risk to those providing services to adults, they did not examine characteristics that place some counselors at greater risk than others. Further, it is not clear what, if any impact this type of work has on counselors’ quality of life. The present study examined the prevalence of work-related stress and vicarious
traumatization among child abuse counselors who specialize in work with child survivors of maltreatment. Relationships among (a) level of training, (b) personal coping resources, (c) personal history of abuse, (d) burnout, and (e) vicarious traumatization were explored. In addition, the effects of trauma work on therapists' overall perceived quality of life were evaluated.
CHAPTER III

PROBLEM STATEMENT

Vicarious traumatization has been defined as the development of psychological symptoms often mirroring those for post-traumatic stress disorder following exposure to descriptions of traumatic events within the context of a professional relationship (McCann & Pearlman, 1990). Given the relatively recent identification of this phenomenon by researchers, much of the work in this area has focused upon gaining accurate and thorough descriptions of risk factors, preventative factors, and associated features. Previous investigations focusing upon disaster support workers (e.g., Raphael, et al., 1983), emergency service personnel (e.g., Weiss, et al., 1995), and law enforcement officers (Follette et al., 1994) have highlighted the (a) influences of personal victimization histories, (b) proximity of the critical incident, (c) coping resources, (d) job experience, and (e) training on the development of symptoms. However, such studies have failed to distinguish truly vicarious exposure from direct exposure that occurs within the context of such occupations. Investigations of psychotherapists who work primarily with adult clients and whose exposure has been of a more vicarious nature (Follette, et al., 1994; Schauben & Frazier, 1995) suggest that these individuals are also at risk, although findings related to the impact of mediating variables have been mixed. One investigation (Brady et al., 1999) has demonstrated that child abuse counselors are
also at risk for vicarious traumatization. However, the impact of moderating variables was not evaluated.

Findings related to predictor variables tend to vary as a function of the methods of assessment. Consequently, questions remain as to which personal and job-related factors place counselors at increased risk. Identification of such risk factors and particularly factors that reduce risk, may better inform the development of preventative interventions. In addition, while it is clear that counselors may demonstrate elevated scores on key outcome measures, it is unclear how such findings relate to the counselors' quality of life.

The present investigation examined vicarious traumatization in child abuse counselors working directly with children. This study addressed the following goals: (a) to describe the prevalence of vicarious traumatization, burnout, anxiety, and depression among child abuse counselors; (b) to determine the extent to which background factors (e.g., level of training, job experience, personal victimization), coping resources, and burnout predict the development of vicarious traumatization; and (c) to examine the impact of trauma work and vicarious traumatization on therapists' perceived quality of life.
CHAPTER IV

METHOD

Respondents

Recruitment targeted sixty agencies throughout Michigan that provide services to child survivors of maltreatment. Eight agreed to participate. Ninety-two surveys were distributed to these agencies, 34 were returned completed and four were returned incomplete, yielding an overall return rate of 37 percent.

Respondents were 34 (30 female, 4 male) self-identified child abuse counselors who work directly with children. In order to be included, respondents were required to have worked in the child abuse field for at least six months. Only those who reported exposure to physically and/or sexually abused children within a professional context during that time period were eligible to participate.

Respondents were primarily Caucasian (94%) individuals, ranging in age from 21 to 59 years (M = 35.26, SD = 10.19). They reported average experience levels of 8.23 years of work in the field of child abuse and 3.03 years of work at their present job. The highest degrees held by respondents included B.S./B.A. (38.2%) or M.A./M.S./M.S.W. (52.9%). They were employed as staff (55.9%), supervisors or administrators (20.6%), in private practice (5.9%), or other (11.8%). Their primary areas of specialization included (a) social services (50%), (b) counseling (17.6%),
(c) mental health (11.8%), (d) education (2.9%), (e) multiple areas (2.9%), and (f) other (8.8%).

Materials

Everstine Trauma Response Index–Adapted (ETRI)

Experiences with work-related vicarious exposure to traumatic events, personal trauma histories, and direct PTSD were assessed with an adapted version of the ETRI (Everstine & Everstine, 1993). The original version of the instrument is a 35-item questionnaire that assesses the intensity and duration of symptoms of PTSD based on the DSM III-R criteria for the disorder. The adapted version used in the present study asks respondents to select from a variety of personal and work-related traumatic experiences they have encountered. Respondents then select the most upsetting of the critical incidents to which they were directly exposed. They then rate the intensity and duration of PTSD symptoms experienced in relation to this directly experienced personal trauma. The questionnaire has been adapted from its original form to account for traumatic experiences that are specific to child abuse counselors and to incorporate the DSM-IV criteria for the disorder.

Coping Resources Inventory

The CRI (Hammer & Marting, 1987) was administered to assess respondents' strategies for coping with stressors and for preventing or ameliorating symptoms that may develop in response to stressors. This instrument contains 60 items specific to
each of five resource domains: (1) cognitive, (2) social, (3) emotional, (4) spiritual, and (5) physical.

The CRI has adequate psychometric properties. Internal consistency coefficients (Cronbach's alpha) are 0.91 for the Total Resources Scale and range from 0.71 to 0.84 for the subscales. Six-week test-retest reliability of 0.73 has been reported for the Total Resources Scale. Convergent validity coefficients range from 0.61 to 0.80 for the subscales.

**Modified Maslach Burnout Inventory (MBI)**

The Modified Maslach Burnout Inventory (MBI; Maslach, Jackson, & Leiter, 1996) was administered to assess levels of work-related burnout. This instrument is divided into two components. The first is the Demographic Data Sheet, to which participants answer questions about (a) personal background characteristics (e.g., age, gender, ethnicity, marital status), (b) educational history (e.g., level of education, degree), and (c) employment (e.g., field, position, length of employment). Responses to these items were used to determine the extent to which these personal demographic characteristics contribute to the development of burnout and/or vicarious traumatization.

The second component is the Human Services Survey, a 22-item inventory asking respondents to rate the frequency with which they experience various attitudes or feelings toward their jobs. Responses are combined to produce three subscale scores: (1) Emotional Exhaustion (EE), which assesses the extent to which
respondents feel emotionally overextended by their jobs; (2) Depersonalization (Dp), which measures the degree to which respondents experience a lack of feeling or impersonal response toward their clients; and (3) Personal Accomplishment (PA), which measures feelings of competence and achievement toward respondents’ work.

