

VICARIOUS TRAUMATIZATION, SECONDARY TRAUMATIC STRESS, AND
BURNOUT IN SEXUAL ASSAULT AND DOMESTIC VIOLENCE
AGENCY STAFF AND VOLUNTEERS

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Two constructs, vicarious trauma (VT) and secondary traumatic stress (STS), describe therapists' reactions to clients' traumatic material. VT (TSI Belief Scale [BSL]), emphasizes cognitive belief system changes resulting from cumulative exposure to survivors. STS, (Compassion Fatigue Self-test for Psychotherapists [CFST]) combines PTSD and burnout symptomatology explaining sudden adverse reactions to survivors. Burnout (BO; Maslach Burnout Inventory [MBI]), links emotional exhaustion, depersonalization, and deficient personal accomplishment to inadequate institutional supports in interpersonally demanding work.

This study investigated BSL and CFST validity, counselor trauma history, and client exposure-related VT, STS, and BO in 105 trauma counselors. Results demonstrate concurrent validity between BSL and CFST; other results dispute adequate validity. BO, and client exposure were related. Traumatized counselors scored higher than non-traumatized counselors on CFST, BSL, and SCL-90-R.

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CHAPTER I

INTRODUCTION AND LITERATURE REVIEW

An event may be considered traumatic if the sufferer is unprepared for the unexpected event, with the event overwhelming their ability to adapt, resulting in the disruption and shattering of their basic cognitive schemas and assumptions about the world (Figley, 1985; Janoff-Bulman, 1985; and McCann & Pearlman, 1990). To clarify, the DSM-IV stipulates that an extreme traumatic stressor can involve

direct personal experience of an event that involves threatened death, actual, or threatened serious injury, or other threat to one's physical integrity; or witnessing an event that involves death, injury, or a threat to 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 close associates. (APA, 1994, p. 424)

However, as this definition implies, traumatic events do not occur in a vacuum. Rather, traumatic events hold tremendous meaning for those touching the survivors' lives, affecting all persons involved. In fact, the effects and ramifications of trauma are not limited solely to the survivor, but have also been shown to affect those that help the survivor, such as emergency medical workers or health care providers for seriously ill patients, and most recently in the literature, mental health professionals. These effects

are now being conceptualized as secondary traumatic stress (STS) and vicarious traumatization (VT).

An examination of the current major research validates the concept that those who work with trauma clients may indeed develop reactions specific to the traumatic nature of the client material. Most commonly, service providers such as sexual assault (SA) counselors or police officers with high numbers of SA clients begin to suffer PTSD-like symptoms after frequent exposure to SA survivors (Alexander, de Chasney, Marshall, Campbell, Johnson, & Wright, 1989; Farrenkopf, 1992; Martin, McKean & Veltkamp, 1986; McCann & Pearlman, 1990; Pearlman & Mac Ian, 1995; Remer & Ferguson, 1995; Schauben & Frazier, 1995). Police officers exposed to victims of shootings have also manifested PTSD-like symptoms (Gibbs, Drummond, & Lachenmeyer, 1993; Loo, 1986; McCafferty, Godofredo, & McCafferty, 1990). Therapists working with holocaust survivors have demonstrated trauma-like countertransference symptomatology (Danieli, 1980; Weiss & Durst, 1994). Social workers and other mental health professionals have also demonstrated trauma symptomatology after working closely with victims of debilitating or life-threatening illnesses (Cunningham, 1996) or clients with HIV/AIDS (Gabriel, 1994). As of yet, there are no studies regarding the vicarious effect of working with domestic violence (DV) survivors with PTSD on the staff and volunteers that serve those shelters, but one can speculate that staff and volunteers are not immune to the survivors' struggle with emotional (and physical) injuries. Investigating the available body of work (in further detail below) provides valuable clues and insight

concerning the current status of the field, as well as comparisons for this study and other future, related research.

This evidence of widespread vicarious consequences necessitates proper and efficient identification and treatment of trauma survivors in order to minimize deleterious effects for the survivor, as well as those surrounding the survivor (such as therapists or significant others). Additionally, if the service provider or therapist becomes adversely affected through vicarious assimilation of the trauma symptoms, then treatment for the survivor, the principal target, becomes compromised, stalling the psychological healing of all involved. In other words, appropriate and beneficial treatment for trauma survivors depends on therapists who can adequately cope and adjust to their clients' intense traumatic material. The present study examines the relationships among the constructs of secondary traumatic stress and vicarious traumatization, comparing these two constructs with each other, and with burnout (BO) and general distress (GD), to assess validity regarding the measurement of these constructs and to assess for the effects of counselor's exposure to trauma survivors on manifestation of STS, VT, BO, and GD.

Briefly, secondary traumatic stress, Figley's (1993) construct, entails the distress that arises when one comes into contact with a survivor of trauma. STS combines PTSD and burnout symptomatology to explain the sudden adverse reactions people can have to trauma survivors and is defined as the natural responses resultant from exposure to a survivor's traumatic material. STS develops when "a traumatic event forces a person close to a victim to identify and to empathize" (Figley and Kleber, 1995, p. 95). However, this exertion of empathy can gradually or quickly evince stress, exhaustion,

and PTSD-like symptomatology, particularly if one is close to the survivor or if one ignores emotional self-care.

McCann and Pearlman's (1990) elaboration of their concept of vicarious traumatization entails the possible alteration of the therapist's cognitive world through the hearing of the client's traumatic material. These changes in cognitive schema likewise significantly affect the therapist's feelings, relationships, and life. The therapist may actually begin to incorporate into their schema painful images and emotions associated with the client's traumatic memories, specifically in the form of flashbacks, dreams, painful emotional reactions, or intrusive thoughts that invade the therapist's life (McCann & Pearlman, 1990). At this point, distinguishing therapists treating trauma survivors from the trauma survivors themselves becomes a question of degree and circumstance.

The present research contributes to the body of work pertaining to the newer concepts of STS and VT. This goal is especially critical as no published empirical research exist which examine all three constructs of STS, VT, and BO in trauma counselors, particularly those working in sexual assault and domestic violence agencies. Additionally, the purpose of the present study was to explore convergent and discriminant validity of secondary traumatic stress and vicarious traumatization in relation to each other as well as burnout and general distress, utilizing their respective measures (Compassion Fatigue Self-test for Psychotherapists; Symptom Checklist-90, Revised; TSI Belief Scale, Revision L; Maslach Burnout Inventory). Moreover, this research focuses on the cumulative influence of SA and DV survivors on the staff and volunteers who assist them in their recovery process, investigating the presence and

degree of STS, VT, BO, and GD in SA and DV agency staff/volunteers. This study also examines how a history of personal trauma (particularly sexual trauma) among staff/volunteers affects levels of STS, VT, BO, and GD. Research findings demonstrate that a personal history of sexual assault increases susceptibility to and manifestation of STS/VT in therapists and counselors (Cunningham, 1996; Follete, Polusny, & Milbeck, 1994; Kassam-Adams, 1995; Pearlman & Mac Ian, 1995). BO levels, however, have not been examined in regards to victimization history.

An in-depth discussion of the current literature regarding the three concepts of STS, VT, and BO in the helping professions follows, illustrating the rationale for this topic further. Specifically, the following research topics and populations investigated in the literature review: survivors' responses to SA and DV and others' responses to SA and DV trauma material. Countertransference, the first concept regarding the reactions of therapists' towards their clients, is briefly examined as a starting point. Following countertransference, the three major constructs for the current research, STS, VT, and BO, are explored in greater detail. The examination of these concepts include topics such as definition, symptomatology, prevalence, and populations. The populations investigated in STS research include SA survivors' and combat veterans' significant others, professionals (police officers, nurses) who provide direct services to SA (and other trauma) survivors, and trauma therapists. The populations investigated in VT research include mental health professionals who interact with people with life-threatening illnesses, SA perpetrators, and SA (and other trauma) survivors. Burnout was examined among the following researched populations: medical workers, AIDS workers,

social workers, emergency workers, mental health professionals, domestic violence shelter workers, volunteers.

STS, VT, BO, and other symptoms observed in mental health professionals (therapists, counselors, etc.) who encounter sexual assault (SA) survivors are discussed in the greatest detail as these populations are the most relevant for this research. Before beginning the examination of STS, VT, and BO, however, we first begin with a brief look at the consequences of sexual assault and domestic violence on survivors.

Survivor's Responses to Trauma

Before commencing the literature review regarding others' responses to survivors, it is useful to address the implications of the term "trauma survivor," or, more specifically, "sexual assault survivor" and "domestic violence survivor." Examining the trauma symptomatology of SA and DV survivors will contribute to a deeper understanding of the far-reaching and horrifying ramifications of SA and DV. This will set the stage to examine the effects of the trauma on those located within the survivors' sphere of influence, such as SA and DV center staff and volunteers.

Sexual Assault (SA) Survivors

To obtain a clear picture of the trauma and prevalence of SA, a few words about SA and its effects follow. Understanding the nature, prevalence, and consequences of SA will demonstrate the necessity and validity of the study of SA, and by proximity, the study of SA center staff/volunteers, as a viable and valuable research topic. Therefore, before we begin the exploration of the relevance of VT/STS as a proposed research topic,

we first begin with a look at the reason why SA center staff/volunteers exist: the SA survivor.

Definition and Prevalence

In the last two decades or so, an impressive body of research has examined the effects of sexual assault on the survivor (Cohen & Roth, 1987; Coons, Bowman, Pellow, & Schneider, 1989; Foa, Rothbaum, Riggs & Murdock, 1991; Foa, Rothbaum & Steketee, 1993; Kilpatrick, Veronen, & Resick, 1979). Sexual assault is an event that is becoming more documented and understood as a traumatic upheaval that greatly affects and endangers individuals. Although there are many definitions of SA, it is most broadly defined as "any form of nonconsensual sexual activity obtained through coercion, threat of force, or force" (Vernonen & Kilpatrick, 1983, p. 342).

Coons, Bowman, Pellow, and Schneider (1989) identified a 19 to 31 percent prevalence of sexual abuse among women in non-clinical populations, occurring before age eighteen. Coons et al. (1989) also mentioned a previously documented higher rate of abuse found among clinical populations. Such high rates necessitate the appropriate recognition and treatment of the symptoms and effects of sexual assault. Additionally, the effects and ramifications are not limited solely to the survivor, but have also been shown to affect those close to the survivor, as will be discussed in later sections.

Symptomatology

The sequelae of sexual assault symptomatology in recent years have come to be conceptualized as posttraumatic stress disorder (PTSD). PTSD is characterized by a re-experiencing of the traumatic event (through flashbacks or intrusive thoughts), numbness

and distancing, repression of the event, or other cognitive and emotional problems (Waysman, Mikulincer, Solomon, & Weisenberg, 1993). Kilpatrick, Veronen, and Resick (1979) enumerated the following sexual assault-related symptoms: fear and avoidance of rape-related situations, nightmares, sleep pattern disturbances, exaggerated startle responses, intrusive unpleasant imagery, impairment in concentration or memory, and guilt. Another PTSD-related symptom SA survivors may experience involves the "oscillating cycles of intrusion and denial and feelings of numbness" (Dye & Roth, 1991; Cohen & Roth, 1987). Depression, anxiety, and sexual dysfunctions have also been found to result from sexual assault (Resick & Schnicke, 1990).

The DSM-IV (APA, 1994, p.427-429) lists the following criteria for diagnosis of PTSD:

- 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(s) that involved actual or threatened death or serious injury...to...self or others,
 - (2) the person's response involved intense fear, helplessness, or horror.
- B) The traumatic event is persistently experienced in one (or more) of the following ways:
 - (1) recurrent and intrusive distressing recollections of the event,
 - (2) recurrent distressing dreams...
 - (3) acting or feeling as if the traumatic event were occurring,

- (4) intense psychological distress at exposure to internal or external cues that resemble an aspect of the traumatic event,
 - (5) physiological reactivity on exposure to (said)...cues.
- C) Persistent avoidance of stimuli...and numbing of general responsiveness...as indicated by 3 (or more):
- (1) effort to avoid thoughts, feelings...associated with the trauma,
 - (2) effort to activities, places or people...
 - (3) inability to recall an important part of the trauma,
 - (4) markedly diminished interest or participation in significant activities,
 - (5) feeling of detachment...
 - (6) restricted range of affect...
 - (7) sense of foreshortened future.
- D) Persistent symptoms of increased arousal... as indicated by 2 or more:
- (1) difficulty falling or staying asleep,
 - (2) irritability or outbursts of anger,
 - (3) difficulty concentrating, hypervigilance,
 - (4) exaggerated startle response.
- E) Duration of the disturbance...more than 1 month
- F) The disturbance causes a clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Foa, Rothbaum, Riggs, and Murdock (1991) note that shortly following assault, 94% of rape survivors met symptomatic criteria for PTSD. Three months post-assault,

47% of survivors still retained the diagnosis. Kilpatrick et al. (1979) found that PTSD symptoms (with the exception of anxiety and fear) tend to decline considerably for most individuals within three months. However, Kilpatrick, Saunders, Veronen, Best, and Von (1987) found that 16.5% of rape survivors continued to meet criteria for PTSD following the assault, some for as long as 17.5 years.

The preceding detailed negative effects indicate that SA is an act of extensive, and often long-lasting, consequences for the survivor. The additional finding that approximately one in four women encounter this trauma indicates the epidemic nature of this human transgression. When one considers a survivor's sphere of influence, such as her/his therapist, friends, family, and significant others, it is apparent that few citizens are left untouched by this atrocity. Research has recently begun examining the effects of SA on those surrounding the survivor, providing data suggesting that significant others and therapists experience significant PTSD-like effects, among others. This new focus validates a need for continuing research in this direction in order to determine additional insight into the apparent contagious and ripple-like nature of trauma symptomatology. These concepts are explored further in later sections on STS and VT.

Domestic Violence (DV) Survivors

DV and SA survivors are linked by many similarities, underscoring the necessity of including the population of those who serve DV survivors in this proposed research. DV survivors also often experience SA. In fact, wife battering and marital rape are often companion methods of male violence (Ogawa, B., n.d.). Pagelow (1988), after surveying

the prevalence rates of marital rape among DV survivors, found rates from 33% to 50% in the literature.

Russell (1982) reported that the incidence of marital rape was twice that of stranger rape in a sample of over 900 women (cited in Pagelow, 1988; Pagelow, 1992; & Petrectic-Jackson, 1990). Non-DV SA victims have a 20% chance of being sexually assaulted by a complete stranger (Pagelow, 1988). DV survivors often experience PTSD symptomatic outcomes of the battering they have endured, similar to the PTSD that SA survivors experience in the aftermath of the trauma. In terms of the services offered to DV survivors, the centers which serve DV survivors often also serve SA survivors, and vice-versa, resulting in much overlap regarding the clientele and staff/volunteers of those centers.

Definition and Prevalence

In order to demonstrate the magnitude and aftermath of DV, details regarding the definition and prevalence of DV will be presented. Domestic violence entails "verbal and psychological as well as physical acts of aggression" (Margolin, Sibner, & Gleberman, 1988, p. 93). A battered woman is generally defined as a woman who has "experienced physically injurious behavior at the hands of men (or partner) with whom they once had, or were continuing to have, an intimate relationship" (Margolin et al., 1988, p. 93). Usually the person enacting the violence does so in order to exert dominance and engender fear in the victim.

Compared to research on sexual assault survivors, less definitive information was discovered regarding the statistics of DV survivors. However, the common statistic

regarding the prevalence of battering, that every 15 seconds a woman is battered, demonstrates the epidemic nature of this atrocity (Delk, 1998). "The FBI estimates that one out of every two women will be physically abused at some point in her life by a man with whom she lives" or is intimate with (Denton County Friends of the Family; The Book of Resolutions of the United Methodist Church). "The U.S. Surgeon General has cited family violence as the number one cause of injury to women" (Denton County Friends of the Family). It is also known that "battering accounts for more than 25% of emergency visits by women...[and]...fewer than 1 in 25 are accurately diagnosed," according to Stark et al.'s (1981) paper presentation (as cited in Pagelow, 1992, p. 90).

Symptomatology

Saunders (1994) suggests that domestic violence survivors indeed suffer, not only at the hand of the batterer, but through the reliving and unwanted intrusion of cognitive material and other remnants of the abuse. Saunders (1994) examined two groups of survivors from five states "in order to develop a profile of posttraumatic symptoms experienced by battered women" (p. 40). The larger group ($n = 159$) comprised women who had obtained help at domestic violence programs and shelters (DVP) while the smaller group's ($n = 33$) participants were recruited from other programs (NDVP) or sources. The largely white (91.4%) sample averaged an eight-year relationship with the abuser, with a substantial minority sustaining a permanent (22.6%) or severe injury (16.8%).

Results of the completed questionnaire packets (addressing PTSD, fear, depression, self-esteem, partner characteristics, conflict, and injuries) indicated that

intrusive memories, the most common problem, affected 90% of all women. About 75% of the entire sample also experienced many other symptoms such as hyper-arousal, nightmares, and a tendency to avoid reminders of the abuse. "More of the DVP than the NDVP women reported 'feeling ashamed of being alive'" (p. 38) as well as significantly higher rates of seven of nine symptoms tapped by the Diagnostic Interview Schedule: PTSD Symptoms. Sixty percent of the DVP group and 62% in the NDVP group met the diagnostic criteria for PTSD with the DVP group tending to manifest greater numbers of symptoms. About 60% of all the women had symptoms lasting over 6 months.

Saunders (1994) demonstrated that DV survivors indeed are not immune to the actions of their abuser, physically or emotionally, and that DV has serious consequences. The fact that women who seek help from shelters experienced greater numbers of symptoms is especially salient for the staff that have close daily contact with these suffering women, and bears considerable relevance on the current study. Even though there are no published studies regarding the possible vicarious effect of working with domestic violence survivors with PTSD on the staff and volunteers that service those shelters, this researcher hypothesizes that staff and volunteers are not immune to the survivors' emotional and/or physical struggles. Specifically, in this research, staff and volunteers at domestic violence shelters were examined for possible vicarious and secondary assimilation of the survivors' traumatic material.

Others' Responses to Trauma Survivors

Now that we have briefly examined what it means to be a SA or DV survivor, we turn to an examination of those who work with SA and/or DV survivors: the staff and

volunteers that populate SA and DV centers and shelters. As this research explore the concepts of VT and STS, the documented responses of the staff/volunteers to the SA and/or DV survivors served are of particular interest. First, however, let us begin by enumerating the various types of therapist responses to clients that have been observed and recorded: countertransference, burnout, STS, and VT. After a short introduction and description of countertransference, the original concept explaining therapist's responses to clients, we will examine in greater detail the literature pertaining to the concepts the investigator is most interested in exploring: BO, STS, and VT.

Before commencing the analyses and discussion of others' responses to trauma survivors, it is helpful to imagine the current literature regarding others' responses to trauma survivors as a spiral, in its focus. As one follows the spiral inwards, the research methodology and subjects become more focused in design and sample, and more relevant to this proposed study. The concepts of CT and BO might occupy the outermost ring. Research on significant others of trauma survivors might represent the next inner ring; still important for the topic of STS and VT, but not as useful. Mental health professionals who help persons suffering the trauma of medical and life-threatening illnesses might inhabit the following inner rings, moving closer to the center. The next few rings represent further specificity towards this proposed research subject population (SA and DV counselors/volunteers), in the form of qualitative data, until the center of the spiral is reached. The center is inhabited by quantitative research directly related to SA volunteers and therapists. First we briefly examine the outermost rings, beginning with

countertransference, then followed by burnout. Later we turn to the more focused topics of STS and VT.