According to its developers, this instrument has adequate psychometric properties. Internal consistency reliability estimates (Cronbach’s coefficient alpha) ranged from 0.71 to 0.90 for the three subscales. Two- to four-week test-retest reliability estimates ranged from 0.60 to 0.82. Convergent validity coefficients of the original version of the scale (Maslach & Jackson, 1981) ranged from 0.61 between the MBI and the Meier Burnout Assessment to 0.65 between the MBI and burnout self-ratings. Convergent validity of the present scale has been estimated by three procedures. Correlations between peer ratings and relevant subscale scores ranged from 0.20 to 0.56. Correlations between aspects of the job thought to be related to burnout and relevant subscales ranged from 0.15 to 0.44. Correlations between self-reported personal outcomes and the relevant subscales ranged from 0.16 to 0.47. Measures of discriminant validity have shown low correlations between MBI subscale scores and measures of job satisfaction, which is presumed to be a separate construct (ranging from -0.23 to 0.17). Finally, while the scale has been criticized for its high correlation with measures of depression, the authors contend that the three subscales are more strongly correlated with one another than with any feature of depression.
Symptom Checklist-90-Revised (SCL-90-R)

The SCL-90-R (Derogatis, 1994) was used to assess general psychological functioning across a range of symptom domains. Scores from this 90-item inventory are grouped into nine primary symptom dimensions: (1) somatization, (2) obsessive-compulsive, (3) interpersonal sensitivity, (4) depression, (5) anxiety, (6) phobic anxiety, (7) paranoid ideation, (8) psychoticism, and (9) hostility; and three global indices of distress: (1) Global Severity Index, (2) Positive Symptom Distress Index, and (3) Positive Symptom Total.

Derogatis (1994) reports internal consistency coefficients ranging from 0.77 to 0.90 for the primary symptom dimensions. One-week test-retest reliability ranged from 0.80 to 0.90, while ten-week estimates ranged from 0.68 to 0.83. Convergent-discriminant validity levels with appropriate scales of the MMPI (Hathaway & McKinley, 1940) are acceptable.

Trauma Symptom Inventory (TSI)

The TSI (Briere, 1995) was administered to assess symptoms of PTSD. The TSI contains 100 items, which assess both acute and chronic symptoms. The instrument contains the following 10 clinical scales: (1) anxious arousal, (2) depression, (3) anger/irritability, (4) intrusive experiences, (5) defensive avoidance, (6) dissociation, (7) sexual concerns, (8) dysfunctional sexual behavior, (9) impaired self-reference, and (10) tension reduction behavior. Three validity scales are also included.
The TSI has adequate psychometric properties. Internal consistency coefficients (Cronbach’s alpha) for the clinical scales range from 0.74 to 0.97 (mean $\alpha = 0.86$). The Anxious Arousal, Anger/Irritability, and Depression subscales are well correlated with corresponding subscales of the Brief Symptom Inventory (Derogatis & Spencer, 1982). Reported coefficients were 0.75, 0.77, and 0.82, respectively. Similarly, the Defensive Avoidance subscale is correlated with the Avoidance subscales of the Impact of Events Scale (IES; Horowitz, Wilner, & Alvarez, 1979; $r = 0.69$) and Symptom Checklist (SCL; Foy, Sipprelle, Rueger, & Carroll, 1984; $r = 0.68$). The Intrusive Experiences subscale is correlated with the Intrusion subscales of these measures (IES = 0.67; SCL = 0.73). The Anxious Arousal scale is correlated with the Arousal subscale of the SCL (0.75). In the standardization sample, the TSI predicted PTSD status in 90 percent of positive cases.

World Health Organization Quality of Life Scale (WHOQOL)

Participants were asked to complete the WHOQOL (Bonomi & Patrick, 1997) in order to assess their overall perceived quality of life. This instrument contains 100 items that measure quality of life across six domains: (1) physical, (2) psychological, (3) spiritual, (4) environment, (5) independence, and (6) social.

This instrument possesses adequate psychometric properties. Internal consistency coefficients (Cronbach’s alpha) range from 0.82 to 0.91 for the six subscales in a sample of healthy adults. Test-retest intraclass correlation coefficients
at 2-week intervals ranged from 0.83 to 0.96 for the subscales. Convergent validity estimates with other measures of quality of life are acceptable.

Procedure

Participants were recruited through contact with public and private agencies throughout Michigan that provide services to children who have been maltreated. Permission to recruit from each of the agencies was obtained from the agency director prior to recruitment. Participating agency directors (or their designee) were then asked to distribute informational materials and questionnaires to counselors working within the agency. Counselors first received an informational flyer describing the study and soliciting volunteers. The flyer outlined the qualifications for participation and emphasized that participation was strictly anonymous and voluntary. Counselors interested in participating obtained packets of materials including consent documents, all survey instruments described above, and envelopes for returning materials at a location determined by the agency (e.g., a reception desk, a staff meeting). Participants were instructed to complete each of the questionnaires and to return them in the envelope provided.

Research Design

The present study employed a descriptive survey research design. Descriptive self-report data were collected to evaluate the psychological health of therapists working with child abuse survivors. Interactions among those indirectly exposed to
traumatic events associated with their work, available coping resources, the development of psychological symptoms, and quality of life were examined.

Analysis

Data were analyzed using descriptive statistics. First, the data obtained from the questionnaires were pooled across participants. Means and standard deviations for (a) PTSD symptoms, (b) anxiety, (c) depression, (d) coping, and (e) quality of life were calculated. Where applicable, single sample t-tests were used to compare scores obtained by the current sample with expected scores based upon data from the samples on which the instruments were normed. Frequencies were computed to identify the types of direct and indirect traumas experienced by the sample. To identify background factors that predict vicarious traumatization, stepwise multiple linear regressions were performed. Separate regression equations were computed for each of the outcome measures. PTSD symptoms, burnout, depression, anxiety, and quality of life were each regressed on relevant background factors.
CHAPTER V

HUMAN SUBJECTS PROTECTION

All possible measures were taken to protect the welfare of participants against preventable risks. To help protect subjects, participation in this project was voluntary and anonymous. All participants were assigned a code number upon entry into the study. Specifically, participants were assigned a number pertaining to order of enrollment in this project (1, 2, 3…). All written information pertaining to participants, including all returned questionnaires (both those completed and those not completed) contained only the code number. All returned questionnaires were inspected for identifying information, and procedures were in place for the removal of any such information. However, none of the returned questionnaires contained identifying information. All returned questionnaires will be kept in a locked file cabinet in the Psychology Department in Wood Hall for at least three years. The original data forms will then be destroyed, although computerized data will be maintained in the Psychology Department indefinitely.