Countertransference (CT)

Countertransference (CT) is a phenomenon that has been discussed since Freud's (1910-1912) initial recognition and delineation. It is important to briefly mention CT because this is the first concept that examined and named the counselor/therapist's experiences during the counseling session. Although countertransference is not the focus of this research, the following section on CT is included in order to introduce the concept that therapists have reactions to their clients, and to place CT in its appropriate context in the history of therapists' reactions.

Definitions

There are various definitions of countertransference, ranging from a totalistic definition to a classical definition. Gelso and Fretz (1992, pp. 135) define the totalistic definition of CT as encompassing all of the counselor's emotional reactions to the patient. One of the classical definition dictates that CT is the "counselor's transference to the client's transference" (p.135). Only client transference reactions can trigger the counselor's transference. A more approachable definition, argue Gelso and Fretz, represents CT as "the counselor's transference to the client's material" (p.135). Giovachinni (1975) and Epstein and Feiner (1979) both argue that CT is "an internal experience in the counselor" (as cited in Gelso & Fretz, 1992, p.136). Although there has been much discussion regarding the nature of CT, less research has transpired on this

subject (see Gelso & Fretz, 1992, pp. 135-136, for a discussion of CT and a list of empirical studies).

Countertransference and Trauma Therapists

McCann and Pearlman (1990) suggest that the concept of CT is inadequate to describe the life-pervasive effects of working with trauma victims. They suggest that a version of the traditional definition of CT ["the activation of the therapist's unresolved or unconscious conflicts or concerns" (p.134)] and even the common definition used in the victimization literature [a definition which more broadly incorporates "the painful feelings, images, and thoughts that can accompany" (p. 134) trauma work] are both too narrow because they do not address the pervasive and "lasting alterations in [the therapist's] cognitive schema" (p. 136). These pervasive alterations have a "significant impact on the therapists' feelings, relationships, and life" (p. 136) and occur as a result of working with trauma survivors.

Stamm (1997) believes that "countertransference is a broader topic that refers to our reactions to our clients and their material. It may direct our therapeutic choices and it is a state condition tied directly to the patient" (p. 1). CT is different from vicarious traumatization, Stamm argues, because ST produces "more trait-like changes to our values, beliefs, and behaviors" (p. 1). She argues that VT "always arises as a result of exposure to a client's traumatic material" while CT occurs "outside of the context of exposure to traumatic material" (p. 1). CT "applies more to how our patients affect our work with them, VT is about how our patients affect our lives, our relationships with ourselves, as well as our work" (p. 1).

Countertransference Reactions to Trauma Work

Neuman and Gamble (1995) delineate several types of countertransference reactions specifically useful in analyzing the effects of working with trauma clients on the therapist/counselor. Many of these reactions particularly apply to the new therapist and could possibly extend in application to new volunteers or staff who encounter the trauma survivor. "Common reactions of the new therapist include rescue fantasies and intense preoccupation with clients. Most new therapists experience a strong need not to fail their clients...as well as insecurities about their professional competence" (p.342). Neuman and Gamble (1995) also mention Kauffman's (1992) description of the "countertransference hostage syndrome," a scenario in which "the therapist feels silenced and controlled by the client" (p. 342). "Therapeutic options seem closed off, and the therapist has the sense of losing her own perspective in the face of the client's reality" (p. 342).

Another countertransference theme related to working with trauma survivors involves the discrepancy between the "therapist's personal and cultural mythologies" (their beliefs about human nature) and the nature of the trauma material as revealed to them by the client. In order to reconcile the discrepant information between the therapist's world view and the client's story, "new therapists may deny" (through generalizing, intellectualizing, labeling, or distancing) "their client's experiences in order to safeguard their own cherished beliefs" (p.342).

A fourth countertransference theme involves the "voyeuristic countertransference" response. "While horrifying and painful to hear, client's stories can sometimes evoke

therapists' fascination" (p.342). If left unattended, these fascinations, upon reaching awareness, may induce feelings of shock, shame, and guilt in the therapist and consequently be "projected onto clients in the form of anger" (p. 342).

A fifth theme involves Saakvitne's (1990) conference presentation on "container countertransference" (cited in Neuman & Gamble, 1995) where the therapist is exposed to wide-ranging, extreme manifestations of emotions on the part of the client. The new therapist may alternate between frustration at the client's lack of emotional articulation and overwhelmed feelings in reaction to the client's extreme emotional lability and flooding. These extremities may lead to confusion on the part of the therapist as well as feelings of professional insecurity.

Therapists who are also survivors of sexual violence may have particularly difficult responses to trauma clients' transference. As the therapists may identify more with the client than with the role of a therapist at an early stage of development, coping with the transference dynamics may be too great a strain. "Coping with the transference dynamics of work with trauma survivors puts a great strain on even the most experienced therapists; for those who are just beginning their careers, a common feeling is that of having been thrown into a maelstrom with no lifeline" (p. 342).

Conclusion

In conclusion, the major distinction regarding CT, VT, and STS involves the distinction that CT is mainly concerned with the negative ramifications of the *counselor's* past experiences on the *client*. VT and STS, the main foci of this research, are concerned with the negative ramifications for the *counselor*, directly related to exposure to the

client, not transference of the counselor's past unresolved material onto the client (see final section in literature on comparisons between CT, BO, STS, and VT for more elaboration).

Secondary Traumatic Stress (STS)

The PTSD symptoms discussed earlier in the section on "Survivors' Responses to Trauma" may not only change the trauma survivor, but also others close to the survivor (Figley, 1995a; Waysman, 1993). Figley refers to this as secondary traumatic stress (STS) or compassion fatigue (1995). Accordingly, this next section moves this literature review closer to the topics of interest, by investigating the first concept examining the direct effect of associating with trauma survivors: secondary traumatic stress.

History of the Concept

Figley (1983) first defined "secondary traumatic stress" as the experiencing of considerable emotional duress in persons who have had close contact with a trauma survivor. Later, Figley (1985) commented that "families and other interpersonal networks are powerful systems for promoting recovery following traumatic experiences" (cited in Figley, 1995a, p. 5). He argued that system members can be "traumatized by concern" and that secondary trauma occurs "when the traumatized stress appears to 'infect' the entire system after first appearing in only one member" (Figley, 1995a, p. 5). The individual close to the survivor may then become an indirect victim of the trauma, a secondary survivor (Figley, 1995a). The initial development of this concept resulted from Figley's examination of the family members of individuals traumatized either by natural disasters or war. However, he now recognizes the susceptibility to STS of not

only trauma workers (such as emergency workers), in addition to family members, but also mental health professionals.

In his discussion of the evolution of STS, Figley mentions the various terms that have been used over the years to denote the idea that there is a "cost of caring" for others in emotional pain" (Figley, 1995a, p. 9). Examples of these terms include: secondary victimization, co-victimization, secondary survivor, emotional contagion, rape-related family crisis (specific to rape), "proximity effects" on female partners of war veterans, generational effects of trauma, the need for family "detoxification" from war-related traumatic stress, and "savior syndrome" (see Figley, 1995a, p. 9, for further elaboration of the history of these terms as well as the original authors of these terms). He suggests that currently, "compassion stress and compassion fatigue (CF) are appropriate substitutes" (Figley, 1995a, p. 9) for secondary traumatic stress. He also mentions vicarious trauma, burnout, and countertransference as the most frequently cited references similar to STS. The differences between VT, BO, and CT are discussed later.

Definition

Figley (1993) clarified the definition of STS "as the natural consequent behaviors and emotions resulting from knowing about a traumatizing event experienced by a significant other - the stress resulting from helping or wanting to help a traumatized or suffering person" (as cited in Figley, 1995a, p. 7). Figley explains the process of STS as "a traumatic event (that) forces a person close to a victim to identify and to emphasize" (Figley & Kleber, 1995, p. 95). After time, however, this compassion "becomes a burden" (p. 95), leading to the development of exhaustion. "This energy depletion

characteristic of secondary traumatic stress is, in part, due to one's loss of empathetic ability, as well as the growing inability to find relief from one's reactions through a sense of satisfaction in helping to relieve suffering" (p. 95).

Figley asserts that "there is a fundamental difference between the pattern of response during and following a traumatic event, for people exposed to primary stressors and for those exposed to secondary stressors" (Figley, 1995a, p. 8). Following this delineation, Figley argues that Secondary Traumatic Stress Syndrome (STSD) results from "exposure to knowledge about a traumatizing event experienced by a significant other" (p. 8). Figley stipulates, however, that "STS is a normal and natural byproduct of working with traumatized people. Left unattended, however, STS can lead to STSD" (Figley, 1995b, p. 573).

Psychometric Measure: Compassion Fatigue Self-test for Psychotherapists (CFST)

Figley has recently developed his own instrument to measure his version of secondary traumatic stress/compassion fatigue (1993). The Compassion Fatigue Self-test for Psychotherapists (CFST) has two sub-scales tapping into the dimensions of compassion fatigue and burnout. This instrument is self-administered, self-scored, and self-interpreted; scoring instructions and interpretations are provided in selected publications (Figley, 1995a). Most of the questions inquire about general feelings relating to experiences of trauma; some request this information specifically in relation to working with trauma clients. Other questions tap into fundamental features of burnout, particularly in relation to the work environment.

Stages

R. Remer and R. Ferguson (1995) discuss a model of adjustment and healing in secondary survivors. The model, similar to P. Remer's (1984) model of the survivor's healing process, includes the following (overlapping and interchangeable) stages: (1) pre-trauma; (2) trauma awareness; (3) crisis and disorientation; (4) outward adjustment; (5) reorganization; and (6) integration and resolution (as cited in R. Remer et al., 1995). R. Remer concludes that "healing of the secondary (survivor) is dependent on the healing of the primary (survivor)" (p. 412) and vice-versa. Therapeutic healing needs to address the progression and resources of both participants in the healing process as well as the intervention of the therapist her-/himself. A therapist's resources can become significantly depleted, creating frustration and secondary traumatization/compassion fatigue, and affecting the healing process of all involved (R. Remer et al., 1995).

Symptomatology

The symptoms associated with STSD are nearly identical to the symptoms of PTSD. The main difference between the two is that the person suffering the trauma directly may develop PTSD, while the person close to the victim/survivor, through hearing about the trauma, may develop the corollary syndrome, STSD. In fact, Figley suggests that PTSD should actually stand for Primary Traumatic Stress Disorder (Figley, 1995a, p. 9). "The difference between PTSD and STSD is that the latter can be more directly tied to the adjustment and recovery of the traumatized person: as the sufferer improves, the supporter experiencing STSD improves" (Figley, 1995b, p. 571). First, we examine Figley's proposed criteria for the symptoms of STSD. Then we look more

specifically at the symptoms of significant others and therapists as indicated by the research.

There are three main categories of psychological STSD symptoms, according to Figley (1995a), which can manifest in people (significant others, therapists) who help trauma survivors: (1) re-experiencing of the survivor's traumatic event; (2) avoidance of reminders and/or numbing in response to reminders; and (3) persistent arousal (all explained further in the following section). Additional types of symptoms include (1) physical complaints (i.e. somatic complaints such as headaches, sleep problems, etc.); (2) addictive or compulsive behaviors; and (3) "impairment of day-to-day functioning in social and personal roles" (i.e. lateness, appointment cancellations, etc.; Dutton & Rubinstein, 1995, p. 85). Another type of STSD problem involves relational disturbances, which can occur both in the personal and professional realms. "Personal relationships may suffer due to increased stress or difficulty with trust and intimacy" (p.87). Trauma workers' sensitivity to similar victim-victimizer dynamics in their own personal relationships may also increase. Other indicators of STSD psychological distress or dysfunction include distressing emotions such as sadness, depression, etc. (Dutton & Rubinstein, 1995).

Psychological. Re-experiencing the client's or significant others' traumatic event can occur in several ways: (1) recollections of the event or traumatized person; (2) dreams of the event/traumatized person; (3) suddenly re-experiencing the event/traumatized person; (4) and having distressing reminders of the event/traumatized person (Figley, 1995a, p. 8).

Avoidance/numbing symptoms can involve (1) efforts to avoid thoughts/feelings; (2) efforts to avoid activities/situations; (3) psychogenic amnesia; (4) diminished interest in activities; (5) detachment/estrangement from others; (6) diminished affect; and (7) a sense of foreshortened future (Figley, 1995a, p. 8).

Symptoms of persistent arousal can include: (1) difficulty falling/staying asleep; (2) irritability or outbursts of anger; (3) difficulty concentrating; (4) hypervigilance for the traumatized person; (5) exaggerated startle response; and (6) physiologic reactivity to cues (Figley, 1995a, p. 8).

Therapist-specific STS Responses. In the therapy relationship the counselor may respond to the client's traumatic material in one of two extremes: over-identification or detachment.

The trauma worker may over-identify with the offender and therefore begin to look for "culpable behavior in the victim" or have difficulty with the victim's anger towards the actual offender. The trauma worker may also over-identify with the client to the point of becoming "paralyzed by his/her reactions to the client's traumatic experience," or, alternatively, taking "excessive responsibility for the client's life, perhaps in an attempt to gain control over an overwhelming situation" (Dutton & Rubinstein, 1995, p. 88).

With the over-identified psychotherapist, the survivor has neither safety nor the implicit permission to experience the full impact of his or her traumatic experience, since to do so may be overwhelming for the therapist, whose response

may then be to rescue, derail, or otherwise impede the therapeutic process.

(Dutton & Rubinstein, 1995, p. 88)

While distancing enables the therapist to get a better grip on her/his emotions and vulnerable feelings (by blocking out the traumatic material), "it leaves the client survivor emotionally isolated and alone, detached even from those who are intent on helping" (Dutton & Rubinstein, 1995, p. 88). Through detachment or distancing, "it is easier to exercise authoritarian controlling behavior" (p. 87). Consequently, this detachment may result in sexual misconduct and boundary violations, particularly among "therapists who detach from their own empathetic responses to their clients' traumatic material" (p. 87). "Distancing may also take the form of withdrawal from family, friends, or colleagues, perhaps out of the belief that no one could understand their distressed response to their work" (Dutton & Rubinstein, 1995, p. 88).

Additionally, one risk factor regarding the development of STSD involves a cognitive distortion where the therapist might think "If I have STSD as a therapist, it means that I am not meant for this type of work" (Figley, 1995b, p. 578). Figley feels that

only the most effective therapists are most vulnerable to STSD. Compassion, sensitivity, empathy, and caring are the fundamental building blocks for establishing a therapeutic alliance between therapist and client. Under some conditions, however, these therapist features contribute to the therapist's becoming overly involved with the client's stressful experiences and reactions. (1995b, p. 578-579)

Significant Others

Briefly examining significant others' symptomatology may prove useful when later analyzing the effects of working with trauma survivors on therapists/counselors/staff. The symptomatology of wives of combat veterans is similar to the effects of SA on the survivors' significant others (Davis, Taylor, & Bench, 1995). Some of these symptoms have also been shown to occur among the therapists/counselors of SA survivors.

Secondary traumatic stress, as a concept, has focused on the significant others of trauma survivors. The secondary effects of trauma have manifested themselves in significant others of war veterans, holocaust survivors, and survivors of sexual assault. There is a paucity of research focusing on the significant others of combat veterans, followed by even less research investigating the significant others of sexual assault survivors. However, as we examine the symptomatology of STS, the available research regarding both categories of significant others is touched upon briefly below, providing valuable insight into the pain experienced by individuals close to trauma survivors.

Wives of combat veterans. Some of the particular documented psychological effects on the partners of combat veterans include: loneliness (Solomon et al., 1992), helpless and hopeless feelings, depression, guilt, anger, grief, as well as increased level of psychiatric symptoms, and somatic complaints (Waysman et al., 1993). In Solomon et al.'s (1992) study, the combat veterans wives' problems also consisted of a greater severity in psychiatric symptoms, particularly somatization (and related complaints),

depression, obsessive-compulsiveness, anxiety, paranoid ideation, interpersonal ideation and sensitivity, and hostility.

In another retrospective, descriptive study of therapy group participants who were women partners of Vietnam veterans, the women initially reported increased levels of stress and feelings of worthlessness (Verbosky & Ryan, 1988). In other studies of wives of Vietnam veterans, the wives reported poor self-esteem (Waysman et al., 1993), and views of themselves as righteous victims, in attempt to cope with their partners' PTSD symptoms (Verbosky & Ryan, 1988).

Some documented interpersonal effects on the partners of combat veterans include: isolation, change in level and degree of sexual intimacy, and social rejection (Waysman et al., 1993). The women in Verbosky and Ryan's (1988) study, many whom had entered the group presenting an inability to tolerate their husbands' increases in alcohol/substance abuse consumption, physical abuse, and PTSD symptoms, appeared to have numerous dysfunctional methods of dealing with their partner's PTSD symptomatology. These methods included overcompensating for partners' shortcomings and assuming greater or total responsibility, ultimately enhancing the veterans' dependence. In another study, wives also experienced impaired marital and family relations, and discontent with social network (Solomon et al. 1992).

These studies corroborate previous findings that individuals close to survivors of trauma indeed manifest increased levels of distress, not unlike the stress experienced by the survivor. This also provides further support for the idea that people who work

closely with survivors (i.e. counselors) can also demonstrate increased levels of stress, particularly in the form of secondary traumatic stress.

Symptomatology Antecedents. Solomon et al. (1992) provided possible explanations for the high levels of distress in the wives. One explanation stipulates that close and prolonged contact with a person who has experienced a severe trauma may serve as a chronic stressor, which over time leads to both somatic and psychiatric impairment among wives...consistent with findings about increased levels of distress among spouses of individuals suffering from a variety of chronic mental disabilities. (p. 297)

This statement can arguably be generalized to mental health professionals who work with trauma survivors.

It is possible that secondary traumatic stress could indeed explain the elevated levels of distress as the wives are "contending with some stressors that are unique to the spouses of trauma victims" such as "the veteran's withdrawal and immersion in traumatic memories" (p. 297). Because the wives feel isolated and vulnerable, they may over-identify with the veterans, internalizing "their partner's stressor imagery," eventually feeling and behaving like their traumatized husbands. In fact, the authors found that "the profile of psychiatric and somatic symptoms displayed by these wives in many ways parallels the findings of our team regarding the veterans themselves" (Solomon et al., 1992, p. 297). The wives' symptoms are very similar to burnout symptomatology (isolation), and STS/VT symptomatology (internalizing of imagery, over-identification).

Solomon et al. (1992) also stipulate that "irrespective of whether or not the soldier sustained a combat stress reaction during the war, wives who reported current PTSD symptoms in their husbands were found to have elevated levels of paranoia, interpersonal sensitivity and hostility... loneliness, impaired marital and family relations, and lack of social support" (p. 298). These problems can all "stem from the specific nature of certain symptoms and associated features of PTSD" (p. 298). One final telling point, the fact that the detrimental effects of combat trauma on veterans' wives were shown to be present 6 years after their husbands' traumatic experiences, only provides further support for the concept of secondary traumatization.

Partners of sexual assault survivors. Parallels can be drawn between the pressures experienced by veterans of war and survivors of sexual assault. Ledray (1985) notes that rape survivors are often forced to make quick decisions concerning jobs and homes. As a significant portion of assaults occur in the home, the unsafe home is often quickly (and permanently) abandoned for a different (perceived) "safe" house or apartment. Negative emotional and physical manifestations may create barriers regarding employment. The survivor may find herself quitting a job she "never liked anyway," contributing significantly to the stress experienced by all parties involved. The rape itself may have resulted in longer-lasting physical injuries, creating in the survivor an increased dependence on significant others and consequently lower self-esteem. Friends and loved ones may find themselves distancing and denying the trauma. Additional stress will be created if the survivor chooses to reestablish those relationships (Ledray, 1986). All these effects are similar to what veterans can experience upon returning home after war.