In order to protect both volunteers who chose to participate and those who did not, agencies were not made privy to data from individual participants. Surveys were returned directly to the researchers so that it would not be apparent which employees chose to participate and so that the employer could not review individual data. Further, no compensation or incentive was provided by the researchers or employers
to promote participation. One potential risk to subjects was that because they were describing traumatic events, they might have become emotionally upset. This risk was described in the informed consent document (Appendix B). Informed consent was obtained prior to participation by including the consent document as the cover page of the questionnaires. The consent document instructed participants that return of the completed questionnaires would be considered evidence of their consent to participate. To minimize potential risks, volunteers were informed that they were free to withdraw from the study at any time without penalty or prejudice. Further, they were provided with contact telephone numbers for the researchers in the event that they required additional assistance. This project was approved by the Human Subjects Institutional Review Board at Western Michigan University (see Appendix C for the HSIRB approval letter).
CHAPTER VI

RESULTS

Preliminary Analysis

In order to maximize the availability of stimulus cues associated with their work respondents were asked to complete their surveys at their places of employment, in a private location. Eighteen respondents reported that they complied with this request, while 12 completed their surveys at home in a private location. The remaining respondents completed them at home or work with others present or in multiple locations. Independent samples t-tests revealed no significant differences between respondents who completed their surveys at home and those who completed them at work on the primary dependent measures (TSI Intrusive Experiences, $t(30) = -0.087, p = 0.931$; TSI Defensive Avoidance, $t(30) = -0.698, p = 0.491$; TSI Anxious Arousal, $t(30) = -0.473, p = 0.639$; and TSI composite index, $t(30) = -0.789, p = 0.436$).

Critical Incident Exposure

Exposure to critical incidents was assessed using an adapted version of the ETRI. Respondents selected from among two lists of potential traumas: (1) those to which they had been directly exposed, and (2) those to which they had been exposed
vicariously through their work. Respondents reported exposure to an average of 0.97 personal traumas (range 0 to 4). Table 1 lists the specific traumas to which respondents had been exposed. They reported vicarious exposure to an average of 3.82 types of trauma (range 1 to 5), including (a) physical abuse, (b) sexual abuse, (c) life threatening neglect, and (d) death of a client (see Table 1 for frequency data). Children who have been physically and/or sexually abused comprise 70.85 percent of the average counselor’s caseload. Respondents reported direct exposure to such clients an average of 16.95 hours per week.

PTSD

Lifetime prevalence of PTSD was assessed using the ETRI. Respondents were asked to rate the intensity and duration of symptoms corresponding to the DSM-IV criteria for PTSD related to their most upsetting personal (i.e., direct) trauma. Symptoms reported with duration of one month or more were tallied and categorized into one of four domains: (1) intrusion, (2) avoidance, (3) arousal, or (4) interference. Respondents endorsing one intrusion item, three avoidance items, two arousal items, and 1 interference item were classified as meeting full criteria. Those satisfying at least two of these categories were classified as meeting subclinical criteria.

Of the 23 respondents reporting at least one directly experienced personal trauma nine (39.1%) met full criteria for PTSD, and three (13%) met subclinical criteria. Among those reporting a history of childhood abuse, three endorsed full PTSD criteria, three did not endorse a significant number of symptoms, and one
**Table 1**

Critical Incidents Experienced Directly and Vicariously by Child Abuse Counselors

<table>
<thead>
<tr>
<th>Critical Incident</th>
<th>Number of Respondents (n)</th>
<th>Percent of Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Direct Exposure</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Childhood Abuse or Neglect</td>
<td>7</td>
<td>20.6</td>
</tr>
<tr>
<td>Accident at Home</td>
<td>6</td>
<td>17.6</td>
</tr>
<tr>
<td>Violent Crime</td>
<td>5</td>
<td>14.7</td>
</tr>
<tr>
<td>Motor Vehicle Accident</td>
<td>4</td>
<td>11.8</td>
</tr>
<tr>
<td>Sexual Assault</td>
<td>2</td>
<td>5.9</td>
</tr>
<tr>
<td>Natural Disaster</td>
<td>2</td>
<td>5.9</td>
</tr>
<tr>
<td>Death of a Family Member</td>
<td>3</td>
<td>8.8</td>
</tr>
<tr>
<td>“Other”</td>
<td>4</td>
<td>11.8</td>
</tr>
<tr>
<td><strong>Vicarious Exposure</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Life Threatening Neglect of a Child</td>
<td>25</td>
<td>73.5</td>
</tr>
<tr>
<td>Physical Abuse of a Child</td>
<td>31</td>
<td>91.2</td>
</tr>
<tr>
<td>Sexual Abuse of a Child</td>
<td>31</td>
<td>91.2</td>
</tr>
<tr>
<td>Mental Abuse of a Child</td>
<td>31</td>
<td>91.2</td>
</tr>
<tr>
<td>Homicide / Death of a Child</td>
<td>7</td>
<td>20.6</td>
</tr>
<tr>
<td>“Other”</td>
<td>5</td>
<td>14.7</td>
</tr>
</tbody>
</table>
provided ambiguous data. One-way ANOVA revealed no significant differences among groups meeting full, partial, or neither criteria for PTSD on the primary dependent measures (TSI Anxious Arousal, $F(2,30) = 0.878, p = 0.464$; TSI Intrusive Experiences, $F(2,30) = .345, p = 0.711$ TSI Defensive Avoidance, $F(2,30) = 0.366, p = 0.696$ TSI composite score, $F(2,30) = 0.543, p = 0.587$). Consequently, data for these groups were combined for the remaining analyses.

Coping Resources

Utilization of coping resources was evaluated using the CRI. Group averages for each of the five coping resources domains and the total resources are presented in Table 2. Scores on the CRI are presented as t-scores based on comparisons with the normative sample. Higher scores represent greater utilization of coping resources, while lower scores represent less utilization. Respondents reported average usage of coping resources across all domains.

Quality of Life

Respondents' perceived quality of life was assessed using the WHOQOL. Scores on this instrument are based on a 0 to 100 scale. As such, scores represent the percent of the maximum possible score, and higher scores are associated with higher quality of life. Scores for each of the six subscales along with data from the normative sample of healthy adults are presented in Table 3. This sample of
Table 2
Average Scores Obtained on the Coping Resources Inventory

<table>
<thead>
<tr>
<th>Subscale</th>
<th>Mean</th>
<th>Standard Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cognitive Resources</td>
<td>49.85</td>
<td>10.18</td>
</tr>
<tr>
<td>Social Resources</td>
<td>51.44</td>
<td>8.90</td>
</tr>
<tr>
<td>Emotional Resources</td>
<td>50.00</td>
<td>9.91</td>
</tr>
<tr>
<td>Spiritual Resources</td>
<td>50.21</td>
<td>11.04</td>
</tr>
<tr>
<td>Physical Resources</td>
<td>45.26</td>
<td>9.29</td>
</tr>
<tr>
<td>Total Resources</td>
<td>49.21</td>
<td>10.60</td>
</tr>
</tbody>
</table>

Respondents scored significantly lower than the normative sample on the Physical and Psychological domains, indicating lower perceived physical and psychological well-being, respectively. They scored significantly higher than the normative sample on the Environmental and Spirituality domains, indicating increased satisfaction with their environmental surroundings and spiritual well-being than the typical adult. They were within normal limits on the Independence and Social Resources domains.

TSI, Anxiety, and Depression

Current PTSD symptoms were assessed using the TSI. Because this instrument is not anchored to any particular trauma, it was used to assess PTSD symptoms from multiple vicarious sources. Collateral symptoms of anxiety and depression were assessed using the SCL-90-R. On both instruments, scores are
Table 3
Average Quality of Life Scores and Scores Reported for the Normative Sample

<table>
<thead>
<tr>
<th>Subscale</th>
<th>Mean</th>
<th>Standard Deviation</th>
<th>Normative Sample M(SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical</td>
<td>68.76**</td>
<td>17.35</td>
<td>77.1 (11.6)</td>
</tr>
<tr>
<td>Psychological</td>
<td>66.18**</td>
<td>16.39</td>
<td>75.1 (10.7)</td>
</tr>
<tr>
<td>Independence</td>
<td>85.82</td>
<td>13.51</td>
<td>90.0 (9.9)</td>
</tr>
<tr>
<td>Social Resources</td>
<td>65.82</td>
<td>17.15</td>
<td>71.7 (14.4)</td>
</tr>
<tr>
<td>Environmental</td>
<td>76.03*</td>
<td>11.37</td>
<td>71.7 (11.5)</td>
</tr>
<tr>
<td>Spirituality</td>
<td>76.68*</td>
<td>22.30</td>
<td>68.0 (23.6)</td>
</tr>
</tbody>
</table>


** p < 0.01; * p < 0.05

presented as t-scores, with higher scores corresponding to greater impairment. The sample scored within the average range on the Intrusive Experiences, Defensive Avoidance, and Anxious Arousal subscales (Table 4). The sample scored significantly higher than the normative sample on both depression and anxiety, although the average falls well within the normal range on both measures. Clinical significance for PTSD, Anxiety, and Depression was defined as scores greater than 65, and borderline clinical significance was defined as scores between 60 and 64. While 8.8 percent of the sample scored within the clinical or borderline clinical range
Table 4

Average PTSD, Anxiety, and Depression Scores and Frequencies of Scores Falling Within the Borderline or Clinically Significant Range

<table>
<thead>
<tr>
<th>Subscale</th>
<th>Mean</th>
<th>Standard Deviation</th>
<th>Borderline Clinical Range(^a) (n)</th>
<th>Clinical Range(^b) (n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>TSI Intrusive Experiences</td>
<td>48.29</td>
<td>7.79</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>TSI Defensive Avoidance</td>
<td>48.88</td>
<td>8.74</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>TSI Anxious Arousal</td>
<td>49.26</td>
<td>8.77</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>SCL-90-R Depression</td>
<td>58.32**</td>
<td>8.79</td>
<td>7</td>
<td>9</td>
</tr>
<tr>
<td>SCL-90-R Anxiety</td>
<td>55.62**</td>
<td>8.74</td>
<td>4</td>
<td>6</td>
</tr>
</tbody>
</table>

\(^a\)The borderline clinical range includes scores falling between 60 and 64.

\(^b\)The clinical range includes scores of 65 or greater.

**Significantly higher than the reported normative sample mean of 50 (p < 0.01).

on intrusion, 17.6 percent on avoidance, and 14.7 percent on hyperarousal, only one individual’s scores were significantly elevated across all three measures of PTSD. Forty-seven percent of the sample scored significantly high on depression, and 29 percent scored significantly high on anxiety.

**Burnout**

The sample scored within the average range on the MBI, which measures the three component factors of burnout (Table 5). Burnout is defined as elevated emotional exhaustion and depersonalization, and low levels of personal
Table 5
Average Burnout Scores and Frequencies of Scores Falling Within the Borderline or Clinically Significant Range

<table>
<thead>
<tr>
<th>Subscale</th>
<th>Mean</th>
<th>Standard Deviation</th>
<th>Borderline Clinical Range&lt;sup&gt;a&lt;/sup&gt; (n)</th>
<th>Clinical Range&lt;sup&gt;b&lt;/sup&gt; (n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>MBI Emotional Exhaustion</td>
<td>53.18</td>
<td>10.17</td>
<td>7</td>
<td>6</td>
</tr>
<tr>
<td>MBI Depersonalization</td>
<td>52.00</td>
<td>10.46</td>
<td>7</td>
<td>3</td>
</tr>
<tr>
<td>MBI Personal Accomplishment</td>
<td>52.94</td>
<td>8.72</td>
<td>3</td>
<td>0</td>
</tr>
</tbody>
</table>

<sup>a</sup>The borderline clinical range includes scores between 60 and 64 for the emotional exhaustion and depersonalization scales and between 36 and 40 for the personal accomplishment scale.

<sup>b</sup>The clinical range includes scores of 65 or greater on the emotional exhaustion and depersonalization scales and 35 or less on the personal accomplishment scale.

Consequently, higher scores on the emotional exhaustion and depersonalization subscales and lower scores on the personal accomplishment subscale are associated with higher levels of impairment.

While 38 percent of the sample reported borderline to clinically significant emotional exhaustion and 29 percent reported similar levels of depersonalization, only 9 percent reported borderline lowered personal accomplishment. Further, only one individual was classified within either range on all three indices, meeting subclinical criteria for burnout. No one met full criteria (i.e., scored within the clinical range on all three indices).
Correlations Among Independent and Dependent Variables

Table 6 shows the intercorrelations among the independent variables. Respondents' MBI composite score was correlated with the majority of the other independent variables, excluding the number of hours per week spent with survivors. Correlations were also found between (a) CRI Total Resources and years of experience, (b) highest degree earned and hours per week spent working with survivors, and (c) history of PTSD resulting from a personal trauma and CRI Total Resources.