Davis, Taylor, and Bench (1995) analyzed the effects of sexual and non-sexual assault on 138 male and female significant others of the assault survivors. Statistical analyses on the questionnaires (SCL-90-R, etc.) revealed that female family and friends reported greater distress than either male romantic partners or male family and friends, implying that the sex of the significant other, not the nature of the relationship, is the best predictor of distress. Female significant others particularly experienced a greater fear of crime than male significant others. Romantic male significant others were not more distressed than nonromantic male significant others, possibly related to the fact that that most nonromantic significant others were immediate family members. This study sufficiently demonstrates the ripple-like ramifications, in this case, increased levels of distress and fear, of SA on the survivors' sphere of influence.

Conclusion (Significant Others). In conclusion, very limited research has been conducted on the effects of trauma on the significant others of sexual assault survivors. However, some research has been conducted on PTSD (perceived) and CSR (diagnosed) veterans' significant others. This research indicates that significant others experience increased degrees of emotional and physical symptomatology, manifestations similar to the symptoms of the trauma survivors themselves (Solomon et al., 1992). As PTSD is typically diagnosed in combat veterans and rape survivors, Solomon et al. (1992) and Waysman's et al. (1993) research can possibly be generalized to the significant others of rape survivors. However, further research specifically addressing the experiences of these "secondary victims" is necessary, especially in assessing the particular needs of

these populations. Figley (1993) and Remer (1995) provide interesting and possibly heuristic conceptual vehicles with which to propel future research.

Professionals (Direct Exposure to Survivors)

In gathering evidence of STS, it is helpful to investigate other types of professionals who encounter trauma survivors frequently and have demonstrated trauma-like symptoms while servicing or responding to this population. Some early research described and investigated PTSD symptomatology in police officers. McCafferty, Godofredo, and McCafferty (1990) initially outlined and described a paradigm of PTSD in police officers, examining current prevalence rates and treatment methods. Loo (1986) examined the stress reactions of 66 police officers involved in shootings, finding that participants "experienced the most stress reactions within three days of the shooting" (p. 27). He found that the average time for officers feeling that they were back to a normal working, social, and family life was 20 weeks.

A very early study by Martin, McKean, and Veltkamp (1986) investigated post-traumatic stress disorder in police relating to their work with victims. Questionnaires distributed at a crime seminar contained a checklist of PTSD (DSM III criteria) symptoms and open-ended questions regarding possible stresses related to victims and any victim-related effect on their empathy. The analyses indicated that 26% of the 53 respondents reported PTSD symptoms following exposure to "psychologically traumatic on-the-job events relating to their own victimization or working with victims" (p. 99). PTSD symptoms were more prevalent among those who had been personally threatened, had their families threatened, or who had reported the chronic stresses of working with

child and spouse abuse or rape victims. "Eighty-three percent of respondents reported that their psychological trauma helped them to be more sympathetic with rape victims" (p. 99). It was also demonstrated that female officers "more openly feel and attempt to deal with the psychological stress of being a victim and working with victims" (p. 101). The authors speculated that this may be related to the females' being exposed to more traumas with which they identified. Additionally, the male officers, as a group, were older and therefore may have more developed coping mechanisms that facilitated emotional distance from the traumas. However, this distancing may detract from empathetic responses from the male officers; indeed the male officers did not describe empathetic responses to the rape victims as often as female officers described.

In conclusion, a significant proportion of police officers reported PTSD symptoms as related to their stress (Martin, McKean, and Veltkamp, 1986). Officers suffered an increased risk of manifesting PTSD symptoms when exposed to multiple stresses. Ultimately, "this study suggests that differences in response to stresses may be related to the degree of identification with the victims, frequency of exposure to victims, and coping styles" (p. 101). Additionally, this study has provided further evidence related to STS as well as a good analysis of possible gender differences in relation to exposure to victims. Two weaknesses involve the utilization of a non-validated questionnaire as well as the limited generalizability of this small and specific sample (females = 19, males = 34).

A recent dissertation (Good, 1996) examined STS symptoms in art therapists ($n = 146$) and other mental health professionals ($n = 106$) utilizing the CFST and the MMPI-2

PK scale (measuring PTSD symptoms). There was no significant correlation between STS and therapists' work with traumatized clients. However, participants with greater STS had a history of PTSD, suggesting a greater susceptibility. There were also significant relationships between STS and (female) gender, and greater years of therapy work with less STS symptoms.

Another dissertation (Lee, 1996), assessing STS symptoms (unspecified instrument) among nationally surveyed marriage and family counselors found a moderate level of STS compared to other (unspecified) sample groups. "Cognitive schemas and level of satisfaction with total case load were significantly correlated with STS. Hours spent listening to client traumatic material were significantly correlated with the Intrusion sub-scale of the Impact of Events Scale" (Lee, 1996, p. 4586).

Truman's (1997) dissertation investigated STS and PTSD in trauma counselors (N = 54) who work with survivors of crime-related, war-related, or natural disaster-related trauma. She found that while most participants reported experiencing some symptoms of STS reactions (unspecified instrument), only two had high enough scores on the PTSD instruments to indicate post traumatic stress reactions.

Vicarious Traumatization (VT)

Now that we have examined the first construct (STS) addressing traumatic responses resulting from exposure to trauma survivors, we can turn to the latest manifestation regarding this concept: vicarious traumatization (VT). VT has gained further interest and credibility as a research topic in the last decade, becoming an increasingly salient topic for therapists and other individuals who help the trauma

survivor, particularly those who help sexual assault survivors (Cunningham,1995; Kassam-Adams, 1996; McCann & Pearlman, 1990; Pearlman & Mac Ian, 1995; Remer & Ferguson, 1995; Schauben & Frazier, 1995). VT is a process that can manifest itself in persons who work with victims of trauma. The helper suffering vicarious traumatization "may experience profound psychological effects, effects that can be disruptive and painful for the helper and can persist for months or years after work with traumatized persons" (McCann & Pearlman, 1990, p. 133). It is believed that working with trauma survivors can elicit reactions considerably different from working with other difficult populations because the therapist "is exposed to the emotionally shocking images of horror and suffering that are characteristic of serious traumas" (McCann et al., 1990, p. 134).

Definition

Specifically, Pearlman and Saakvitne define VT as the permanent "transformation in the therapist's inner experiences resulting from (the cumulative) empathic engagement with clients' traumatic material" (1995, pp. 151). This transformation involves "significant disruptions in one's sense of meaning, connection, identity, and world view, as well as in one's affect tolerance, psychological needs, beliefs about self and others, interpersonal relationships, and sensory memory, including imagery" (Pearlman & Saakvitne, 1995, p. 151). These

profound changes in the core aspects of the therapist's...psychological foundation...include shifts in the therapist's identity and world view; in the ability to manage strong feelings; to maintain a positive sense of self and connect to

others; and in spirituality or sense of meaning, expectation, awareness, and connection; as well as in basic needs for and schemata about safety, esteem, trust, dependency, control, and intimacy. (Pearlman & Saakvitne, 1995, p. 152)

Pearlman and Saakvitne also add: "the therapist is vulnerable to intrusive imagery and other post-traumatic stress symptomatology" (1995, p. 152).

Psychometric Measure: The TSI Belief Scale, Revision L (BSL)

This scale, developed by the most visible advocate of vicarious trauma, Pearlman, is based on "Constructivist Self Development Theory" which "draws upon and integrates self psychology, object relations, interpersonal and social cognition theories" (Pearlman, 1996, p. 415). This instrument measures disruptions in cognitive schemas, or beliefs/needs about self and others, that arise from psychological trauma or from vicarious exposure to trauma through psychotherapy or other helping relationships (Pearlman, 1996). Scores obtained include a total score (a higher score indicating more disruption) and 10 sub-scale scores (average scores) which indicate relative disruptions of the five need/schema areas as they relate to the self and to others: self-safety, other-safety, self-trust, other-trust, self-esteem, other-esteem, self-intimacy, other-intimacy, self-control, and other-control (Pearlman, 1996). "Other" involves how the individual views others in relation to the schema, such as how safe others are. "Self" involves how the individual views her/his own ideas regarding a schema, such as how safe s/he feels. [See the "Methodology" section regarding their measure, the TSI Belief Scale, Revision L, for an in-depth description of their 10 cognitive schemas.]

Symptomatology

The helper suffering vicarious traumatization may "experience profound psychological effects, effects that can be disruptive and painful for the helper and can persist for months or years after work with traumatized persons" (McCann & Pearlman, 1990, p. 133). The main symptoms of vicarious trauma, as identified and theorized by the major proponents in the field (McCann and Pearlman) involve cognitive shifts. The other symptoms associated with VT involve intrusive imagery.

Cognitive. In McCann and Pearlman's (1990) elaboration of the concept of vicarious traumatization, they propose that the therapist's cognitive world can be altered by verbal exposure to the client's traumatic material. These changes in cognitive schema likewise significantly affect the therapist's feelings, relationships, and life. The effects of this disruption and transformation of cognitive schema then become hinged upon the "centrality or salience of these schemas" to the therapist (p. 137).

Intrusive imagery. One area in which the therapist may experience disruption involves their imagery system of memory. The experiencing of painful images and emotions associated with the client's traumatic memories may incorporate themselves into the therapists' memory systems. This re-experiencing or avoidance of aspects of their client's traumatic memories becomes tangible in the form of flashbacks, dreams, painful emotional reactions, or intrusive thoughts that invade the therapist's life (McCann & Pearlman, 1990). At this point, distinguishing therapists treating trauma survivors from the trauma survivors themselves becomes a question of degree and circumstance.

Risk Factor: Victimization History

One frequent investigation entails the service provider's own history of victimization. Several studies indicate that a history of victimization is related to greater levels of PTSD-like symptoms, or vicarious traumatization. Pearlman and Mac Ian (1995) found that trauma therapists with a personal trauma history demonstrated more negative effects from the work than those without a personal history. Follette, Polusny, and Milbeck (1994) also found that members of both professional groups (law enforcement and mental health professionals) with a history of childhood abuse reported significantly higher levels of trauma survivor-like symptoms than their non-abused counterparts.

Cunningham (1996) found that social workers/clinicians with "a history of sexual abuse (17%) were significantly more likely to work with sexually abused clients" (p. iv). They also "reported significantly more disruptions on the self-safety, self-esteem, and other-esteem sub-scales of the BSL. When history of sexual abuse was controlled for, there were still significant differences between the clinicians who worked with sexual abuse survivors and those who worked with cancer patients" (p. iv). Kassam-Adams (1995) also found that therapists' personal history of victimization (particularly childhood trauma) significantly predicted trauma symptoms. Van de Water (1996) found that "therapists with a history of incest or rape experienced a very high degree of difficulty in personal relationships. However, having a history of domestic violence was related to less difficulty with professional relationships" (p. 2168). O'Malley Reyntjens and Rubin (n.d.) found that a trauma history was positively related to all dependent measures

(Impact of Events Scale: total score, Intrusion sub-scale, Avoidance sub-scale and Trauma Work Impact Scale). Specifically, trauma history significantly predicted trauma distress. Schauben and Frazier (1995), Green (1996), Simonds (1997), Walton (1997) however, all found that counselor VT, STS, or PTSD symptomatology was not related to counselors' own history of victimization.

Professionals with Vicarious Trauma

Introduction. As the present research seeks to understand and demonstrate the presence of vicarious traumatization in SA and DV counselors/staff/volunteers (mental health professionals), the following discussion of the current VT literature bears substantial significance in the validation of VT as a viable research topic concerning this population. Most of the research investigated below involves the use of professionals as subjects, indicating a need for research on volunteers. However, even the research on professionals is embryonic, needing further exploration. Further research on both volunteers and professionals will aid in determining the full implications and intervention/prevention of VT in reference to the helping professions.

Mental health professionals: AIDS group therapists. One study investigating secondary trauma in therapists examined the effects of working with AIDS groups (Gabriel, 1994). This was the only article specifically investigating secondary/vicarious trauma in mental health professionals who conduct group therapy for people with AIDS. This article differs from the earlier AIDS articles described in the burnout section on several accounts. The perspective of this article includes reflections of the traumatic nature of working with AIDS clients, and the possible vicarious reactions to such clients

(there is no detailed discussion of burnout by this author). Also, this article is descriptive, rather than empirical. Additionally, this research makes use of previously existing paradigm of reactions (Lifton's survivor themes), applying this paradigm to the present concern of working with AIDS clients.

This study examined the traumatizing effects of multiple AIDS-related deaths of group members on therapists. The observations were derived from Gabriel's six years of working with group therapists providing therapy to persons with AIDS. Although the evidence offered in this article is highly subjective and not assessed with systematic empirical measures, Gabriel (1994) offers insight into the experiences of the AIDS group therapist.

Gabriel categorizes group therapists' reactions to the deterioration and death of group members from AIDS according to Lifton's survivor themes (as cited in Gabriel, 1994) which include "death imprint, survivor's guilt, psychic numbing, suspicion of counterfeit nurturance, and the survivor's struggle for meaning" (p.170). The "death imprint" refers to "indelible images" of death, including "grotesque and absurd forms of death" (p. 170). This imagery ranges from gas chambers, for Holocaust survivors, to the "sunken" and "wizened faces" (p. 170) of persons with AIDS, as articulated by group therapists. Smells similar to what can be found in hospitals can also become a death imprint, as some therapists have reported.

Therapists have expressed guilt in the manner of "It made me too guilty to go on living when so many are dying" (p.171). This guilt is born out of "the survivor's inability to act in a way they deem appropriate (i.e. saving people)" (p. 171). The "diminished

capacity to feel" can be identified as "psychic numbing" (p. 171). This manifests itself in therapists as an "affectless manner of recounting events, such as reporting deaths, describing hospital visits, discussing member's physical deterioration, and recounting funerals and memorials" (p. 172).

"Suspicion of counterfeit nurturance refers to the shattering of the survivor's basic moral assumptions about the world" (p. 173). Survivors (in this case, AIDS group therapists) who bear witness to living and dying devoid of logic begin to view the world as counterfeit and illusory. These therapists become mistrustful of relationships as well as antagonistic. This transformation of worldview involves the concept of contagion. "Survivors feel they are treated as carriers of the horrors they have witnessed" (p. 173) and begin to feel isolated by their work, especially when newly informed people, in their reactions to the therapist's (survivor's) job description, speak sentiments such as "I could never do that kind of work" (p.173).

The final feature comprising the survivor's experience involves the struggle for meaning. Essentially, the survivor is struggling to reinstate the appearance of a moral universe. This can be seen through developments such as the National Quilt Project, AIDS fundraising, and media-notification and bombardment.

In conclusion, Gabriel is essentially suggesting, through anecdotal experience of longitudinal observation, "that group therapists who experience deaths of group members from AIDS are currently manifesting many of the traumatic stress symptoms observed in trauma survivors" (1994, p. 174). Unfortunately, this article relies solely upon subjective

observation, but the merit of Gabriel's analysis and interpretation nonetheless rests in the insight and theory provided regarding VT.

Other professionals (indirect exposure to SA survivors). Another population to examine for presence of VT involves professionals that are exposed to trauma survivors indirectly, such as reading case material or hearing about trauma through a secondary source. This population might be termed 'indirect secondary survivors.' The following study demonstrates the power of indirect, distanced exposure to traumatic material. In fact, the undeniable influence of written case study material on neutral, unaffiliated research assistants, such as the nurses depicted in the study below, is especially frightening because of the lack of human interaction involved in the process of VT acquisition. The nurses never met any survivors of the case studies they read and transcribed, yet many of their cognitive schemas and physical responses were (negatively) altered.

Alexander et al. (1989) investigated parallel reactions between sexual trauma survivors and the researchers whose work intersected with survivors of trauma: five nurses who recorded data from sexual assault cases. Over three months the nurses reviewed and coded data on 1,215 rape crisis center records in order to analyze demographic predictors of sexual abuse. The nurses were all experienced with the issue of rape in a clinical context. None of the nurses had any direct contact with the survivors or the assailants; the nurses only had contact with the researchers.

During the meetings with the researchers, while discussing reactions and feelings, it became obvious that the nurses were experiencing reactions that could indicate Rape

Trauma Syndrome (similar to PTSD). Upon categorization, the five areas of the nurses' similar reactions involved emotional responses, somatizing, sleeping disorders, increased caution, and need for social support. The nurses experienced anger at the victim, assailant, and husband of the victim, anxiety, fear of self and children being harmed, of being raped, and of men as strangers. The nurses also found themselves blaming the victim, selectively attending during data collection, limiting time of data collection or leaving early, and feeling sadness (Alexander et al., 1989).

The SA survivors in the case studies reported being angry at themselves for feeling anxious and for being afraid of being alone, at home, and raped again. Blaming self, avoiding reminders of rape, and depression were also reported by the SA survivors. All of these reactions are similar to the reactions the nurses developed in response to constant indirect exposure to case material (Alexander et al., 1989).

In the somatizing realm, both researcher/nurse and SA survivor reported experiencing pain (the survivor experienced pain specific to the area of assault while the researchers' was general) and nausea. In addition, the survivors experienced eating disorders and crying. Both survivor and researcher experienced insomnia and nightmares. In the other areas of caution and social support, similar reactions were experienced by both survivor and researcher (Alexander et al., 1989). The authors neglected to address any possible SA victimization history of the nurses. However, although these reactions and data are highly subjective and are not corroborated with systematic and qualitative instruments and measures, the frightening similar accounts and

patterns of nurse/researcher and survivor alike speak of the need for serious investigation into vicarious traumatization.

This article, although observational in nature, parallels finding of the STS literature. Many of the PTSD-like symptoms ascribed to the nurses parallel the identified symptoms of STS in combat veterans' wives, SA survivors' significant others, and police officers. This article is also similar to early descriptive articles on BO (to be examined later, in the “Burnout” section), where the focus of the article involved describing and naming the process and characteristics of burnout (nurse/researchers' trauma-like reactions, in this case, rather than BO). It is the structure of the article, the descriptive element, which is most like early BO literature, rather than the content.

Mental health professionals (direct exposure to perpetrators). Reactions similar to those experienced by individuals with vicarious traumatization due to exposure to SA survivors were also found among therapists working with sex offenders (Farrenkopf, 1992). In this study, 24 therapists responded to a structured questionnaire regarding the impact of working with sex offenders. Over half (54%) reported "diminished hopes and expectations," an increase in cynicism and pessimism, and a decrease in naiveté. Additionally, 42% acknowledged rising anger and frustration as well as a "hardening or dulling of emotions."

Personal coping strategies were also investigated. Emotional distancing was also present among the therapists, not only towards their clients, but also towards their social circles. Some did experience greater sensitivity and empathy (17%). "Almost one-third felt they were more hypervigilant and suspicious of others and more protective of their

own or their family's personal safety. Some therapists saw potential abusers everywhere" (p. 219). When gender differences were examined it was found that "female therapists (n = 20), in particular, reported more fearfulness, even nightmares" (Farrenkopf, 1992, p. 219), as well as paranoia, than male therapists (n = 4).

The following theoretical perceived stages/phases of impact were gleaned from the participants' responses: (1) shock, (2) the "Mission," (3) "anger," and (4) erosion or adaptation. Stages 1-3 comprise the reaction phase configuration. Stage 1 (shock) involves the prominent feeling of fear and vulnerability. In Stage 2, the "Mission", emotional repression and desensitization are implemented to empathetically provide treatment. In Stage 3, anger is present. This Stage is characterized by repressed emotions, anger, confrontation, intolerance of criminal thinking, and loss of idealism.