Table 6
Pearson Product-Moment Intercorrelations Among Independent Variables

<table>
<thead>
<tr>
<th>Variable</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Years of Experience</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>2. Hours per Week with Survivors</td>
<td>-0.234</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>3. CRI Total Resource</td>
<td>0.318*</td>
<td>-0.072</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>4. MBI Composite Score</td>
<td>0.551**</td>
<td>0.207</td>
<td>0.633**</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>5. Degree</td>
<td>0.284</td>
<td>-0.341*</td>
<td>0.281</td>
<td>-0.590**</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>6. ETRI PTSD (personal trauma)</td>
<td>0.182</td>
<td>0.008</td>
<td>-0.339*</td>
<td>0.097*</td>
<td>-0.213</td>
<td>--</td>
</tr>
</tbody>
</table>

Note: CRI = Coping Resources Inventory; MBI = Maslach Burnout Inventory; ETRI = Everstine Trauma Response Index.

** p < 0.01; * p < 0.05
Table 7 shows the intercorrelations among the dependent variables. All of the dependent measures were strongly and significantly correlated with one another in the expected directions.

Table 7
Pearson Product-Moment Intercorrelations Among Dependent Variables

<table>
<thead>
<tr>
<th>Variable</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. TSI Total (Composite)</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>2. MBI Total (Composite)</td>
<td>0.464**</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>3. SCL-90-R Anxiety</td>
<td>0.539**</td>
<td>0.560**</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>4. SCL-90-R Depression</td>
<td>0.535**</td>
<td>0.682**</td>
<td>0.804**</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>5. WHOQOL Total (Composite)</td>
<td>-0.573**</td>
<td>-0.492**</td>
<td>-0.703**</td>
<td>-0.763**</td>
<td>--</td>
</tr>
</tbody>
</table>

Note: TSI = Trauma Response Index; MBI = Maslach Burnout Inventory; SCL-90-R = Symptom Checklist–90–Revised; WHOQOL = World Health Organization Quality of Life.

** p < 0.01

** Regression Analysis

In order to examine the extent to which background factors are predictive of vicarious traumatization, stepwise multiple linear regression analyses were conducted for each of the primary dependent measures. Predictor variables were selected based upon empirical support for their relationship to vicarious traumatization in other
populations, as reported in the literature. The list of predictors was refined by examining the Pearson r correlations between each predictor and each of the dependent measures. Only those predictors significantly correlated with the dependent variable (p < 0.01) were entered into the regression equation. In addition, two equations included dependent measures in the equation. The MBI composite score was regressed on the TSI composite score to examine the relationship between burnout and PTSD. Similarly, both PTSD and burnout were included in the quality of life equation. Results of the regression analyses are presented in Table 8.

The TSI composite score was derived by summing standardized scores based upon each of the primary PTSD symptom domains assessed by the TSI (i.e., intrusive experiences, defensive avoidance, and anxious arousal). This measure represents current PTSD symptoms. The TSI composite score was regressed on level of education (based on the highest degree held by the respondent), CRI total score, and MBI composite score. Education and coping were the predictors identified that accounted for a significant proportion of the variance in TSI scores, with less education and poorer utilization of coping resources associated with more impairment.

To identify factors associated with burnout, the MBI composite score was regressed on (a) years of experience, (b) level of education, and (c) CRI Total Resources. The three predictors combined to account for a significant proportion of the variance. Less utilization of positive coping strategies, less education, and less experience predict increased levels of burnout. Depression and Anxiety scores were
Table 8
Stepwise Multiple Regression Analysis for Each of the Dependent Measures

<table>
<thead>
<tr>
<th>Variable</th>
<th>F test</th>
<th>df</th>
<th>R</th>
<th>R²</th>
<th>B</th>
</tr>
</thead>
<tbody>
<tr>
<td>TSI Composite Score</td>
<td>7.40**</td>
<td>2, 28</td>
<td>0.588</td>
<td>0.299</td>
<td>-0.398</td>
</tr>
<tr>
<td>Highest Degree Earned</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CRI Total Resources</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MBI Composite Score</td>
<td>17.91**</td>
<td>3, 27</td>
<td>0.816</td>
<td>0.628</td>
<td>-0.429</td>
</tr>
<tr>
<td>CRI Total Resources</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Highest Degree Earned</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Experience (years)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SCL-90-R Depression</td>
<td>9.37**</td>
<td>2, 28</td>
<td>0.633</td>
<td>0.358</td>
<td>-0.457</td>
</tr>
<tr>
<td>CRI Total Resources</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Highest Degree Earned</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SCL90-R Anxiety</td>
<td>10.52**</td>
<td>2, 28</td>
<td>0.655</td>
<td>0.388</td>
<td>-0.425</td>
</tr>
<tr>
<td>Highest Degree Earned</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CRI Total Resources</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>WHOQOL Total Score</td>
<td>24.39**</td>
<td>2, 30</td>
<td>0.786</td>
<td>0.592</td>
<td>0.601</td>
</tr>
<tr>
<td>CRI Total Resources</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TSI Composite Score</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: TSI = Trauma Response Index; MBI = Maslach Burnout Inventory; SCL-90-R = Symptom Checklist–90–Revised; WHOQOL = World Health Organization Quality of Life.

**p < 0.01

regressed on CRI Total Resources and education. Both predictors accounted for a significant proportion of the variance in each equation, with lower scores on these predictors associated with higher levels of distress.
The WHOQOL total score was regressed on the CRI Total Resources score, TSI composite score, and MBI composite score. Higher levels of coping and lower levels of PTSD symptomatology predicted higher scores on the quality of life measure.

Because coping resources is a multifaceted variable, post-hoc stepwise multiple regression analyses were run for each of the dependent measures for which coping was a significant predictor. Each dependent variable was regressed on each of the five subscales that comprise the coping measure. Results of these analyses are presented in Table 9. The Cognitive Resources domain accounted for the greatest proportion of the variance in TSI composite scores and SCL-90-R anxiety and depression scores. The Emotional Resources domain accounted for a significant proportion of the variance in MBI composite scores. Quality of life was predicted by two coping variables, Cognitive Resources and Physical Resources.