The final and fourth stage consists of two possibilities: erosion or adaptation. In the erosion possibility, anger and intolerance increase to resentment; depression and exhaustion is prevalent; and burnout can occur. In the adaptation possibility, the participant becomes even more detached, lowers expectations, and tolerates the human dark side in order to regain therapeutic motivation and compassion. The above phase progression determined in this study "resembles the trauma/grief cycle" which includes "shock, fear, repression, anger, depression, and finally acceptance/recovery" (Farrenkopf, 1992, p. 22).

Some strengths of this study involve the fact that specific reactions identifiable as aspects of vicarious traumatization were found. Emotional distancing and repression, anger, hypervigilance, fearfulness and nightmares were tangible reactions experienced by

the therapists, particularly the female therapists. Certainly 24 therapists (and only 4 male therapists) constitute a small sample size, but this study nonetheless corroborates the concept of vicarious traumatization, with concrete data obtained from structured (but unvalidated) questionnaires inquiring about the personal impact of working with sex offenders, perceived phases of impact, and personal coping strategies. The examination of gender differences was also beneficial.

This article possesses similarities to the STS literature regarding the small sample size, methodology (examining symptomatology), and obtained results (therapists' trauma-like reactions). The examination of coping is similar to one prevalent goal of the burnout literature. The BO literature tends to examine how methods of coping, particularly social support, mediate BO manifestation.

A recent dissertation (Moore, 1998) also investigated the traumatic effects therapists ($N = 75$) can experience following their work with sexual abuse perpetrators. Results indicated that less experienced therapists had significantly greater short-term trauma symptoms (unspecified instrument) while therapists in the middle range of experience had greater long-term stress in the form of disrupted beliefs (compared to therapists with more or less experience).

Mental health professionals (direct exposure to trauma survivors). Now we turn to the center of the spiral. The following analysis on mental health professionals and VT is especially in-depth, as this population bears direct significance and relevance to the population (SA and DV counselors/volunteers) of this study. This portion of the literature analysis particularly supports and validates the concept of VT and the need for

further research. Overall, this segment of the literature has been better tested with more precise methodology, in-depth demographics, use of validated and multiple instrumentation, larger and more random sample sizes, and a greater theoretical development and application of the results. Therefore, this segment (VT) occupies the central domain of this research and is the construct by which all other relevant concepts (CT, STS, BO) are compared and contrasted.

Lobel's (1997) qualitative (semi-structured open-ended interviews) dissertation investigated vicarious effects in 10 therapists who treat female survivors of adult sexual assault. Lobel found that seven out of ten participants experienced negative long-term changes in cognitive schema (particularly the frame of reference schema) and eight out of ten reported positive changes in schema (particularly the esteem schema) and vicarious enrichment (positive effects from work). Only three participants reported no vicarious traumatization.

Follette, Polusny, and Milbeck (1994) investigated the impact on professionals of working with populations experiencing trauma. This study particularly affirms the personal dangers and stresses associated with working with survivors of trauma, demonstrating a relationship between working with trauma survivors and various types and degrees of service provider distress. In this study, 225 mental health professionals (licensed professional counselors and marriage and family therapists) and 46 law enforcement professionals (trained police officers) answered questionnaires regarding distress and trauma.

Results indicate that mental health professionals experienced relatively low levels of general psychological distress, trauma symptoms, and PTSD symptoms while reporting moderate levels of personal stress (Follette, Polusny, & Milbeck, 1994). Law enforcement professionals, however, were significantly more distressed than mental health professionals on all measures of psychological symptoms (trauma, general psychological distress, and PTSD symptoms). This can possibly be attributed to the greater percentage of mental health professionals seeking personal therapy (59.1%) in comparison to law enforcement professionals (15.6%), as well as theorized differences in training and work tasks. Additionally, for both law enforcement and mental health professionals, the percentage of their clients reporting sexual abuse history was not related to trauma symptoms in the professionals (Follette, Polusny, & Milbeck, 1994).

This study, although finding little evidence for the specific effects of secondary traumatization, successfully identified specific helping populations more prone to experiencing general trauma symptoms and personal stress (Follette, Polusny, & Milbeck, 1994). Strengths involve the use of a large sample size ($N = 271$) and standard questionnaires. However, subjects were self-selected and answered self-report questionnaires. Additionally, neither gender nor race was examined.

One major study demonstrating deleterious VT effects on therapists working with trauma survivors comes from Pearlman and Mac Ian (1995). This study validates the need for additional analyses of therapists' experiences of VT. Pearlman and Mac Ian distributed questionnaires to counselors, receiving completed questionnaires (a 32% return rate from 136 females and 52 males) from self-identified trauma therapists who

volunteered to participate in an investigation analyzing the effects of trauma work on therapists. The subjects were primarily white (93%) and had worked with trauma survivors an average of 9.59 years. Independent measures included the therapists' experience with trauma clients as well as their own trauma history. Dependent measures were examined through the TSI (Traumatic Stress Institute) Belief Scale, the Impact of Event Scale (measuring avoidance and intrusive signs and symptoms of PTSD), the Symptom Checklist-90-Revised (differentiating general distress from trauma-specific distress), and the Marlowe-Crowne Social Desirability Scale (assessing the participants' need for approval from authority).

Pearlman and Mac Ian (1995) found that those therapists without a trauma history and who had been doing trauma work longer were affected in the area of other-esteem. Those newer to the work (less than 2 years) had more disruptions in self-trust, self-intimacy, and self-esteem, as well as higher SCL-90-R symptoms. By breaking down years of work experience, this study was able to begin investigation of possible time-related VT patterns. This study provides a good model for a validation study. The authors found a .61 intercorrelation between the TSI Belief Scale total score and the SCL-90-R total score.

Cunningham (1996) conducted her dissertation on the vicarious traumatization of two groups of clinicians (working with cancer patients versus sexual abuse survivors; $N = 182$; average age = 46) enlisted through two professional organizations which address cancer and sexual trauma, respectively. The clinicians were predominantly female ($n = 149$) and social workers ($n = 173$). Using the TSI Belief Scale, Revision L, (TSI-BSL; to

measure disrupted cognitive schemas) and the Impact of Event Scale (IES; to measure intrusive/avoidant PTSD symptoms), she found that clinicians working with sexual abuse survivors were more negatively effected than those working with cancer patients. Clinicians working with sexual abuse survivors "reported more disruptions in several cognitive schemas on the TSI-BSL, including the safety schemas, other-trust, and other-esteem. However, those with higher percentages of sexually abused clients reported fewer PTSD-like symptoms on the IES, a statistically significant finding, but in the opposite direction predicted. Those who worked with cancer patients reported significantly less disruptions in the safety schemas" (Cunningham, 1996, p. iv). She also found that "for all subjects, years of experience correlated positively with several subscales of the BSL" (Cunningham, 1996, p. iv).

Kassam-Adams' (1995) unpublished dissertation examined the presence of vicarious trauma in 100 psychotherapists (in mental health out-patient settings) treating sexually traumatized clients. She found that therapists' level of PTSD symptoms (as measured by the Impact of Events Scale) was significantly related to higher levels of exposure to sexually abused/assaulted clients (Kassam-Adams, 1995). Therapists' gender and personal history of victimization (particularly childhood trauma) significantly predicted trauma symptoms.

Van de Water's (1996) dissertation also investigated the effects of trauma survivors on 130 female and 35 male therapists, utilizing an instrument specifically designed by Van de Water to measure therapists' reaction to trauma work (The Trauma Work Impact Scale, .90 reliability). Van de Water found that therapists with a high

percentage of survivors (76% or above) indicated increased concern for others' safety and that female therapists had high concerns for their personal safety. Also, feeling adequately trained for trauma work related to less work-related burnout, and having children was associated with less difficulty in listening to trauma material, as well as negative feelings toward survivors and difficulty in professional relationships.

Walton (1997) also investigated vicarious traumatization in 165 nationally sampled therapists utilizing the TSI-BSL, Impact of Event Scale-Revised (IES-R), and Interpersonal Reactivity Index (IRI) to measure cognitive schema disruptions, PTSD symptoms, and empathy style. The participants indicated that they spend an average of 16.82 hours per week providing direct therapy to trauma survivors. Results indicated that for the IRI, the personal distress empathy style ("experiencing feelings of discomfort and anxiety when witnessing the negative feeling of others") was the best predictor of PTSD symptoms, and for the TSI-BSL, the self-control cognitive schema ("need to be in charge of one's own feelings and behaviors") was the best predictor of PTSD. Additionally, cognitive schema disruptions and PTSD symptoms significantly correlated.

O'Malley Reyntjens and Rubin (n.d.) investigated vicarious traumatization and spirituality matching in 102 trauma therapists utilizing the IES, the Trauma Work Impact Scale (TWIS) and the Spiritual Well-Being Scale (SWBS). Results indicated that lower levels of therapist existential spirituality (SWBS) was significantly related to higher trauma symptomatology (IES, TWIS). Supervised therapists had higher levels of trauma distress (IES). Therapists with a personal trauma history had higher levels of trauma distress (IES) and vicarious traumatization (TWIS). Therapists with 50% or greater

trauma client caseload demonstrated significantly higher vicarious traumatization compared to therapists with a lower percentage caseload. Younger age and less experience with trauma survivors were other significant predictors of greater vicarious traumatization and trauma distress.

Schauben and Frazier (1995) published research highly relevant and meaningful for this present study. Their population (counselors who work with sexual assault survivors) is especially relevant as this research investigates the effects of working with SAs on rape crisis center staff and volunteers. Their methodology (self-administered questionnaires such as the MBI and TSI-BSL) is particularly significant as this study also utilizes those two measures, among others.

In this very noteworthy study, Schauben and Frazier (1995) examined the effects on female counselors of working with sexual violence survivors. They hypothesized that the percentage of sexual violence survivors in a counselor's caseload is positively associated with disruptions in beliefs, PTSD symptoms, vicarious trauma, and negative affect. They also examined how a counselor's reactions might be affected by their own victimization experiences. Psychologists ($n = 118$) and sexual violence counselors ($n = 30$) completed the TSI Belief Scale (measuring safety, self-trust, other-trust, other-esteem, and other-intimacy; the components affected by vicarious trauma), the Brief Symptom Inventory (four sub-scales measuring anxiety, hostility, depression, obsessive-compulsive symptoms; with established reliability and validity), the Maslach Burnout Inventory (also containing established validity and reliability), and COPE (a coping strategies list developed by Carver, Scheier, & Weintraub, 1989).

PTSD was assessed with a non-validated symptom checklist developed from DSMIII-R criteria by the authors. Vicarious trauma was assessed with a 5-point scale developed by the authors, not described in the article. This measure reportedly significantly correlated with PTSD symptoms, negative affect, and disruptions in beliefs. The qualitative open-ended data (with a 78% and 77% inter-rater reliability) concerned the five most difficult and the five most enjoyable aspects of working with sexual violence survivors as well as additional coping strategies.

Statistical analyses indicated that counselors who worked with more sexual violence survivors reported more disrupted beliefs about themselves and others, more PTSD-related symptoms, and more vicarious trauma. Working with survivors did not appear to be related to more general measures of negative affect nor was it related to burnout. Counselor symptomatology was related to percentage of clients in caseload, not their own history of symptomatology.

Although this was the most comprehensive study assessed (and therefore the study most exhaustively analyzed for strengths and weaknesses), flaws were still evident. Only white women were surveyed (limiting generalizability), the questionnaires were self-administered, and participants were self-selected. They neglected to examine the training the counselors received or whether victimized counselors worked through the sexual abuse history through personal therapy. They also did not examine the relationships between years of general experience, income, age, and level of vicarious trauma.

The authors utilized some newly constructed measures with no proven validity and reliability to determine the particular psychometric properties of the instruments. Although necessary for the calibration of new measures, this unfortunately detracts from the usefulness of the instruments until replication with similar results occurs. The present research is designed to replicate some of their results, also extending them by examining the presence of VT in domestic violence shelter staff/volunteers. This research also extricates differences between STS, VT, and BO.

Additionally, it would have been beneficial to observe exact group comparisons of counselors' years of experience (split up counselors by groups of 6 months experience, 1 year, etc.). Separating counselors' years of experience might help determine patterns of VT development. There may be a 'peak time' of development, such as initial exposure or prolonged exposure. Determining a particular pattern or period of likely VT would enable centers to provide better support mechanisms at the appropriate time. Finally, more information regarding counselors' victimization experience (assaulted by whom, what age) would have been enlightening. Some hearty strengths, however, include the use of some valid measures, a relatively large subject population, in depth demographics, and the inclusion of open-ended questions resulting in individualized data pointing to future areas of research.

Conclusion. In conclusion, the previous VT research indicates that VT is indeed present to varying degrees in individuals who come into consistent contact with trauma survivors. McCann and Pearlman's (1990) concept that VT involves pervasive changes to cognitive schemas is supported by the symptomatology and results delineated in the

preceding literature review. Subjects demonstrated a variety of pervasive changes in regards to their work with trauma survivors such as increase in hypervigilance, distrust, avoidance, nightmares, and cognitive schemas. The subjects mainly consisted of therapists and mental health professionals working with sexual assault clientele. There are certain gaps in the literature, however, such as investigations of VT among volunteers (and staff) at SA and DV centers. Also missing are comparisons between BO and VT, as well as validity studies regarding the VT and STS instrumentation. Additionally, discrepancies in the literature exist regarding the effects of a personal victimization history on vicarious traumatization.

Burnout (BO)

It is important to examine burnout (BO) in greater detail because STS, VT, and BO, the three foci of the proposed study, share many similarities. They all tend to result from direct exposure to involving clients and they can result in the obstruction of the mental health providers' services, in addition to other similarities enumerated in subsequent sections. Because of these similarities, it is essential to examine mental health professionals' reactions for the possible evidence of all three concepts. If evidence of the presence of VT/STS is found independent of any evidence of BO, this will ensure that these two concepts are indeed discrete, despite some shared variance. Such a finding will enhance the validity of the concept of VT/STS; the main focus of this research. Examining BO first also provides a contrasting background for the discussion of VT and STS.

Additionally, it has already been established in the known literature that therapists helping "difficult" populations such as seriously ill individuals can experience a wide range of reactions; general distress, burnout, and countertransference among those reactions (Bennett, Kelaber, & Ross, 1993; Bennett, Michie, & Kippax, 1991; Coady, Kent, & Davis, 1990; Cunningham, 1996; Davidson, 1985; Eakin & Taylor, 1990; Kleiber, Enzmann, & Gusy, 1993; Koocher, 1979; Maslanka, 1996; Oktay, 1992; Vistinini, Campanini, Fossati, & Bagnato, 1996). Burnout, however, can have specific meanings for therapists working with trauma victims. For certain therapists, continual exposure to traumatic material that cannot be worked through or integrated may ultimately be expressed as burnout symptomatology. The fact that burnout can mean specific things to trauma therapists necessitates the inclusion of this concept in this proposed study. Furthermore, the fact that "most conceptualizations of burnout have hypothesized a direct link between experienced burnout and a deterioration in the quality of service or care provided to clients" (Maslach, 1982, p. 40) demands investigation into human service providers such as SA and DV staff/volunteers.

Definition and History of the Concept

After studying work-related stress for several years, Maslach (1981) came to define the concept of "burnout" as "a syndrome of emotional exhaustion, depersonalization, and reduced personal accomplishment that can occur among individuals who do people-work of some kind" (cited in Maslach, 1987, p. 98); this is the most widely used definition of burnout. Originally, Maslach defined burnout as occurring when professionals lose "all concern, all emotional feeling, for the persons they

work with," coming "to treat them in detached or dehumanized ways" (1974, p. 16).

Burnout has also been defined as "psychological withdrawal from work in response to excessive stress or dissatisfaction" (Cherniss, 1980, p. 16) and "a coping strategy used when direct-action coping efforts prove futile" (Cherniss, 1980, p. 24).

Freudenberger (1974) first identified and applied the concept of burnout to those who worked in the free-clinic movement, examining how burnout effected the staff of self-help or crisis intervention institutions. In his article on staff burnout, he delineated the physical (fatigue, lingering illness, headaches, insomnia, stomach aches) and behavioral signs (quick anger and frustration, inability to control feelings, suspicion, paranoia, risk-taking behavior, chemical abuse, rigid thinking, negativity, depression, isolation) that can indicate burnout, as well as the type of person most prone (the dedicated and committed).

Maslach (1976) then investigated and generalized burnout to health and social service professionals "who work intensely with others, learning about (others') psychological, social, or physical problems" (p. 16). This was the first major study investigating this phenomenon among a variety of people-workers.

In general, "burnout occurs at an individual level" and "is an internal psychological experience involving feelings, attitudes, motives, and expectations" (Maslach, 1982, p. 31-32). Burnout is also considered to be negative because "it concerns problems, distress, discomfort, dysfunction, and/or negative consequences" (Maslach, 1982, p. 31-32).

Psychometric Measure: The Maslach Burnout Inventory

The instrument most commonly used to measure BO was developed by Maslach and Jackson and is referred to as the Maslach Burnout Inventory (1981). The Maslach Burnout Inventory (MBI) contains three subscales which tap into the following dimensions: (1) Emotional Exhaustion, (2) Depersonalization, and (3) Personal Accomplishment. The Emotional Exhaustion sub-scale describes "feelings of being emotionally overextended and exhausted by one's work" (Maslach & Jackson, 1981, p. 101). The Depersonalization sub-scale describes "an unfeeling and impersonal response towards recipients of one's care or service. For both the Emotional Exhaustion and Depersonalization sub-scales, higher mean scores correspond to higher degrees of experienced burnout" (p. 101). The Personal Accomplishment sub-scale describes "feelings of competence and successful achievement in one's work with people" (p. 101). On this sub-scale, lower scores indicate higher degrees of experienced burnout. This measure is reviewed in greater detail in the "Methodology" section of this paper. The following sections discuss the findings and theory related to these three components of burnout.

Emotional Exhaustion. BO "leads to loss of concern for clients, loss of positive regard for co-workers and agency, and emotional withdrawal from work" (Cherniss, 1980, p. 25). Pranger and Brown (1992) investigated the existence of BO among a group of mental health occupational therapy personnel (N = 91). The personnel, with an average client caseload of 17.8, had significantly greater emotional exhaustion on the MBI than the original 1981 normative sample. The senior therapists (who see the most clients, on average) had the highest emotional exhaustion score. The final scores of the

assistants and senior occupational therapists indicate "moderate overall intensity of burnout" (Pranger & Brown, 1992, p. 85). "Both the frequency and intensity of feelings of burnout were significant when compared to the established norms for mental health workers" (p. 87).

Depersonalization. The major finding of the original study on BO indicated that most professionals who work with people "tend to cope with stress by a form of distancing that not only hurts themselves but is damaging to their human clients" (Maslach, 1976, p. 16). This distancing, a form of depersonalization, can occur in many ways. Professionals may begin to think of their clients in negative and derogatory terms, blaming them for their problems and feeling they deserve their problems. The terminology used to describe their clientele changes to object-like, abstract, or animal-like nomenclature (i.e. "my caseload," "the poor," "animals"). Distancing can also be achieved by describing the clientele and their problems as scientifically as possible, labeling clients by their problems, and/or "recasting a volatile situation in more intellectual and less personal terms" (Maslach, 1974, p. 18).

Professionals also create distance by drawing sharp boundaries between job and personal life, or by simply spending less time with clients. Minimizing physical contact, especially in tense encounters (i.e. standing at a distance) can also create detachment. "Going by the book," applying formulas and stereotypes, and superficially generalizing all create distance. Seeking social support from colleagues and using humor can both also lead to detachment.