Summary

All respondents reported a history of vicarious exposure to some form of child maltreatment through their work. In addition, 23 respondents reported a history of directly experienced personal trauma. Among those with a personal trauma history, 39 percent reported a lifetime history of PTSD and 13 percent reported a lifetime history of subclinical PTSD. Neither a history of personal trauma nor a history of PTSD were significantly correlated with the primary outcome measures, suggesting that the vicarious PTSD measure was in fact tapping the effects of vicarious trauma.
Table 9

Post-hoc Stepwise Multiple Regression Analysis for Each of the Dependent Measures and the Coping Resources Subscales

<table>
<thead>
<tr>
<th>Variable</th>
<th>F</th>
<th>df</th>
<th>R</th>
<th>$R^2$</th>
<th>B</th>
</tr>
</thead>
<tbody>
<tr>
<td>TSI Composite Score</td>
<td>6.45*</td>
<td>1, 33</td>
<td>0.409</td>
<td>0.142</td>
<td>-0.409</td>
</tr>
<tr>
<td>CRI Emotional Resources</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MBI Composite Score</td>
<td>19.82**</td>
<td>1, 33</td>
<td>0.618</td>
<td>0.363</td>
<td>-0.618</td>
</tr>
<tr>
<td>CRI Cognitive Resources</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SCL-90-R Depression</td>
<td>17.48**</td>
<td>1, 33</td>
<td>0.594</td>
<td>0.333</td>
<td>-0.594</td>
</tr>
<tr>
<td>CRI Cognitive Resources</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SCL-90-R Anxiety</td>
<td>12.77**</td>
<td>1, 33</td>
<td>0.534</td>
<td>0.263</td>
<td>-0.534</td>
</tr>
<tr>
<td>CRI Cognitive Resources</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>WHOQOL Total Score</td>
<td>24.30**</td>
<td>2, 32</td>
<td>0.786</td>
<td>0.593</td>
<td>0.589</td>
</tr>
<tr>
<td>CRI Cognitive Resources</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CRI Physical Resources</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>-0.364</td>
</tr>
</tbody>
</table>

Note: TSI = Trauma Response Index; MBI = Maslach Burnout Inventory; SCL-90-R = Symptom Checklist–90–Revised; WHOQOL = World Health Organization Quality of Life.

* $p < 0.05$  ** $p < 0.01$

While the sample scored within the average range on vicarious PTSD symptoms, they scored above average on both anxiety and depression. Further, 47 percent of the sample had significantly elevated depression scores, and 29 percent had significantly elevated anxiety scores. The sample scored average with respect to burnout, however, 38 percent reported elevated levels of emotional exhaustion, and
29 percent reported elevated levels of depersonalization. Coping scores were within the average range. With regard to quality of life, the sample reported above average spiritual and environmental quality of life and below average physical and psychological quality of life. All other measures were within normal limits.

Multiple regression analyses revealed that vicarious PTSD symptoms, depression, and anxiety could be predicted by equations containing the highest degree earned by respondents and their CRI Total Resources score. Burnout was predicted by an equation containing CRI Total Resources, the highest degree earned, and years of experience. Finally, quality of life was predicted by the TSI composite score and the CRI Total Resources score.
CHAPTER VII

DISCUSSION

The present study examined the prevalence of vicarious traumatization, background factors that predict VT, and the impact of trauma work on quality of life among 34 self-identified child abuse counselors. While the rate of vicarious exposure to child abuse and neglect was high (71 percent of the average counselor’s caseload was comprised of survivors), on average, this sample reported no more symptoms of PTSD than expected, based on general population norms. Further, only one individual reported significant elevations across all three symptom domains (intrusion, avoidance, and arousal) of PTSD.

While these findings are encouraging, the present sample was not exempt from psychological distress. When compared to general population norms, this sample was significantly more anxious and depressed. Approximately 18 percent of the sample had significantly elevated scores as measured by the SCL-90-R anxiety scale, and another 12 percent of scores were within the borderline range. With regard to depression, approximately 26 percent of the sample fell within the clinical range, and another 21 percent fell within the borderline range. This is well above the prevalence rates for depression in the general population (APA, 1994).
While depression is recognized as a component of VT (Figley, 1995; McCann & Pearlman, 1990), little attention has been focused specifically on the prevalence of depression in trauma therapists. In their constructivist self-development theory of traumatization, McCann & Pearlman (1990) place heavy emphasis on disruptions to cognitive schemas about the self, the world, and others. A number of investigations (Brady et al., 1999; Johnson & Hunter, 1997; and Pearlman & Mac Ian, 1995) have documented disrupted schemas in various samples of trauma therapists. These disruptions closely parallel the core cognitive disruptions in the cognitive model of depression (Beck, 1972). Consequently, from a theoretical perspective, the connection between VT and depression is appealing. What remains is to determine whether these cognitive disruptions are a cause, consequence, or collateral feature in this population.

The present investigation also examined the prevalence of burnout. A number of individuals in this sample evidenced high levels of emotional exhaustion. Interestingly, the other two components (depersonalization and lowered personal accomplishment) were less frequent. While this might suggest that the sample is not experiencing burnout, a number of investigations (e.g., Evans & Fischer, 1993; Garden, 1987, 1989, 1991; Green, Walkey, & Taylor, 1991) have suggested alternatives to the three-factor model of burnout. Many have suggested that emotional exhaustion alone is indicative of burnout (e.g., Garden 1987, 1989, 1991). Others suggest a two-factor model comprised of emotional exhaustion and depersonalization (e.g., Evans & Fischer, 1993). Nevertheless, the majority support
the full model (see Taris, Schreurs, & Schaufeli, 1999 for a review). Across models, emotional exhaustion is consistently included and typically emerges most strongly in factor analysis.

Taking the more conservative three-factor approach, the present sample is not currently experiencing burnout, but those with high levels of emotional exhaustion may be in the early stages of developing the syndrome. Individuals with the full syndrome may have self-selected out of the present sample by leaving the field early. Conversely, the emotional exhaustion may be an artifact of their other symptoms (e.g., depression), and other characteristics of the sample may serve a protective function from the development of the full syndrome. Further examination of burnout in this population is warranted. Specifically, a closer look at the developmental course of the syndrome would help identify those individuals at greatest risk so that preventative action can be taken.