Personal accomplishment. When examining a group of psychotherapists' responses to the Maslach Burnout Inventory (MBI) in greater detail, the area with the highest indication of burnout was the Personal Accomplishment sub-scale (Farber, 1990). In this sub-scale (containing such questions as "I feel I'm positively influencing other people's lives" and "I have accomplished many worthwhile things in my life") 19.2% of psychotherapists had scores signifying burnout. When specifically questioned on the possible reasons contributing to these feelings of despair and inadequacy, most psychotherapists cited "lack of therapeutic success" (p. 37). This suggests that perhaps psychotherapy does not work as often or as well with clients as therapists hope (Farber, 1990). An entire sample of mental health occupational therapists exhibited higher scores (meaning lower frequency) on the Personal Accomplishment sub-scale than the original normative group (Pranger & Brown, 1992). In a different study, among short-term residential facility for emotionally disturbed children, personal accomplishment was inversely related to emotional exhaustion (Kruger, Bernstein, & Botman, 1994).

Stages

Cherniss (1980) identified three stages in the burnout progression: (1) stress, (2) strain, and (3) defensive coping. "The first stage (stress) involves an imbalance between resources and demand" (Cherniss, 1980, p. 17). Contributing factors to stress include personal expectations, interpersonal (interactions with clients and coworkers), and organizational stressors such as the amount of workload (Capner and Caltabiano, 1993). "The second stage (strain) is the immediate, short-term emotional response to this imbalance, characterized by feelings of anxiety, tension, fatigue, and exhaustion"

(Cherniss, 1980, p. 17). Manifestations of 'strain' include psychological (low self-esteem), somatic (headaches), and behavioral aspects (alcoholism). A counselor with a diminishing low self-esteem may feel that she or he can no longer help clients, new or previous ones (Capner et al., 1993).

Defensive coping, the third stage of burnout, one that specifically affects the therapist-client interaction, entails many changes in attitudes and behaviors towards the client such as "blaming the victim for their own victimization" (Capner et al., 1993). In this stage there is a "tendency to treat clients in a detached and mechanical fashion or a cynical preoccupation with gratification of one's own needs" (Cherniss, 1980, p. 18).

In summary, "burnout is a process that begins with excessive and prolonged levels of job stress. This stress produces strain in the worker (feelings of tension, irritability, and fatigue). The process is completed when the workers defensively cope with the job stress by psychologically detaching themselves from the job and becoming apathetic, cynical, or rigid" (Cherniss, 1980, p. 21).

Prevalence/Incidence Across Groups

Unfortunately, no general statistics were found regarding the prevalence of burnout specifically among trauma counselors or volunteers. Only one study investigated burnout in shelter workers ($N = 91$), finding that although "the shelter workers did not meet the criteria for burnout as specified by Maslach's classification, positive correlations between coping mechanisms and burnout components were revealed" (Brown and O'Briend, 1998 add). This study did reveal that shelter workers were moderately distressed, as indicated by scores on the Shelter Stress Inventory. Burnout among trauma

workers and volunteers is an area that appears to have been overlooked, an unfortunate occurrence as trauma workers tend to have different work environments, responsibilities, and roles than psychotherapists. However, we can look at other professions (medical, emergency, and general mental health) in order to gain some sense of prevalence, incidence, or available information. Additionally, many of the studies touched upon below, in the following section, address the stress, not necessarily the associated burnout, of working with the various populations.

Medical workers. Medical workers, such as nurses, have demonstrated psychological manifestations of stress in the face of caring for the critically ill, the dying, and the bereaved (Vachon, 1987, as cited in Hartman, 1995; see Hartman for a more extensive discussion of nurses and stress). Riordan and Saltzer (1992), after reviewing the literature on burnout among health care providers for the terminally ill, concluded that providers indeed suffer unique stressors, but also experience stressors similar to other health care providers (as cited in Stamm, 1997). Koocher (1979) commented upon the "problem of emotional 'burnout' among health care professionals who work with cancer patients," delineating the major stressors contributing to burnout. More specifically, Davidson (1985) found that "the emotional impact of cancer causes particular job stresses for social workers who work with cancer patients and their families" (p. 81). Coady, Kent, and Davis (1990) found a significant relationship between team and supervisory support and low burnout scores among social workers working with patients with cystic fibrosis.

AIDS workers. There is a growing body of literature investigating burnout and stress among people who volunteer or work with people with AIDS. Eakin and Taylor (1990) discuss the psychosocial impact of AIDS on health workers, providing a conceptual framework for this phenomenon. Vistini, Campanini, Fossati, and Bagnato (1996) found that HIV work, among 410 Italian nurses, indeed elicits psychological stress. They found a low overall rate of burnout among the nurses, "but a small proportion had a high level" (Vistini et al. (1996, p. 183). They found a significant correlation between the MBI and the three scales on the AIDS Impact Scale that specifically measured the "emotional involvement of nurses with their patients" (Vistini et al., 1996, p. 183). They also found that empathic, involved relationships help prevent burnout, and that work stress is better tolerated if supportive social roles are received.

Maslanka (1996) found in 265 volunteers working at a gay man's health center that youth was related to negative outcomes; specifically, younger volunteers displayed greater needs to withdraw. While she found that the mean scores on the MBI scales were actually fairly low, current stress later impacts levels of burnout variables such as the need to withdraw. She found that a "desire to enhance one's career when linked with a heightened sense of one's efficacy as a volunteer (a reward) leads to decreases in burnout" (Maslanka, 1996, p. 202-203). Also, "being younger and having experienced more stress lead to heightened perceptions of burnout while rewards and (staff) support" decreased burnout perceptions (Maslanka, 1996, p. 203). Staff support indeed "played an important role in lowering stress" (Maslanka, 1996, p. 204) and increasing feelings of efficacy.

Oktaý (1992) found that hospital social workers (128) who worked with AIDS patients "had slightly higher rates of emotional exhaustion and depersonalization on the MBI, but also felt a substantially higher level of personal accomplishment" (p. 432). She also found that "the younger workers were more burned out" (Oktaý, 1992, p. 435). She found that "the variables that were the best predictors of (low) burnout were belonging to a support group, age (older), and autonomy (Oktaý, 1992, p. 436). Bennett, Kelaber, and Ross (1993) found, through a one-year longitudinal study of 32 health care professionals working with AIDS, that "the number of hours per week in HIV/AIDS work was related to BO with increasing hours related to increasing levels of BO" (p. 41). Increasing age was also related to lower levels of burnout. Bennett, Michie, and Kippax (1991), comparing presence and degree of burnout among oncology and AIDS nurses (with the MBI), found that while oncology nurses "suffered burnout with greater frequency, nurses working in the area of AIDS showed greater intensity of burnout after adjustment for frequency of burnout" (p. 181). It was also found that "nurses who had worked on a particular unit for a greater length of time were more likely to suffer burnout," (p. 181) with age significantly affecting BO inversely.

Emergency workers. Gibbs, Drummond, and Lachenmeyer (1993), in their review of the literature regarding the effects of disasters on emergency workers, delineate the many emotional (grief, depression, anger, irritability, anxiety, tension, and distress), physical (illness; sleep and appetite problems; reduced sex drive; migraines; stomach, neck, and back aches; and skin disorders), behavioral (substance abuse), and cognitive changes (confusion, memory loss, shift in values). They also mention other symptoms

found in the literature: presence of relationship problems, increased number of accidents, and intrusive and avoidant imagery.

Jenkins (1996) examined "social support and debriefing efficacy among 36 emergency medical workers after a mass shooting," finding that "feeling that others understood their experience was related to lower acute obsessive-compulsive, general, and psychosomatic symptom levels" (p. 1). Empathy from others was also related "to better recovery from obsessive-compulsive, depressive, and hostility symptoms" (Jenkins, 1996, p. 1). Attending critical incidence stress debriefing "was related to better recovery from depressive and anxiety symptoms" (Jenkins, 1996, p. 1).

Psychotherapists. The prevalence of burnout among psychotherapists as opposed to other professions, such as teaching, is relatively low, an expected result as the presence of BO implicates the structural features of work environments. Approximately two to four percent of psychotherapists experience BO, while 19.3% (suburban) to 21.6% (urban) of teachers experience burnout (Farber, 1990). One study by Snibbe, Radcliffe, Weisberger, Richards, and Kelly (1989) investigated burnout (using the MBI) among 276 primary care physicians and mental health professionals in HMO environments, representing approximately 10% of this entire HMO group. This investigation demonstrated moderate emotional exhaustion and depersonalization among primary care physicians. High emotional exhaustion and depersonalization (and high personal accomplishment), was found among members of the psychiatric staff, a common result in similar research (with the exception of personal accomplishment - usually it is found to

be low). Individuals obtaining significantly higher scores on depersonalization included psychiatrists and social workers, as opposed to psychologists or primary care physicians.

When compared to Maslach's normative sample, almost the entire professional group had significantly higher emotional exhaustion, depersonalization, and personal accomplishment. These characteristics, however, may be related to a professional work pattern rather than specifically indicative of burnout. Psychologists' depersonalization scores did not differ significantly from the norm. Physicians with less than 6 years of experience reported greater depersonalization when compared to physicians with 6 or more years of experience.

Domestic violence shelter volunteers/staff. Mickish (1987) wrote theoretically and descriptively about stress among volunteer advocates for battered woman. She described the organization and operation of one particular shelter, pointing out possible sources of stress well as preventative measures. Black (1992) assessed 191 volunteers at SA and DV centers, finding that the aspects of volunteering the respondents liked least included: lack of support and resources, pain, inconveniences, and distractions. Five percent of the volunteers felt isolated and 16.2% expressed a lack of concern and encouragement from the staff and board of directors. "Fourteen volunteers described the pain they witnessed and experienced as being very difficult for them to handle" (Black, 1992, p. 6). "It can be too emotionally draining at times" is a comment characteristic of this feeling of pain (Black, 1992, p. 6).

McKenna (1986) found evidence of the existence of job stress in shelter services in her pilot study. More specifically, overwhelming caseloads "combined with a lack of

feedback on performance was a significant source of stress" for almost half of the surveyed shelter staff (McKenna, 1986, p. 21). "A general feeling of lack of support was consistently identified as a source of job stress by over three quarters of the shelter workers interviewed" (McKenna, 1986, p. 21). Other unorganized structures in the shelters (i.e. delivery method problems) contributed to feelings of stress. The financial stress of low salaries was associated with job stress. A general lack of staff and volunteer support for full-time staff was also associated with major frustration.

Volunteers vs. professionals. Capner and Caltabiano (1993), determining that there is a dearth in research concerning possible differences between volunteers and counselors regarding burnout, investigated differences between professional ($n = 49$) and volunteer ($n = 32$) counselors regarding a number of variables such as "stressors, strain, defensive coping, social support, and breakdown" (p. 555). Professionals and volunteers (averaging 7.7 and 3.6 years counseling experience, respectively), from private and public settings, returned various questionnaires with results indicating that 8 of 18 possible stressors were common to both groups [i.e. "too much work, too little pay" (p.558)]. There were also stressors unique to each group such as loneliness and lack of client feedback experienced by volunteers, and lack of confidence experienced by professionals. However, despite the different stressors present, both groups' responses were surprisingly similar regarding number of job stressors (few), strain (low to medium), counselor (emotional) breakdown (medium), defensive coping (low), and social support (high).

Counselor breakdown relates to the lowering of self-esteem. In other words, the counselor feels she can no longer help the client. Overall, a strong relationship was found between counselor breakdown and perception of strain, confirming Seligman's learned helplessness model of stress and Selye's general adaptation syndrome (discussed in Capner et al., 1993). In general, the high social support experienced by both volunteers and professionals within the counseling community buffered many possible negative aspects associated with burnout. Accordingly, this data obligates researchers interested in understanding VT to ask how social support might influence the development of VT.

Symptomatology

"Burnout adversely affects clients and the organizational effectiveness of community agencies, as well as the burned-out worker" (Cherniss, 1980, p. 24-25). Maslach and Pines (1978) found that "mental health workers experience personal stress as a result of working closely and intensely with patients over an extended time" (p. 236). A description and review of burnout symptomatology in the literature regarding mental health professionals follows.

In the workplace, BO has also been implicated as a key factor leading to "low worker morale, absenteeism and high job turnover (for a common response is to quit and get out)" (Maslach, 1976, p. 16). Burnout also affects the "quality of care and treatment provided to clients" (Cherniss, 1980, p. 27). Burnout can strongly influence administrative functioning: "high rates of burnout can cause havoc in community programs" (Cherniss, 1980, p. 27). "Higher levels of experienced burnout have been

associated with more negative ratings of certain aspects of the work environment: autonomy, comfort, challenge, client contact, and coworker support" (Maslach, 1987, p. 97). Burnout has also been "associated with lower job satisfaction and greater intention to quit" (Maslach, 1987, p. 97).

In the physical realm, "burnout often leads to a deterioration of physical well-being" (Maslach, 1976, p. 19). Symptoms such as exhaustion, insomnia, ulcers, migraine headaches, muscle tension, back problems, perspiration have all been linked to burnout (Freudenberger, 1974; Maslach, 1976). "In order to cope with these physical problems, the worker may turn to tranquilizers, drugs, or alcohol - "solutions" that have the potential for being abused" (Maslach, 1976, p. 19).

Emotionally, burnout "affects the staff member's morale and psychological well-being" (Cherniss, 1980, p. 27). Burnout has also been found to correlate with greater levels of mental illness and suicide (Maslach, 1976). BO has also been related to "lower levels of self-esteem, lower use of coping mechanisms, and more hassles in one's daily life" (Maslach, 1987, p. 97).

Burnout also affects relationships, more specifically, BO been found to correlate with damaging levels of marital conflict (Maslach, 1976). Maslach theorizes that "if stress cannot be resolved while on the job, then it is often resurrected at home. Sometimes the professional is unaware of the causes and wrongly attributes the increased fighting to something else that has gone wrong in the family relationship" (1976, p. 16). Burnout can also be related to workplace relationships. Pines and Maslach (1978) found

that better relationships between staff and patients involved fewer work hours as well as working with a "less seriously ill patient population" (p. 234).

Risk Factors

Workplace. Farber discovered in 1985 that therapists who work in institutions, rather than private practice, are more at risk for burnout (cited in Farber, 1990, p. 37). This implies that the job structure is often predictive of BO, emphasizing an important distinction between BO and VT; VT has not been linked to workplace conditions whereas workplace conditions are inherently related to BO. Counselors working in an institutional setting may be more likely to experience burnout because of the "second-class citizenship" (p. 38) of the nature of their position. Their abilities may go unnoticed or under-utilized. Their opinions may be side-stepped in favor of those with medical degrees (and less counseling experience).

To illustrate this point, in one study, occupational mental health assistants responding to open-ended questions about burnout expressed concerns regarding limited positive feedback, excessive rules, multiple levels of authority, "little opportunity for input into decision-making," inadequate staffing numbers, and high turn-over. All these concerns are related to the structural aspects of BO (Pranger & Brown, 1992, p. 85). Pines and Maslach (1978) also found that "staff who felt they had input into the institution's policies and who felt free to express themselves on the job had a much more positive view of themselves and of the patients" (p. 236).

Work stress, negative attitudes towards peers, and negative perceptions of work were associated with self-assessments of burnout in Australian TAFE (Technical and

Further Education) counselors, also an expected finding (Jupp & Shaul, 1991). Doctoral-level counselor/interns "who were supervising another counselor reported greater emotional exhaustion" (Ross, Altmaier, & Russell, 1989, p. 467). Higher job stress was also associated with higher burnout in this study (Ross, Altmaier, & Russell, 1989). Additionally, Pines and Maslach (1978) also found that a "high frequency of staff meetings was correlated with very negative and dehumanizing attitudes towards the patients" (p. 235), perhaps due to the use of meetings as a time to label and focus excessively on difficult patients, rather than using the time to discuss feelings and problems.

Work overload is also found to relate to various aspects of burnout. Prosser, Johnson, Kuipers, Szmuckler, Bebbington, and Thorncroft (1997) found that among hospital and community mental health staff, stress from work "overload was associated with being outside an in-patient ward, and with emotional exhaustion and worse (staff) mental health" (p. 51). Depersonalization was associated with client-related stress (Prosser et al., 1997). In a study on burnout symptoms among drug and alcohol service employees, high burnout was associated with "larger agency size, high levels of total work stressors, work overload and daily hassles, and a lower level of peer cohesion" (Price & Spence, 1994, p. 67). "Work overload, role ambiguity and daily hassles were significant predictors of emotional exhaustion" (Price & Spence, 1994, p. 67).

Task. Various task factors such as administrative red-tape, bureaucratic regulations, and budget considerations, as well as time limitations, all can contribute to

"disheartened" (p. 38) working conditions, conditions in which burnout can easily manifest itself (Farber, 1990).

Caring for too many people is another high contributor to burnout (Maslach, 1976). Longer work hours specifically involving continuous direct contact with clients have been found to correlate with greater stress and more negative attitudes (Maslach, 1976, p. 20). Pines and Maslach (1978) found among mental health staff that a larger patient-staff ratio was negatively related to staff workers liking their jobs (p. 234). Additionally, staff members who worked longer hours on a daily basis liked their jobs less, felt less responsible for the patients, and felt less in control over the in-patients' institutional lives (Pines & Maslach, 1978, p. 235). Also, "when staff-patient interaction was good, staff members liked their work, felt successful about it, and found self-fulfillment in it" (Pines & Maslach, 1978, p. 235).

Pines and Maslach (1978) originally found that "staff who spent a great deal of time in administrative work liked their jobs less and working with patients less" (p. 235). However, Prosser, et al. (1997) later found that "higher job satisfaction was associated with 'management' and 'working with people' as sources of satisfaction, whereas emotional exhaustion and poorer mental health (among staff) was associated with less 'career' satisfaction" (p. 51). The contradiction might possibly rest in differences regarding the definitions of Prosser's et al. (1997) concepts of "management" and "working with people" (however, neither of these factors was elaborated upon). Regarding "working with people," Prosser et al. (1997) speculated that "when one is enjoying one's job, satisfaction is derived particularly from "working with people," but if

one experiences work as stressful, it is the satisfaction derived from the job related to "career" that is most likely to be reduced" (p. 59).

Other factors cited in accounting for burnout involve...the general difficulty in dealing with patient problems, discouragement as a function of the slow and erratic pace of therapeutic work, the tendency of therapeutic work to raise personal issues...the passivity...and the isolation. (Farber, 1990, p. 37)

Individual/personal characteristics. Higher education, greater work expectations, and younger age are characteristics that have all been associated with burnout. Therapists who are intensely involved in their work and allow their work to continue after hours are at greater risk for burnout. Not yet understanding and accepting the nonreciprocal nature of therapeutic work might also play a part in the progression to burnout (Farber, 1990).

Pines and Maslach (1978) found that mental health staff with higher education felt "more pessimistic about the possible effects of their work" and "saw themselves as more tense, distant, and introverted" (p. 235). This is likely because they entered this field with higher expectations about fulfillment, rather than simply considering adequate job conditions. In a study on burnout symptoms among drug and alcohol service employees, younger age was associated with higher rates of emotional exhaustion and depersonalization (Price & Spence, 1994).

General distress. Higher levels of general distress have also been associated with greater degrees of burnout. In one study, Australian TAFE student counselors (involved in inter- and intra-personal issue counseling) with more life stress and general distress manifested more psychological-physical distress (Jupp and Shaul, 1991). Burnout (26%)

was the greatest contributing factor to general distress with general work stress (17%) and life stress (6%) following as the next greatest factors (Jupp & Shaul, 1991). In another study, doctoral-level counselors who experienced higher numbers of stressful events was also more likely to manifest higher levels of emotional exhaustion and lower levels of personal accomplishment (Ross, Altmaier, & Russell, 1989).

Length of counseling experience. There is substantial evidence that length of counseling experience is related to levels of burnout, particularly among experienced counselors. However, less experienced therapists are also at risk, possibly due to the inexperience with handling stressors and difficulties (Farber, 1990). Counselors who had been employed for longer periods had significantly higher levels of burnout, consistent with the concept proposed by Maslach (1986), Edelwich and Brodsky (1982), and Perlman and Hartman (1982) that stress accumulated from professional contact results in burnout (cited in Jupp & Shaul, 1991). Additionally, Pines and Maslach (1978) found that "the longer staff had worked in the field, the less they liked working with patients, the less successful they felt...and the more custodial rather than humanistic" their attitudes were (p. 236). Doctoral-level counselors on internship "who reported the fewest years of postdoctoral experience and who were married reported greater emotional exhaustion" (Ross, Altmaier, & Russell, 1989 p. 467). Residential counselors who initially (at day 15) experienced higher levels of burnout continued to manifest higher levels when interviewed on the 36th day (Kruger, Botman, & Goodenow, 1991).

Mediating Variables

There has been much research investigating burnout in relation to aspects such as social support and perceived work stress. Less investigated variables include gender and ethnicity.

Social support. Social support, on its own, has generally been found to slow the progression of BO. In one study, counselors who were married, supervising another counselor, and had fewer years of postdoctoral experience reported greater emotional exhaustion (Ross, Altmaier, & Russell, 1989). Conversely, "counselors with supportive supervisors reported lower levels of emotional exhaustion and depersonalization and higher levels of personal accomplishment" (pp. 467 - 468), all unsurprising findings in light of the typical data regarding BO. Staff who consistently communicated with like-minded others and who experienced guidance and affirmation manifested less emotional exhaustion and depersonalization and greater personal accomplishment. Social support from supervising colleagues was associated with lower burnout, but did not have a buffering role against job stress (Ross, Altmaier, & Russell, 1989).

In another study, residential counselors for emotionally disturbed children who indicated high co-worker support (rather than supervisor support) also reported greater personal accomplishment and lower burnout (Kruger, Botman, & Goodenow, 1991). A different study of short-term residential faculty for emotionally disturbed children found that personal accomplishment was positively related to friendships among team members (the number of reciprocal relationships a team member had with other team). Higher personal accomplishment was related to having fun with friends; lower levels of

depersonalization were related to having work discussions with team members (Kruger, Bernstein, & Botman, 1994)

Gender. Gender, when mentioned in the literature, has been found to influence levels of BO, sometimes in contradictory ways. In one study, male residential counselors (for emotionally disturbed children) reported lower levels of emotional exhaustion than female counselors (Kruger, Botman, & Goodenow, 1991). In a different study regarding short-term residential faculty for emotionally disturbed children, while men and women reported the same number of friendships, men reported less frequent contact with team members when compared to women (Kruger, Bernstein, & Botman, 1994). Women were more likely to have fun and discuss personal concerns and work concerns with team members, which may pertain to other types of counseling experience and countertransference effects. Women who counsel trauma patients may be buoyed by a greater developed social support system while male counselors may lack that mediating factor in the development of VT or countertransference (Kruger, Bernstein, & Botman, 1994).

Price and Spence's (1994) study on burnout symptoms among drug and alcohol service employees also found some interesting gender differences, specifically in the way in which women and men respond "to work and non-work stressors" (p. 67). Low levels of home problems appeared to protect women from the adverse impact of work stressors. The burnout levels of women were relatively unaffected by work stressors, unless home stressors were also high. The level of daily hassles had a direct effect upon symptoms of emotional exhaustion, but did not interact with work stressors in predicting emotional

exhaustion for women. Burnout levels of male employees on (the) emotional exhaustion and depersonalization scales were strongly linked to level of work stressors...Symptoms of emotional exhaustion in males were predicted by severity of daily hassles (Price & Spence, 1994, p. 67).

Ethnicity. Only two studies concerning mental health professionals and BO examined ethnicity, one finding that interns "representing minority groups reported experiencing fewer stressful events in their jobs" (Ross et al., 1989, p. 469), and the other finding that being nonwhite was related to stress regarding the future (Prosser et al., 1997).

Conclusion

In conclusion, high emotional exhaustion and depersonalization, and low personal accomplishment, the main indicators of BO, were common results in the BO literature. The defining characteristic that differentiates burnout from other therapist responses appears to be related to structural aspects such as work conditions. Additionally, the previous literature review indicates that there is a lack of research regarding BO among volunteers or trauma therapists. Only one research study examined BO among volunteers, determining BO symptoms indeed exist among this population (Capner & Caltabiano, 1993). No studies empirically examined BO among SA center staff/volunteers; a few studies provided descriptive, qualitative data on BO in DV shelter staff/volunteers. This research seeks to add to the understanding and description of burnout in these two populations.

Criticism of the Literature

Most of the research problems in the burnout literature involve sampling methodology. Some obvious problems involve the limited generalizability of the majority of the studies, as they were mainly conducted on specialized populations: TAFE counselors in Australia (Jupp & Shaul, 1991); psychological doctoral-level interns (Ross et al., 1989); residential counselors (Kruger et al., 1991; Kruger et al., 1994); drug and alcohol service employees (Price & Spence, 1994); and primary care physicians and mental health professionals in the managed care system in Hawaii and California (Snibbe et al., 1989). Only Ross et al. (1989) featured an extensive, nation-wide sample.

Most studies utilized sample sizes between 75 and 100 participants (Brown & O'Brien, 1998; Capner & Caltabiano, 1993; Jupp & Shaul, 1991; Kruger et al., 1994; Pranger & Brown, 1992); the exception being Price et al. (1994) and Prosser et al. (1997) with approximately 120 subjects each. Some studies exhibited unmatched numbers in comparison groups (Capner & Caltabiano, 1993; Jupp & Shaul, 1991; Pranger & Brown, 1992) or unmatched characteristics (Capner & Caltabiano, 1993). Self-selection and self-report methodology were present in all but one study (Kruger et al., 1994); non-random sampling (participants were enlisted at departmental meetings) was present in another study (Snibbe et al., 1989).

Some researchers modified the questionnaires used, possibly compromising validity (Capner et al., 1993; Jupp & Shaul, 1991; Kruger et al., 1991; Kruger et al., 1994). However, several studies utilized reliable measures such as the MBI (Pranger &

Brown,1992; Price & Spence, 1994; Prosser et al., 1997; Ross et al., 1989; Snibbe et al., 1989).

The strength of Kruger, Botman, and Goodenow (1991), its short long-term nature, is also its weakness. As most of the studies reviewed are cross-sectional in nature, this study's long-term nature is an exception to the general pattern of the methodology. Data can be lost over measurements; the results based on the short intervals between measurements may differ vastly if longer lapses of time were allowed. Also, subject attrition due to job turnover can also influence data collection and reliability.

Paired Comparisons Between the Theoretical Constructs

The following section compares the four major constructs (countertransference, secondary traumatic stress, vicarious traumatization, and burnout) to each other, completing the groundwork for the hypotheses for the current research. Similarities and differences among all constructs are discussed, as well as predictions of similar and different patterns of correlations among STS, VT, and BO based on their theoretical relationships to each other.

Secondary Traumatic Stress (STS) and Countertransference (CT)

The more contemporary definition of CT, as discussed in the section on CT, frames CT as all of the emotional reactions of the therapist toward the patient. However, Figley (1995) argues that STS includes, but is not limited to, what psychology views as CT. Figley reports that it is "assumed that CT happens only within the context of psychotherapy; it is a reaction by the therapist to the transference actions on the part of

the client, and it is a negative consequence of therapy and should be prevented or eliminated" (Figley, 1995, p. 11). STS, in contrast, is a "natural consequence between two people," (the traumatized individual and the person close to the traumatized), not limited to the therapeutic relationship, but possibly found in any close relationship. These effects, he argues, "are not necessarily a problem, but" rather, "a natural by-product of caring for traumatized people" (Figley, 1995, p. 11), one consequence of empathy.

Vicarious Trauma (VT) and Countertransference (CT)

Pearlman and Saakvitne understand countertransference to be "the therapist's responses to a particular client and all that client represents to the therapist, whereas vicarious traumatization refers to the cumulative impact of trauma work on the therapist, across clients" (Pearlman & Saakvitne, 1995, p. 153). They believe that "vicarious traumatization increases the therapist's susceptibility to certain countertransference responses" (Pearlman & Saakvitne, 1995, p. 153).

Secondary Traumatic Stress (STS) and Burnout (BO)

Burnout, a subject of extensive research, has come to be seen as a "collection of symptoms associated with emotional exhaustion" (Figley, 1995, p. 11), in relation to the workplace. From his review of the burnout research, Figley determined that "the most salient factors associated with the symptoms of burnout" are "client problems (chronicity, acuity, complexity) that are beyond the capacity of the service provider" (Figley, 1995, p. 12). He stipulates that STS "is more specific than burnout and sometimes more pervasive" (Figley & Kleber, 1995). It is theorized that burnout may be a risk factor for

STS/compassion fatigue (CF; Rudolph, Stamm, & Stamm, 1997). Furthermore, Figley argues that

in contrast to burnout, which emerges gradually and is a result of emotional exhaustion, STS can emerge suddenly with little warning. In addition to a more rapid onset of symptoms, with STS there is a sense of helplessness and confusion, and a sense of isolation from supporters; the symptoms are often disconnected from real causes, and yet there is a faster recovery rate. (Figley, 1995, p. 12)

However, in Figley's instrument for STS (the CFST), one of the two sub-scales that comprises this measure is a scale for burnout. Additionally, the only published article to date utilizing this measure analyzed both sub-scales separately, rather than combining them into a total score of STS/CF (Stamm, 1997).

Regarding hypothesized predictions of correlation patterns between STS and BO (determined by comparing CFST and MBI scores, respectively), one would likely expect a significant, positive correlation between the two total scores, particularly as half of the CFST taps BO. One would especially expect a high correlation between the BO sub-scale of the CFST and the total MBI score, as both measure BO. One would expect a positive correlation, albeit most likely non-significant, between the compassion fatigue (CF) sub-scale of the CFST and the total MBI score.

VT and Burnout

Pearlman and Saakvitne stipulate that "burnout is related to the situation, but does not incorporate the interaction of the situation with the individual that is essential to vicarious traumatization" (1995, p. 153). Here one would expect some degree of

correlation between measures of VT and BO (obtained from the TSI-BSL and MBI, respectively), as these two instruments and concepts are concerned with the negative results of working with clients. However, these two measures and concepts are concerned with different aspects of the effects of clients on therapist (and with different environmental issues: high MBI scores are highly correlated with institutional characteristics). A positive correlation between the TSI-BSL and MBI, while present, may not be significant.

Secondary Traumatic Stress (STS) and Vicarious Trauma (VT)

Theoretical comparisons can clearly be made between VT and STS regarding the following dimensions: (1) theory usage, (2) symptomatology, (3) populations susceptible to STS or VT, (4) amount of exposure to trauma survivors (observable, checklist-type symptoms vs. more covert changes in thinking), and (5) treatment approaches.

The first major distinction between Pearlman and Saakvitne's delineation of vicarious traumatization versus Figley's development of his concepts of secondary traumatic stress and STSD involves differences regarding theory development and usage. Pearlman and Saakvitne have written extensively about the relationship of vicarious traumatization to constructivist self development theory, a "developmental, interpersonal theory explicating the impact of trauma on an individual's psychological development, adaptation, and identity" (1995, pp. 151-152). Constructivist self development theory "emphasizes the progressive development of a sense of self and world view in response to life experiences " (Pearlman & Saakvitne, 1995, pp. 159-161).

Additionally, the differences in theory also incorporate distinctions in symptomatology formulation, the second dimension. Vicarious traumatization, Pearlman and Saakvitne argue, "includes the symptomatology of STSD in the context of profound changes in the therapist's sense of meaning, identity, world view, and beliefs about self or others" (1995, p.153). However, VT "differs from STS in focus and context" (p. 153). They maintain that the conceptualization of STS "focuses on observable symptoms, and while acknowledging context and etiology, gives them less attention" (p.153). Figley, while occasionally mentioning this distinction in reference to the constructivist schemata which forms the foundation of VT, has neglected to stipulate whether he agrees or disagrees with Pearlman and Saakvitne's analysis. In contrast, the VT concept presumes a particular developmental model of personality, "one in which meaning and relationship are integral parts of any human experience" (Pearlman & Saakvitne, 1995, p. 153).

To reiterate theoretical and symptomatology differences, McCann, Pearlman, and Saakvitne focus on the theoretical underpinnings of vicarious trauma, a condition which can result from cumulative exposure to trauma clients, and while they discuss in great length the mechanics of VT (how VT changes the schema of the afflicted person), Figley focuses on the symptomatology of his concept of STS. Figley repeatedly asserts the fact that STS "strikes" after exposure to someone's traumatic material, and while he acknowledges the shifts in belief systems and schemas that occur as a result of STS, he spends a great deal of time discussing the various forms of tangible STS symptomatology (i.e. physical and relational). McCann, Pearlman, and Saakvitne, in their delineation of VT, indeed discuss tangible manifestation of symptoms, but in their writing and

discussion of VT, they focus mainly on the shifts in belief system that occur, over time, in someone experiencing VT.

Regarding the third dimension, Figley has historically focused on the presence of STS in relatives or friends of traumatized people (although in the last 5 years or so he has expanded STS to include mental health professionals, caregivers, and other helpers). McCann, Pearlman, and Saakvitne have typically focus on mental health professionals in their research and theory development.

For the fourth dimension, McCann, Pearlman, and Saakvitne accentuate the fact that VT results from cumulative exposure, and results in gradual but dramatic changes to the therapist's belief system. Figley tends to emphasize that exposure to only one other person's traumatic material can lead to symptoms similar to PTSD.

Concerning the fifth dimension, treatment, Pearlmen and Saakvitne indeed confirm that although VT and STS differ conceptually, the treatment approaches are appropriate for both (1995, p. 151). McCann, Pearlman, and Saakvitne focus on the changes and disruptions in cognitive schemas; for these changes they offer treatment ideas that attack below the overt symptoms. Figley and Kleber (1995) cite McCann and Pearlman's (1990) suggestion that "strategies to counteract the negative effects on therapists who do trauma work should emphasize the need for balance, the use of external resources, self-acceptance, connection, and the need to foster one's sense of meaning, interdependence, and hope" (Figley & Kleber, 1995, p. 91).

Figley, in numerous articles, appears to endorse, through citation, the idea that many of the treatments for VT (i.e. a team-oriented approach) are also applicable to his

concept of STSD; he also mentions PTSD-like treatments for STSD (Figley, 1995b). However, after mentioning these specific treatment approaches, Figley neither clearly nor specifically affirms or disconfirms the appropriateness of their usage. He appears to leave it up to the reader to assume that these strategies would work for his version of STS/VT. When he directly addresses treatment, his suggestions reflect the more transient constructs and straightforward symptomatology of his conceptualization of STSD, and he mentions many preventative/treatment measures also discussed in the VT and BO literature (knowledge, supportive relationships, boundaries between work and home, supervision, personal therapy, continuing education).

In conclusion, both STS and VT essentially refer to the same observed phenomena; the changes in a therapist or person who is exposed to someone recovering from a traumatic event; however, they differ regarding their conceptualization of the depth and nature of changes. STS emphasizes DSM-IV PTSD-based symptomatology (easily identifiable) grounded in observed empiricism, as well as variations in development speed. VT, a conceptually-driven construct, emphasizes more gradual, covert, and permanent changes in cognitive schema.

Present Study

Validity Aspects

Empirically, one would expect a high significant correlation between the two instruments utilized to measure the two constructs of secondary traumatic stress and vicarious trauma (the CFST and the TSI-BSL, respectively), even though these instruments may be assessing slightly different consequences of the same phenomena.

Therefore, critical element of this study involves the validation of Figley's (1993) Compassion Fatigue Self-test for Psychotherapists (CFST), measuring secondary traumatic stress and compassion fatigue-related burnout, with the TSI Belief Scale, Revision L (TSI-BSL), a slightly more established instrument measuring vicarious trauma. These instruments are correlated with each other and with the well-known and validated Maslach Burnout Inventory (MBI) and Symptom Checklist-90-Revised (SCL-90-R). Specifically, the burnout sub-scale of the CFST is compared to the MBI for evidence of convergent validity regarding burnout. The compassion fatigue sub-scale and total score of the CFST are compared to the TSI-BSL for evidence of convergent validity regarding secondary/vicarious trauma. Lastly, the MBI total scale, TSI-BSL total scale, and CFST sub-scales (2) and total score are compared to the SCL-90-R measure of general distress (GD) for evidence of convergent validity. This is a major focus of this present study because no empirical research exists which investigate the statistical or construct validity relationships among these instruments (CFST, TSI-BSL, MBI, SCL-90-R) and concepts (STS, VT, BO, GD). These measures, sub-scales, and validation aspects are examined and discussed in greater detail in the "Instruments" and "Validity Testing" sub-sections of the "Methodology" and "Results" section.

Research Hypotheses

Hypothesis 1

Greater exposure to adult sexual assault and/or domestic violence survivors is correlated with higher rates of secondary traumatic stress, vicarious traumatization, burnout, and general distress symptomatology (measured by the CFST, TSI-BSL, MBI,

and SCL-90-R, respectively) in sexual assault and/or domestic violence agency personnel.

Hypothesis 2

Personnel with: (a) a history of sexual assault and/or domestic violence (measured by the TSI Life Event questionnaire) and (b) no or minimal history of obtained counseling (related to victimization) will have higher levels of secondary traumatic stress, vicarious traumatization, burnout, and general distress (measured by the CFST, TSI-BSL, MBI and SCL-90-R, respectively) compared to personnel with (a) a history of SA and/or DV and (b) counseling received in relation to their trauma history.

CHAPTER II

METHOD

Participants

The participants for this study were volunteer and paid staff counselors affiliated with sexual assault and/or domestic violence agencies and who recruited from eight agencies throughout Dallas/Fort Worth. The sample consisted of 101 sexual assault counselors (SAC) and domestic violence counselors (DVC; see Table 1). Participant response rate is difficult to calculate, as questionnaires were mostly distributed and collected on the same occasion. On approximately four (out of 11) distribution opportunities (approximately 10 meetings and 1 mailing), questionnaires were distributed at one meeting and collected the following week, or left with staff and volunteers to return via mail. Response rates for these occasions ranged from approximately 50% to 100%.

Staff and volunteer SAC comprised 35% of the sample ($n = 35$). Staff and volunteer DVC comprised 17% ($n = 17$). Forty eight percent ($n = 49$) of the sample were associated with an agency that served both sexual assault and domestic violence survivors. Participants' work and/or volunteer titles included counselor, therapist, psychologist, intern, crisis worker, hotline worker, caseworker, case manager, supervisor, director, and educator. Four respondents, who had not seen any traumatized clients

within the last 90 days, were excluded. One respondent, who indicated not being affiliated with a SA or DV center, but rather with a mental health hospital and occasionally counseling traumatized clients, was also excluded. Thus, the maximum N for most analyses is 101.