A second goal of the present study was to examine background characteristics that predict VT in child abuse counselors. Two predictors emerged to account for a significant proportion of the variance across the majority of outcome measures. The highest degree earned was an important predictor of anxiety, depression, PTSD, and burnout. This suggests that education is an important factor in reducing the probability of negative outcomes. Those counselors who received more training developed fewer symptoms across measures. This is consistent with the findings reported by Pearlman & Mac Ian (1995).
One interpretation for these findings is that more education better prepares counselors for their work and the stresses associated with their work. Further, they may develop skills that give them competence to perform their jobs effectively, reducing frustration and feelings of helplessness. However, level of education is associated with a number of job characteristics that may mediate this relationship. For example, counselors with higher degrees are more likely to be in supervisory or administrative positions that are associated with less direct contact with survivors. Therefore, it is not possible in this sample to separate the effects of training from the effects of job characteristics associated with different levels of training.

The association between level of training and VT may account for the high level of depression found in the present sample that has not been widely reported in the literature. While previous work has primarily included doctoral and master's level professionals (Brady et al., 1999; Pearlman & Mac Ian, 1995; Follette et al., 1994), the present sample was skewed in the direction of less training, with the sample being equally divided between master's and bachelor's level counselors. Consequently, the present study may have identified levels of depression that were absent in more highly educated samples. Alternatively, because depression was not closely examined in prior research, relevant findings may have been omitted or obscured when depression measures were combined with other measures to produce a single composite score (e.g., Brady et al., 1999; Pearlman & Mac Ian, 1995).

Coping was another important predictor. Poorer coping, particularly poorer cognitive and emotional coping, was associated with higher levels of symptoms.
While individuals with poorer coping resources may be more prone to symptoms, the reverse may be an equally appropriate interpretation. It may be that symptoms interfere with the individual’s ability to cope. Thus, while in times of normal stress, individuals may exhibit adequate coping resources, they may be less apt to make use of them under conditions of extreme distress. The true direction of this relationship remains to be examined empirically.

There was no relationship between vicarious traumatization and level of exposure as measured by (a) years of experience, (b) hours per week spent working with survivors, or (c) the percent of survivors on the counselor’s caseload. Other studies have linked these factors to VT (Brady et al., 1999; Schauben & Frazier, 1995). It is possible that the range of exposure in the present sample was too restricted to detect an effect. The sample consisted of individuals who self-identified as child abuse counselors. Consistent with this self-identification, the majority reported that a high percentage of their caseload was devoted to survivors. In fact, over 75 percent of the sample reported that 60 percent or more of their caseload was devoted to survivors. Further, it is possible that those reporting a small percent of survivors currently may have had a history of more exposure. For example, even those individuals reporting a low percentage of survivors on their current caseloads self-identified as child abuse counselors. Thus, it is possible that such individuals had a history of higher levels of exposure even though current exposure was low.

There was no relationship between a history of personal trauma nor a history of PTSD associated with a personal trauma and VT in the present sample. Findings
regarding personal trauma history have been mixed (Follette et al., 1994; Schauben & Frazier, 1995). Differences in findings across studies could be an artifact of the measurement techniques employed. For example, in the present study, the VT measure was not anchored to any particular event. Thus it may have tapped current PTSD symptoms resulting from any number of sources. The lack of a relationship gives support to the notion that the present study was measuring truly vicarious effects; however, this is a rational argument that requires empirical demonstration.

While burnout and VT are hypothesized to be distinct phenomena, correlations between measures of the two constructs were significant, suggesting that they are related. Likewise, in this sample, factors that predicted VT (i.e., education and coping) were also key predictors in the burnout model. Thus, individuals at greatest risk for VT were also at risk for burnout. Burnout may leave counselors vulnerable to the effects of stress. Likewise, those counselors who experience psychological distress may burnout more easily.

In some respects, the present sample reported better quality of life than expected in the general population, while in other respects they reported lower quality of life. The present sample reported that their spiritual life was satisfying. This is consistent with previous studies on the relationship between VT and spirituality (Brady et al., 1999). Trauma therapists tend to be more spiritual than the general population. Hypothesized explanations for such findings have included the notion that exposure to trauma survivors may challenge counselors’ spiritual beliefs, making
them more likely to examine their spirituality and thus be more aware. Conversely, individuals who are strong spiritually may be drawn to this type of work.

The present sample’s high environmental quality of life suggests that they enjoy adequate financial resources, access to health care and social resources, and feel safe in their home environments. Feelings of safety require further investigation, as they are in contrast to previous research exploring beliefs about safety.

The present sample reported lower than expected physical and psychological quality of life. This is not surprising, as many symptoms noted in the sample are tapped by these domains. For example, physical exhaustion, lack of energy, and sleep disturbances are tapped by the physical domain and are associated with both depression and burnout. The psychological domain includes facets measuring positive and negative feelings and problems with concentration, both of which would be expected to be affected in depressed and burned out individuals.

On balance, quality of life is average in this sample. While some areas may be adversely affected, others are positively affected. Looking at overall measures, current PTSD symptoms (as measured by the hypothesized vicarious measure) and coping were the strongest predictors of quality of life. Thus, in a sample experiencing higher levels of PTSD, one would expect to encounter poorer quality of life than in the present sample.
Limitations

A number of limitations of the current investigation should be noted. First, the small sample size limited the power for statistical analyses. Thus, it is possible that the interactions among certain of the variables were not detected due to reduced power as opposed to lack of a true relationship. Further, a number of analyses which may have shed light on remaining questions were not possible because there were not a sufficient number of individuals in the present sample falling into certain subsample categories (e.g., individuals with a history of childhood abuse).

The generalizability of the results to other populations of child abuse counselors is limited. Given the voluntary nature of participation, selection was not random. As with other surveys of this nature, there may be important differences between individuals who volunteer and those who do not. Further, selection was biased toward individuals working in agencies who chose to participate. A very small proportion of those agencies invited to participate agreed. This sample may be qualitatively different from those that chose not to participate. For example, most of the directors at participating agencies reported awareness of VT, concern about VT, or described their efforts to prevent VT. Such recognition may directly relate to the quality of supervision and support within the work environment.

Relatedly, as with the majority of work in this area, only actively employed individuals were included in the sample. Such selection strategies will potentially select out individuals who are most disturbed by their work. Those individuals who are most symptomatic and who experience the most disruption in their ability to
function may leave the field, and thus would not be eligible to participate. Future studies should attempt to sample from the full range of trauma therapists, including those who are no longer in the field.