The sample consisted of 96 females and four males, with a normal distribution of ages ranging from 21 to 65. Over half (51.5%) of the sample were married. The majority were heterosexual (93%), Anglo-American (77.2%), and Protestant (65.3%). Rates of religious attendance were evenly distributed, forming a rectangular distribution, with a modal service attendance frequency of 3 to 4 times a month. The majority of participants had bachelors (36.6%) or Masters degrees (46.5%) in the mental health field (62.4%). Most participants averaged a yearly income of \$20,000 or more (75.3%) or \$10,000 or under (12.9%).

Comparison of the means and standard deviations of the basic demographic data with previously published research indicates that the sample does not differ radically from other similar populations and norms, supporting external validity. Characteristics of the total populations from each participating agency were obtained in order to compare the pooled sample with the total population. The demographic characteristics of this sampled population did not deviate from the total populations volunteering or working at the centers.

Table 1

Sample's Demographic Characteristics

Basic Demographic Variables (N = 101)	Frequency	(%)	Modal Category
Gender ^a			Female
Female	96	(95)	
Male	4	(4)	
Missing Data	1	(1)	
Age			36-45
21 - 25	16	(16)	
26 - 35	21	(21)	
36 - 45	24	(24)	
46 - 55	22	(22)	
56 - 65	9	(9)	
Missing Data	9	(9)	
Marital Status			Married
Single (Never married, committed)	18	(17.8)	
Married	52	(51.5)	
Living w/Partner	8	(7.9)	
Divorced/Separated/Widowed	22	(21.8)	
Missing Data	1	(1)	
Sexual Orientation			Heterosexual
Heterosexual	93	(92)	
Bisexual	5	(5)	
Homosexual	1	(1)	
Celibate	1	(1)	
Missing Data	1	(1)	
Race/Ethnicity			Anglo-American
Asian	1	(1)	
African-American/Black	3	(3)	
Anglo-American/White	78	(77.2)	
Hispanic	9	(8.9)	
Other (Middle-Eastern/European)	2	(2)	
Missing Data	8	(7.9)	

Religion		Protestant
None	9	(8.9)
Protestant (& non-denominational)	66	(65.3)
Other Christian (Mormon)	2	(2)
Catholic	15	(14.8)
Jewish	3	(3)
Other (Pagan, Wiccan, etc.)	6	(6)
Religious Attendance		3-4 times a month
Never	9	(8.6)
Rarely	15	(14.9)
3-6 times a year	11	(10.9)
Every month or two	16	(15.8)
1-2 times a month	11	(10.9)
3-4 times a month	24	(23.8)
More than once a week	14	(13.9)
Missing Data	1	(1)
Education		Masters Degree
High School/GED	14	(13.9)
College Graduate	37	(36.6)
Masters Degree	47	(46.5)
Doctorate	1	(1)
Missing Data	2	(2)
Discipline		Mental Health
Mental Health (Psyc., Couns., etc.)	63	(62.4)
Family Studies	5	(5)
Liberal Arts, etc.	16	(15.9)
Other	5	(5)
Missing Data	12	(11.9)
Income		30,001 and above
10,000 or under	13	(12.9)
10,001 to 15,000	5	(5)
15,001 to 20,000	2	(2)
20,001 to 30,000	35	(34.7)
30,001 and above	41	(40.6)
Out of range	5	(5)

^aBinary coded as (1) Female and (2) Male

Procedure

The agencies' human resource/volunteer directors were approached via letter and follow-up telephone call as to the center's interest in research participation. If the center expressed interest, the procedure of the study was explained to the director (or designated contact person) in appropriate detail. Occasionally directors requested (and were sent) examples of the research materials to facilitate their final decision on the agency's participation. The directors were given the opportunity to voice any questions or comments regarding the study, as well as propose possible ideas and hypotheses to be included in the study.

Following confirmation of participation, site visit appointments with agency volunteers/staff were arranged. Most scheduled visits coincided with pre-scheduled staff meetings or volunteer in-services. The researcher typically attended the scheduled meeting and introduced the topic of the study, distributed questionnaires and consent forms, and assured participants of confidentiality. After gathering completed questionnaires, the researcher answered miscellaneous questions, provided participants with a lecture about vicarious traumatization, and facilitated a discussion regarding methods of prevention and intervention. For those who wished to ponder over the questionnaires at a later date and return them via mail, self addressed stamped envelopes were provided (consent forms were collected at questionnaire disbursement). The names and telephone numbers of the researcher and faculty sponsor were given at the meeting for questions arising at a later date. For a few agencies interested in participating, but unable to schedule a meeting for the staff/volunteers with the researcher, questionnaires,

with self addressed stamped envelopes, were dropped off to the center with instructions for packets to be completed by a certain deadline. On the designated date, the researcher returned to gather the questionnaires and present a discussion on the research topic.

The centers and shelters approached were chosen for ease of location (within the Dallas/Fort Worth area) and included Denton County Friends of the Family, the Rape Crisis Center of Collin County, Victims' Outreach, Women's Haven of Fort Worth, Women's Center of Fort Worth, Brighter Tomorrows (Grand Prairie), Rape Crsis and Child Center of Dallas, and New Beginnings Center (Garland). Upon completion of questionnaires and final conclusion of this research, participants were sent copies of the results. If requested, the researcher returned to present the findings in person. Lastly, interested participants who gave addresses (anonymously and separately from their questionnaire) were entered in a drawing for three monetary rewards (\$15, \$15, and \$30).

Instruments

Multiple measures were used to assess a variety of beliefs, feelings, actions, and symptoms associated with secondary traumatic stress, vicarious traumatization, burnout, and general psychological distress, as well as the participants' demographics and work/volunteer history.

Demographics

Subjects were asked basic demographic information regarding sex, age, relationship status, sexual orientation, race/ethnicity, religion, religious service attendance, education level, discipline, and income (Appendix C). These questions were obtained from several sources (Kassam-Adams, 1995; Jenkins & Ingram, 1996).

SA/DV Center/Shelter History and Activities (Exposure to Clients)

Subjects provided information concerning their work or counseling experience, particularly regarding the past month. Questions regarded: (1) weeks spent working at this center; (2) time since last meaningful contact with trauma survivor; (3) numbers of clients counseled in an average week in the past month; and (4) average hours per week (in the last month) spent working directly with this population in various capacities (Appendix C). These questions were obtained from several sources (Cunningham, 1996; Kassam-Adams, 1995; Jenkins & Ingram, 1996)

The questions regarding weekly counseling and hourly exposure to clients were combined into a single index to foster ease of statistical analysis measuring direct counseling exposure. This index was computed by adding together the hours per average week (in the past month) spent engaged in three types of direct counseling (individual therapy, group therapy, crisis intervention).

One question inquired about the hours of supervision utilized in an average week in the past month, at the SA/DV center (Appendix C). This question is loosely based on a question developed by Kassam-Adams (1995). Two questions addressed training received. The first was a "yes" or "no" question asking if the participant had received any training specifically for work with this population. The second question was an open-ended inquiry asking the participant to describe their training (Appendix C).

Participants responded to an open-ended question regarding their motivations for volunteering/working for the centers/shelters (Appendix C). Participants were also given

the opportunity to write any changes in an open-ended question asking about alterations resulting from working with this particular population (Appendix C).

TSI Life Events Checklist (short form)

Staff/volunteers' personal victimization history was evaluated through the TSI Life Events Checklist (short form; Appendix D). On this questionnaire they indicated which of the following traumatic events they had survived and/or witnessed/observed: war or holocaust; natural or human-induced disasters; loss of loved one; life-threatening illness; witnessing or experiencing domestic violence or neglect as a child or adult; physical or verbal/emotional abuse as a child or adult; sexual abuse, rape, or other unwanted sexual activity as a child or adult; and assault, murder, or mugging. For abuse, they were asked to indicate the age(s) at which the trauma occurred and by whom (family member or non-family member). The questionnaire also asked if they have heard about any traumatic experiences occurring to others for whom they care.

The TSI Life Event questionnaire is "based on a constructivist perspective," attempting to assess "the individual's response (amount of distress)" to the various traumatic events. Because of the developmental component, it also addresses "the individual's age at the time the event took place" (Pearlman, 1996, p. 419). The short form contains 19 questions regarding "potentially traumatic or stressful life events."

For the present study, three variables were calculated from this questionnaire. The first variable, experience of only sexual assault trauma, was calculated as a presence or absence variable based on a "yes" response to any of the three questions addressing sexual assault: item #12, experienced sexual contact before age 18 with someone in your

family who was at least 5 years older; item #13, experienced sexual contact before age 18 with someone other than a family member, who was at least 5 years older; item #18, experienced rape or other sexual assault at age 18 or older. The second variable, experience of only domestic violence trauma was also calculated as a presence or absence variable based on a "yes" response to either of the two questions addressing domestic violence: item #8, experienced domestic violence, neglect, or physical abuse as a child; item #9, experienced domestic violence, neglect, or physical abuse as an adult. The third presence/absence variable, experience of either sexual assault or domestic violence trauma, was derived from the presence of a "yes" response to any of the five SA and DV questions (questions #8, 9, 12, 13, 18). Although this questionnaire also addresses age at which trauma occurred, this data was not used in the present study.

Therapy/Counseling History

The participants were asked about any personal therapy/counseling sought related to the possible presence of a SA and/or DV history (for how long, when, the satisfaction of the counseling regarding abuse-related issues; Appendix D).

Compassion Fatigue Self-test for Psychotherapists (CFST)

Participants were asked to complete the Compassion Fatigue Self-Test for Psychotherapists (CFST) developed by Charles Figley (Appendix G). The CFST, developed specifically by Figley to assess the degree of secondary traumatization in professionals who work with trauma survivors, was used to assess secondary traumatic stress (compassion fatigue). This instrument contains two sub-scales, providing measures of burnout (CFST-BO) and compassion fatigue/secondary traumatic stress (CFST-CF).

These scores are derived from adding together designated questions for each sub-scale. For the present study, all responses have also been added together for a total scale score (CFST-SUM). Each sub-scale is interpreted separately, based on a scoring system. For the BO sub-scale, the following intervals are interpretable: 36 or less equals extremely low burnout risk, 37 to 50 equals moderate risk, 51 to 75 equals high risk, and 76 to 85 equals extremely high burnout risk. For the CF sub-scale, 26 or below equals extremely low compassion fatigue risk, 27 to 30 equals low risk, 31 to 35 equals moderate risk, 36 to 40 equals high risk, and 41 and above equals extremely high compassion fatigue risk.

This instrument employs a Likert 5-point scale (1 = rarely; 5 = very often) response system and contains 40 questions, typically completed from 5 to 15 minutes. "Alpha reliability scores range from .94 to .86; structural analysis yielded at least one stable factor which is characterized by depressed mood in relationship to work accompanied by feelings of fatigue, disillusionment, and worthlessness. Structural reliability (stability) of this factor...is .91" (Figley, 1995, p. 14).

Although this instrument addresses questions to "therapists," Figley has stipulated that "therapist" can and has been replaced with other descriptors regarding the helping professions, such as volunteer or staff, and that this change does not noticeably affect the psychometric properties of the instrument (Figley, 1998). "Therapist" was changed to "staff and volunteer" (or some variation).

Some examples of questions tapping burnout (CFST-BO) include: (15) I have thought that there is no one to talk with about highly stressful experiences, (16) I have concluded that I work too hard for my own good, (31) I have felt weak, tired, rundown as

a result of my work as a therapist, (34) I feel little compassion towards most of my coworkers, (38) I have thoughts that I am a "failure" as a psychotherapist, (39) I have thoughts that I am not succeeding at achieving my life goals. Some examples of questions contributing to the compassion fatigue subscale (CFST-CF) include: (1) I force myself to avoid certain thoughts or feelings that remind me of a frightening experience, (2) I find myself avoiding certain activities or situations because they remind me of a frightening experience, (3) I have gaps in my memory about frightening events, and (4) I feel estranged from others.

To date, only one published study (Rudolph, Stamm, & Stamm, 1997) has utilized this measure. The researchers looked at compassion fatigue and burnout among mental health providers and administrators, finding that 37% of the participants reported a high risk of compassion fatigue and 54% reported high risk of burnout, as indicated by the CF and BO sub-scales of the CFST. More specifically, Masters level providers have the highest risk for compassion fatigue and burnout, followed by doctoral level providers (moderate risk) and bachelor level providers (significantly lower risk). This measure was not correlated with any other measure, although correlational data is purportedly in progress (Figley, 1995a). For the current study, Cronbach's alphas of .84 for the CF sub-scale, .83 for the BO sub-scale, and .90 for the total summed score (CFST-SUM) were calculated.

TSI Belief Scale, Revision L

Vicarious traumatization was measured with the TSI Belief Scale, Revision L (TSI-BSL), an instrument which can be completed in 15 to 20 minutes (Appendix H).

This scale is based on "Constructivist Self Development Theory" which "draws upon and integrates self psychology, object relations, interpersonal and social cognition theories" (Pearlman, 1996, p. 415). This 80-item, 6-point Likert scale (0 = "disagree strongly," 6 = "agree strongly") instrument measures disruptions in five cognitive schemas/beliefs "about self and others that arise from psychological trauma or from vicarious exposure to trauma through psychotherapy or other helping relationships" (Pearlman, 1996, p. 415).

Scores obtained include a total score calculated from the sum of all responses; a higher score indicates greater disruption. The average score for mental health professionals is 166.83. Ten sub-scale scores (averages), which indicate relative disruptions of the five need/schema areas as they relate to the self and to others, are also included. These sub-scales include: self-safety, other-safety, self-trust, other-trust, self-esteem, other-esteem, self-intimacy, other-intimacy, self-control, and other-control (Pearlman, 1996, p. 415).

Self-safety is "the need to feel one is reasonably invulnerable to harm inflicted by self or others." Other-safety is "the need to feel that valued others are reasonably protected from harm inflicted by oneself or others" (Pearlman, 1996, p. 418). Sample safety items include: (1) I generally feel safe from danger, and (9) I'm reasonably comfortable about the safety of those I care about.

Self-trust is "the belief that one can trust one's judgments." Other-trust is "the belief that one can rely upon others" (Pearlman, 1996, p. 418). Sample trust items include: (44) I feel uncertain about my ability to make decisions, and (47) I can depend on my friends to be there when I need them.

Self-esteem is "the belief that one is valuable and worthy of respect." Other-esteem is "the belief that others are valuable and worthy of respect" (Pearlman, 1996, p. 418). Sample esteem items include: (27) I deserve to have good things happen to me, and (31) This world is filled with emotionally disturbed people.

Self-intimacy is "the belief that time spent alone is enjoyable" (Pearlman, 1996, p. 418). Other-intimacy concerns "the belief that one is close and connected to others." Sample intimacy items include: (35) Some of my happiest experiences involve other people, (39) I often feel cut off and distant from other people.

Self-control is "the need to be in charge of one's own feelings and behaviors" (Pearlman, 1996, p. 418). Other-control is "the need to manage interpersonal situations" (Pearlman, 1996, p. 418). Sample control items include: (68) I feel bad about myself when I need others' help, (24) I don't have much control in relationships.

"The overall reliability (Cronbach's alpha) of the total TSI-BSL is .98. The subscale reliabilities range from .77 (other-control) to .91 (self-esteem)" (Pearlman, 1996, p. 416). Pearlman and Mac Ian (1995), Schauben and Frazier (1995), and Cunningham (1996) have all utilized this measure in their examination of the vicarious traumatization symptomatology of mental health professionals who work with sexual assault survivors. For the current study, a Cronbach's alpha of .95 for the total score and alphas from .62 to .83 for each of the 10 sub-scales were calculated.

The Maslach Burnout Inventory (MBI)

To assess the degree of volunteer/ staff burnout, counselors were asked to complete the Maslach Burnout Inventory, a questionnaire which can be completed in 10

to 15 minutes. The MBI is a 22-item self-report inventory that taps into the areas of emotional exhaustion, depersonalization, and reduced sense of personal accomplishment, producing three scales by those names, as well as a total score. The Emotional Exhaustion (EE) scale entails being mentally and emotionally overextended and exhausted by one's work. Depersonalization (DP) refers to a detached and impersonal response toward one's clients. Personal Accomplishment (PA) is related to "feelings of competence and successful achievement in one's work with people" (Maslach, 1981, p. 101), and is reversed to indicate burnout. High Emotional Exhaustion and Depersonalization and low Personal Accomplishment scores indicate greater degrees of burnout (Kruger, Bernstein, & Botman, 1994; Maslach, 1981). There are three ranges of experienced burnout for mental health workers for each of the three sub-scales (Maslach, 1996). The average range of EE scores is: 13 or less equals low (lower third) EE, 14 to 20 equals average (middle third) EE, 21 or greater equals high (upper third) EE. For DP, 4 or less equals low, 5 to 7 equals average, and 8 or greater equals high DP. For PA, 34 or greater equals low, 33 to 29 equals average, and 28 or less equals high PA.

The MBI questions the respondent on the frequency ("how often") with which various feelings related to burnout occur during their work year (Maslach & Jackson, 1981; Snibbe et al., 1989). The 7-point Likert scale for the MBI ranges from "never" (0) to "every day" (6). Each of the three sub-scale scores is derived from adding designated responses. The total score is derived from adding all responses, after reversing the PA score. The 7-point Likert scale for the PA sub-scale questions is reversed in value: 0 becomes the value of 7, 1 becomes 6, etc. These new values for each PA sub-scale

question are added to the unmodified endorsed values of the remaining questions resulting in a summed total score.

Validity and reliability is supported by alpha coefficients of .86 (Kruger et al., 1991) and .83 (Maslach & Jackson, 1981) for the total scale. The following reliability coefficients (Cronbach's alphas) have been reported at various times for the three dimensions: .90 and .89 for Emotional Exhaustion, .79 and .74 for Depersonalization, and .71 and .77 for Personal Accomplishment (Maslach & Jackson, 1981). Other research has shown that the MBI has adequate test-retest reliability, convergent, and discriminant validity (Maslach & Jackson, 1981; and as cited in Pranger & Brown, 1992). For the current study, Cronbach's alphas of .91 for the Emotional Exhaustion (MBI-EE) sub-scale, .81 for the Depersonalization sub-scale (MBI-DP), .92 for the Personal Accomplishment sub-scale (MBI-PA), and .91 for the total summed score (MBI-SUM) were calculated.

Several researchers have used the MBI to investigate evidence of burnout in therapists who work with SA survivors (Schauben & Frazier, 1995), mental health professionals (Pranger & Brown, 1992; Price & Spence, 1994; Prosser, 1997; Ross et al., 1989), and people who work with AIDS clients (Maslanka, 1996; Oktay, 1992; Vistini et al., 1996).

The Symptom Checklist-90, Revised (SCL-90-R)

Symptoms of general psychological distress were assessed utilizing the Symptom Checklist-90, Revised (SCL-90-R). This measure is a multidimensional self-report inventory containing 90 Likert scaled items rated from 0 (not at all) to 4 (extremely); it is

typically completed in 10 to 20 minutes. The SCL-90-R examines general psychological symptom patterns for the last seven days, and yields three global indicators examining the severity and range of psychological distress.

The Global Severity Index (GSI), the score chosen to indicate general psychological distress, "provides the most sensitive single numeric indicator of the respondent's psychological distress, combining information on numbers of symptoms and intensity of distress" for all items (Derogatis, 1983, p. 27). This score is derived from averaging all responses. Some sample questions of this measure include: (3) repeated unpleasant thoughts that won't leave your mind; (14) feeling low in energy or slowed down; and (32) feeling no interest in things (Appendix I). A score of .31 for the GSI is the average for non-patient normals.

The SCL-90-R also measures a range of strain symptoms along the following nine dimensions: somatization, obsessive-compulsiveness, interpersonal sensitivity, depression, anxiety, hostility, and phobic anxiety, paranoid ideation, and psychoticism (Derogatis, 1983). These were not utilized for this particular set of analyses.