The instrument used to assess vicarious PTSD symptoms was not anchored to any particular event. Anchoring the PTSD measure to specific vicarious events might have yielded a better estimate of VT. A potential problem with such an approach is that because the cumulative effects of exposure are hypothesized as the key etiologica! factor in VT, anchoring may have resulted in underprediction in cases where the individual was unable to identify the specific source of symptoms. The present measure should have overpredicted symptoms. The finding that a small number of individuals were presently experiencing symptoms from any source suggests that more specific measures would identify fewer individuals.

Future Directions

There is a great deal of discrepancy across studies seeking to identify the key aspects of VT. Further, very little prevalence data have been reported for any population of trauma therapists. Further work aimed at identifying the primary components of VT is essential before further identification of predictive, preventative, and remediating factors can be fully addressed. Such work should include assessment of a broad range of potential symptoms including (a) behavioral, (b) cognitive, and (c) affective symptoms.
Work in this area provides a unique opportunity for experimental work exploring the etiology and developmental course of VT. The extent to which VT parallels primary PTSD holds promise for developing a human model of PTSD. Unlike many forms of traumatization, VT presents populations of individuals for whom exposure to trauma can be reliably predicted a priori. Thus the impact of exposure to vicarious trauma holds the potential for experimental manipulation.

Finally, a coherent theoretical model remains to be developed and explored. Most of the work in the area has centered on the constructive self-developmental model. While features of the model have received empirical support (e.g., trauma therapists tend to experience disruptions in core beliefs), such findings could be cited as evidence to support any number of alternative models. The primary limitation of the prevalent model is that it is not an empirically derived model. Future studies should be aimed at exploring the applicability of more empirically-based models of PTSD to this population. Further, a model of depression as applied to this population warrants further exploration.

Conclusion

Vicarious traumatization has been conceptualized broadly as the psychological consequences to therapists of exposure to their victim clients (McCann & Pearlman, 1990). Research in this area has most often focused on symptoms similar to those described for PTSD and disruptions in beliefs (Schauben & Frazier, 1995; Pearlman & Mac Ian, 1995; Follette, et al., 1994). The present sample was no
more likely than the general population to experience PTSD symptoms as a consequence of their work. However, depression, anxiety, and emotional exhaustion were reported by a number of respondents. These symptoms are highly correlated with one another and can be predicted by the individual’s level of education and utilization of coping resources. Those individuals with less education and fewer coping resources tended to report more depression, anxiety, burnout, and PTSD. Further, these symptoms adversely impacted quality of life. Further work is needed to examine the full range and developmental course of symptoms that characterize VT and to develop a coherent theoretic model of VT. Future work should also address the unique characteristics of individuals who have chosen to leave the field of trauma work.
Appendix A

DSM-IV Diagnostic Criteria for Post-traumatic Stress Disorder
A. The person has been exposed to a traumatic event in which both of the following were present:

(1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others

(2) the person’s response involved intense fear, helplessness, or horror.

*Note: In children, this may be expressed instead by disorganized or agitated behavior*

B. The traumatic event is persistently reexperienced in one (or more) of the following ways:

(1) recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. *Note: In young children, repetitive play may occur in which themes or aspects of the trauma are expressed.*

(2) recurrent distressing dreams of the event. *Note: In children, there may be frightening dreams without recognizable content.*

(3) acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated). *Note: In young children, trauma-specific reenactment may occur.*

(4) intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

(5) physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:

(1) efforts to avoid thoughts, feelings, or conversations associated with the trauma
(2) efforts to avoid activities, places, or people that arouse recollections of the trauma
(3) inability to recall an important aspect of the trauma
(4) markedly diminished interest or participation in significant activities
(5) feeling of detachment or estrangement from others
(6) restricted range of affect (e.g., unable to have loving feelings)
(7) sense of foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)
D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:

(1) difficulty falling or staying asleep
(2) irritability or outbursts of anger
(3) difficulty concentrating
(4) hypervigilance
(5) exaggerated startle response

E. Duration of the disturbance (symptoms in Criteria B, C, and D) is more than 1 month

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
Appendix B

Informed Consent Document
You are invited to participate in a research project entitled "Vicarious Traumatization: An Examination of the Effects of Exposure to Traumatic Material in Child Abuse Counselors" designed to examine how traumatic stress, experienced directly or indirectly by witnessing its impact on others, impacts the psychological health of child abuse counselors. This study is being conducted by C. Richard Spates, Ph.D. and Stacey A. Waller, B.A. from Western Michigan University, Department of Psychology. This research is being conducted as part of the thesis requirements for Stacey Waller.

This survey is comprised of 6 individual questionnaires containing multiple choice questions and will take approximately 45 – 60 minutes to complete. Your replies will be completely anonymous, so do not put your name anywhere on the form. You may choose to not answer any question and simply leave it blank. If you choose to not participate in this survey, you may either return the blank survey or you may discard it. Returning the survey indicates your consent for use of the answers you supply. If you have any questions, you may contact C. Richard Spates (616 387-4329), Stacey Waller (616 387-4332), the Human Subjects Institutional Review Board (616 387-8293) or the vice president for research (616 387-8298).

This consent document has been approved for use for one year by the Human Subjects Institutional Review Board as indicated by the stamped date and signature of the board chair in the upper right corner. You should not participate in this project if the corner does not have a stamped date and signature.
Appendix C

Protocol Clearance from the Human Subjects
Institutional Review Board
Date: 23 November 1998

To: Richard Spates, Principal Investigator  
Stacey Waller, Student Investigator for thesis

From: Sylvia Culp, Chair

Re: HSIRB Project Number 98-10-21

This letter will serve as confirmation that your research project entitled “Vicarious Traumatization: An Examination of the Effects of Exposure to Traumatic Material in Child Abuse Counselors” has been approved under the expedited category of review by the Human Subjects Institutional Review Board. The conditions and duration of this approval are specified in the Policies of Western Michigan University. You may now begin to implement the research as described in the application. Please note: You must submit copies of the letters from the agency directors granting you permission to conduct this research at those agencies.

Please note that you may only conduct this research exactly in the form it was approved. You must seek specific board approval for any changes in this project. You must also seek reapproval if the project extends beyond the termination date noted below. In addition if there are any unanticipated adverse reactions or unanticipated events associated with the conduct of this research, you should immediately suspend the project and contact the Chair of the HSIRB for consultation.

The Board wishes you success in the pursuit of your research goals.

Approval Termination: 23 November 1999
BIBLIOGRAPHY