In previous studies, the internal consistency measures for the nine dimensions ranged from .77 to .90 (Derogatis, 1983) with a Cronbach's alpha of .96 (Pearlman & Mac Ian, 1995). Test-retest reliabilities range from .78 to .90, the majority occurring around .85 (Derogatis, 1983) with an average of .83. For the current study, a Cronbach's alpha of .77 for the GSI was calculated. However, very few people indicated moderate to extreme symptomatology; the lack of variance on many of the items cautions one to interpret the alphas accordingly.

Saunders, Arata, and Kilpatrick (1990) developed a crime-related post-traumatic stress disorder (CR-PTSD) scale for women within the SCL-90-R. In a community sample of 355 adult women, they used a "criterion group classification approach" (p. 439) to develop a 28-item scale "that successfully discriminated between the CR-PTSD positive and negative respondents" (p. 439). The scale is scored by taking the average of the 28 items, for a score that can range from zero to four, with a score of .89 or higher indicating the likely presence of CR-PTSD. Sample items for this CR-PTSD sub-scale include: (23) suddenly scared for no reason; (39) heart pounding and racing; (86) thoughts and images of a frightening nature. The selected items for this sub-scale "had a high degree of internal consistency reliability" (p. 444), with an alpha coefficient of .93, indicating that the scale is uni-dimensional. For the current study, a Cronbach's alpha of .89 for the CR-PTSD sub-scale was calculated.

The SCL-90-R, particularly the Global Severity Index, has often been used in research to identify individuals suffering from PTSD. Pearlman and Mac Ian (1995) used the SCL-90-R to differentiate "general distress from the trauma-specific distress reflected" in the other dependent measures they used. They used the sum of the 90 items as a measure of general distress. Other researchers have used this instrument in their investigation of the symptoms of significant others of combat veterans (Solomon et al., 1992; Waysman et al., 1993). Davis et al. (1995) used the SCL-90-R in their examination of the symptomatology of partners of SA survivors. Jenkins (1996) used this instrument in her examination of psychological distress in emergency medical workers after a mass shooting.

Kelley (1990) used the SCL-90-R in her investigation of parental stress response to their sexually or ritually abused children (abused in day-care centers), finding that "parents of sexually abused children reported significantly more psychological distress than parents of non-abused children, with parents of ritually abused children displaying the most severe psychological distress" (p. 25). Parents of abused children also "reported symptom profiles on the SCL-90-R consistent with PTSD" (Kelly, 1990, p. 25).

Perconte and Giger (1991) have used the elevations on the three global indices and the nine dimensions of the SCL-90 R to help identify Vietnam veterans suffering from PTSD in order to place them in treatment groups. Resick, Jordan, Girelli, Hutter, and Marhoefer-Dvorak (1988) have also used the SCL-90-R (among other instruments) to help identify SA survivors for therapy treatment groups. After treatment was completed, the depression, anxiety, phobic anxiety, paranoia, and psychoticism dimensions of the SCL-90-R were used to help determine recovery rates. Another study investigating childhood sexual and physical abuse as factors in adult psychiatric illness examined results on all nine dimensions and the Global Severity Index of the SCL-90-R in order to help determine the effects of abuse (Bryer, Nelson, Miller, & Krol, 1987).

Additionally, although most research investigating vicarious trauma among trauma counselors used the total summed score of the SCI-90-R, the GSI was found to correlate identically with the summed SCL-90-R score and closely with the SCL-90-R CR-PTSD score, $r(101) = .96, p = .000$. Therefore, only the SCL-90-R GSI was used in hypothesis-testing.

CHAPTER III

RESULTS

Descriptive Statistics

The distributions of demographic variables were visually inspected through the use of scatter plots, as well as statistically analyzed, to detect extreme skewness or kurtosis, outliers, and other unpredicted severe deviations. While gender, sexual orientation, race, and religion were not normally distributed, they were characteristic of most volunteers and staff at predominantly White agencies (i.e., female, heterosexual, Anglo-American and Protestant). No other severe deviations from normality regarding the major demographic and predictor variables were noted, with the exception of the variables predicted to depart from a normal distribution. To improve non-normal distributions for some analyses, the categories of sexual orientation, relationship status, race, and religion were dichotomized to combine low frequency groups. Sexual orientation was collapsed into heterosexual versus non-heterosexual (bisexual, homosexual, celibate), relationship status became married versus non-married, race became Anglo-American versus non-Anglo-American, and religion became Protestant vs. non-Protestant.

Information regarding various types of client contact was gathered and analyzed. Mean, standard deviation, and range data were calculated for the variables of work and/or

volunteer history, experience and exposure regarding SA/DV survivors, and personal victimization history and therapy usage. Variables calculated included the type of agency (sexual assault, domestic violence, or both), numbers of staff/volunteer SA and DV counselors, work/volunteer titles, and time (weeks) spent at the agency as SA/DV staff and/or volunteers. Other information collected included (1) days since last meaningful client contact, (2) the hours per average week in the past month various types of client contact transpired (individual and group counseling, crisis intervention), and (3) the numbers of clients counseled in an average week in the past month. Tables 2 and 3 present totals, means, standard deviations, and/or modes of these predictor variables.

The four groups (SA staff, SA volunteers, DV staff, DV volunteers) were combined into one group for hypothesis testing due to the distribution of volunteers and staff. The sample consisted of almost half volunteers (45.5% of respondents said they volunteer) and more than half staff (63.4% said they perform paid work), with some people who both volunteer and receive pay for the work at the centers (14.9%). Almost half (48%) indicated that they worked/volunteered at a dual-purpose sexual assault and domestic violence agency.

Workers and volunteers differed on some demographic and predictor aspects. Regarding demographic variables, people with at least some paid status were more often heterosexual, had greater education, and had a higher income. Regarding other predictor variables, paid staff had seen clients more recently, spent more hours per average week counseling clients, had more clients per week, and had been with the agency longer. Staff also had higher MBI scores in comparison to people who only volunteered.

Table 2

Predictor Descriptive Frequency Statistics

Agency Personnel Variables	Frequency	(Percent)
Center/Shelter Type		
Sexual Assault Center	35	(34.7)
Domestic Violence Shelter	17	(16.8)
Both	49	(48.5)
Missing Data	5	(4.8)
Paid/Unpaid Individuals		
Individuals who do any paid work	64	(63.4)
Individuals who do any volunteer work	46	(45.5)
Individuals who only do paid work	52	(51.5)
Individuals who only volunteer	34	(33.7)
Individuals who both work and volunteer	15	(14.9)
Work Titles ($\underline{n} = 64$)		
Counselor (therapist, intern, caseworker)	29	(45.3)
Manager/Supervisor (director, case manager)	20	(31.3)
Crisis Worker	9	(14.1)
Other (Educator, etc.)	6	(9.4)
Volunteer Titles ($\underline{n} = 46$)		
Counselor/Therapist (intern, caseworker)	14	(30.4)
Crisis Worker	31	(67.4)
Other (Educator)	1	(2.2)

Data was also gathered addressing the personal histories of trauma (The TSI Life Events Checklist) and counseling-seeking behavior. These means and percentages are presented in Tables 4 and 5.

Table 3

Predictor Descriptive Statistics

Predictor Variables (Exposure to Clients)	Range	Mean	(SD)
Weeks Working/Volunteering			
Weeks at that particular agency ^a	0 to 1144	117.8	(182.2)
Weeks as full time volunteer	0 to 72	2	(8.8)
Weeks as full time paid staff	0 to 360	29.9	(65.4)
Weeks as part time volunteer	0 to 300	20.2	(40.4)
Weeks as part time paid staff	0 to 168	6.1	(20.4)
Weeks as full time SA volunteer	0 to 72	1.6	(8.3)
Weeks as full time SA paid staff	0 to 252	13.5	(35.4)
Weeks as part time SA volunteer	0 to 300	13.7	(36.3)
Weeks as part time SA paid staff	0 to 168	5.1	(19.5)
Weeks as full time DV volunteer	0 to 72	1.2	(7.8)
Weeks as full time DV paid staff	0 to 180	9.9	(26.5)
Weeks as part time DV volunteer	0 to 300	8.1	(33.7)
Weeks as part time DV paid staff	0 to 72	2.3	(9.4)
Client Contact			
Total direct exposure hours in average week in the past month (individual & group counseling, crisis intervention, hotline, etc.) ^a	0 to 48	10.8	(10.9)
Days since last meaningful client contact ^a	0 to 90	7.9	(17.1)
Numbers of clients counseled in average week (in the past month) ^a	0 to 35	8.3	(8.3)

^aThese four variables are the ones used in major hypothesis testing

Table 6 presents mean, standard deviation, and range data regarding secondary traumatic stress (CFST-SUM, CFST-CF), vicarious traumatization (TSI-BSL), burnout (CFST-BO and MBI-SUM, MBI-EE, MBI-DP, MBI-PA), and general psychological distress (SCL-90-R: GSI). For the CFST-CF, this sample scored in the moderate range, and for the CFST-BO, this sample scored extremely low, compared to other mental health

Table 4

Sexual Assault and Domestic Violence History (TSI-Life Events Checklist)

Presence or Absence of SA/DV History ($N = 101$)	Frequency	(Percent)
Sexual Assault (SA experienced as a child or adult) ^a	31	(30.7)
Domestic Violence (DV experienced as a child or adult) ^b	46	(45.5)
Either SA or DV ^c	56	(55.4)

^aAny "yes" response to questions 12, 13, 18.

^bAny "yes" response to questions 8 and 9.

^cAny "yes" response to questions 8, 9, 12, 13, and 18.

Table 5

Trauma and Personal Counseling History

SA or DV Trauma History and Counseling	Frequency	(Percent)
Participants with history of sexual assault ($n = 31$)		
No counseling	16	(52)
Received counseling	24	(48)
Participants with history of domestic violence ($n = 46$)		
No counseling	21	(46)
Received counseling	25	(54)

professionals (Figley, 1995a). For the TSI-BSL, this sample's total scores were equivalent to other mental health professionals (Pearlman and Mac Ian, 1995). Most respondents appeared to have endorsed, on average, the Likert point of "2" on the TSI-BSL, typically indicating agreement with positive beliefs and disagreement with negative beliefs. For the MBI, all the sub-scale scores were low compared to other mental health workers (Maslach, 1996). This sample's SCL-90-R GSI also was lower when compared

Table 6

Outcome Measure Descriptive Statistics

Dependent Variables	Range	Mean (SD)	Alpha	Symptom Level
<u>Compassion Fatigue Self-test for Psychotherapists (CFST)</u>				
Total Summed Score (CFST-SUM)	40 to 97	62.14 (13.15)	.90	(unavailable)
Compassion Fatigue (CFST-CF)	23 to 67	34.6 (9.2)	.84	Moderate ^a
Burnout (CFST-BO)	17 to 124	28.7 (12.18)	.83	Extremely low ^a
<u>TSI Belief Scale, Revision L (TSI-BSL)</u>				
Total Score	92 to 248	160.01 (34.46)	.95	Equivalent ^b
<u>Maslach Burnout Inventory (MBI)</u>				
Total Summed Score (MBI-SUM)	0 to 95	25.44 (19.08)	.91	(unavailable)
Emotional Exhaustion (MBI-EE)	0 to 36	11.77 (8.6)	.91	Low ^c
Depersonalization (MBI-DP)	0 to 20	2.33 (3.80)	.81	Low ^c
Personal Accomplishment (MBI-PA)	0 to 48	38.35 (9.73)	.92	Low ^c
<u>Symptom Checklist 90, Revised (SCL-90-R)</u>				
Global Severity Index (GSI)	0 to 2	.06 (.28)	.77	Low ^d

^acompared to 142 psychotherapy practitioners (Figley, 1995a)

^bcompared to 247 mental health professionals (Pearlman and Mac Ian, 1995)

^ccompared to 730 mental health workers' averages (Maslach, 1996)

^dcompared to 974 non-patient normals' averages (Derogatis, 1977)

to non-patient normals (Derogatis, 1977). In fact, this sample's GSI average of .06 indicates extremely low endorsement of symptomatology (most participants appeared to have chosen responses of, or close to, zero: "not at all," indicating they were not distressed by many of the SCL-90-R symptoms).

Relationships among Demographic, Predictor, and Outcome Variables

In order to detect possible unpredicted relationships between variables, triangular zero-order correlation matrices were computed to determine relationships between

demographic factors (i.e. gender, relationship status, education, race), predictor variables (amount of exposure to clients), and outcome variables (CFST, TSI-BSL, MBI, SCL-90-R). Demographic, predictor, and outcome variable associations were also examined, when appropriate, through t-tests and chi-squares, for unexpected significant results. Additionally, as there were four males and seven non-heterosexuals (violating the criteria for reliable statistical analyses of gender and sexual orientation), only very unexpected significant t-test and chi-square analyses regarding these variables will be reported.

Relationships among demographics. A correlation matrix indicated the following significant relationships among continuous (and binary-coded) demographic variables (refer to Table 7). Married participants were heterosexual (an expected finding; there were no married non-heterosexuals), $\phi(98) = .27, p < .05$, and more often older, point biserial $r(91) = .21, p < .05$ (t-tests indicated these age means for married [$M = 41.7, SD = 10.9$] vs. non-married [$M=36.71, SD = 12.37$]). A greater proportion of married people were non-White participants $\phi(92) = -.26, p < .05$, and Protestant, $\phi(98) = .20, p < .05$. Heterosexuals, $\phi(99) = .17, p = .087$, and White participants, $\phi(93) = .33, p < .05$, were more often Protestant. Protestants had higher religious attendance rates, point biserial $r(100) = .33, p < .00$. Participants with greater years of education were marginally more often heterosexual, point biserial $r(97) = .19, p = .07$, and trained in mental health disciplines, point biserial $r(89) = .42, p < .00$. Older participants had higher incomes, $r(87) = .34, p < .05$.

Table 7

Associations Among Demographics

	Age	Relat. Status	Sex Orient.	Race	Relig.	Relig. Attend.	Years Educ.	Disc.	Income
Age	1.0								
Relationship Status	.21*	1.0							
Sexual Orientation	.12	.27**	1.0						
Race	.08	-.26**	-.11	1.0					
Religion	.06	.20*	.17	.33**	1.0				
Religious Attendance	.10	.18	.08	-.09	.33**	1.0			
Years of Education	.18	.04	.19	.16	.09	.15	1.0		
Discipline	.02	-.04	.22*	.03	.12	-.07	.42***	1.0	
Income	.34**	-.03	.01	-.02	-.01	-.05	.11	-.04	1.0

* $p < .05$. ** $p < .01$. *** $p < .001$.

Relationship Status = Married vs. non-Married (single, divorced, widowed, etc.)

Sexual Orientation = Heterosexual vs. non-Heterosexual (homosexual, bisexual, celibate)

Race = White vs. non-White (African American, Latino American, Asian American, etc.)

Religion = Protestant vs. Non-Protestant (Catholic, Mormon, Jewish, etc.)

Discipline = Mental Health vs. non-Mental Health (all other disciplines)

Religious Attendance, Years of Education, Income = continuous variables

A chi-square analysis indicated that both married and non-married participants tended to

be Protestant, although non-Protestant participants tended not to be married, chi square

(1) = 3.91, $p < .05$.

Relationships between demographic and predictor variables. Regarding correlations between demographic and major predictor variables (hours counseling clients, number of clients in an average week, days since last contact, weeks at the center), there were three significant relationships. Participants who had greater years of education also spent more hours per week counseling clients, $r(99) = .27, p < .01$. Participants who had been affiliated with their center, in any capacity, for more weeks were often older, $r(92) = .30, p = .004$, and marginally more likely to be White, $r(93) = .19, p = .07$.

T-tests indicated that participants who only worked at the agencies, and did not volunteer, were more likely to have more education, $t(83) = 2.40, p < .05$, and have a higher income, $t(82) = 1.97, p = .05$. Participants with at least some paid agency affiliation had seen clients more recently than participants with no paid affiliation, $t(99) = 2.10, p < .05$, spent more hours per week counseling, $t(93.15) = -4.58, p < .001$, had more clients per week, $t(93) = -3.59, p < .01$, and had been with the agency marginally longer, $t(98.91) = -1.84, p < .10$. White people had experienced more days since last client contact, $t(78.4) = -2.18, p < .05$, and had been with that particular agency for more weeks, $t(63.38) = -3.31, p < .01$, in comparison to non-Whites. People trained in mental health disciplines spent greater numbers of hours counseling clients, $t(84.87) = -3.51, p < .01$.

Chi-square analyses indicated that non-heterosexuals only worked at the agency, and heterosexuals more often only worked, rather than only volunteer or both work and volunteer, $\chi^2(2) = 6.01, p < .05$. Individuals who both worked and volunteered

tended to be non-Protestant, whereas individuals who only worked or only volunteered were marginally more often Protestant, chi-square (1) = 5.35, $p = .07$.

Regarding the relationship between demographics and personal history of trauma, a chi-square analysis indicated that non-married participants tended to have higher rates of SA/DV trauma history in comparison with married participants, chi-square (1) = 5.34, $p = .02$ (fewer married people tended to have a history of trauma). Individuals with a history of domestic violence, and who had received counseling for the DV, were slightly more likely to be non-Protestant. Individuals without a DV trauma history, or with a history of DV trauma, but no history of counseling, were marginally more likely to be Protestant, chi-square (2) = 4.66, $p = .097$.

Relationships between demographic and outcome variables. There were several significant correlations between demographic and outcome variables. Older participants often had higher MBI-SUM and MBI-EE scores. White participants had higher CFST-SUM, MBI-SUM, and SCL-90-R GSI scores. Participants with greater years of education had a lower TSI-BSL total score and higher MBI-SUM and MBI-EE, and MBI-PA scores (please refer to Table 8).

T-tests indicated that people who only work ($n = 52$) had significantly higher MBI-SUM, MBI-EE, MBI-PA, and MBI-DP scores than people who only volunteer ($n = 33$; see Table 9). Additionally, White participants had significantly higher MBI-SUM, MBI-DP, SCL-90-R GSI, and CFST-SUM scores than non-Whites (see Table 10).

Women had marginally higher TSI-BSL scores ($M = 161$, $SD = 33.56$) than men ($M =$

129.5, SD = 17.90), $t(96) = 1.88, p < .10$. There were no significant findings on any of the other associations between demographic and outcome variables.

Table 8

Correlational Associations between Demographics and Outcome Variables

Measure	Age	Race	Years of Education
CFST-SUM	-.17	.24**	-.04
TSI-BSL	-.17	.00	-.32***
MBI-SUM	-.19*	.23**	.27***
MBI-EE	-.24**	-.19	.28***
MBI-DP	-.06	.17	.11
MBI-PA	.08	.15	.27***
SCL-90-R: GSI	-.13	.22**	-.07

* $p < .10$. ** $p < .05$. *** $p < .01$.

Note: N s range from 87 to 97; race = White vs. non-White; CFST-SUM = Compassion fatigue Self-test for Psychotherapists; TSI-BSL = TSI Belief Scale, Revision L; MBI = Maslach Burnout Inventory; EE = Emotional Exhaustion; DP = Depersonalization; PA = Personal Accomplishment; SCL-90-R = Symptom Checklist 90, Revised; GSI = General Symptom Index

Relationships between major predictor variables. Between major predictor variables, there were two significant correlations. Participants who indicated greater numbers of client contact hours had seen clients more recently, $r(101) = -.20, p < .05$, and had seen more clients in an average week (in the past month), $r(95) = .54, p < .01$.

Non-hypothesized relationships between predictors and outcome variables. A t -test indicated one significant non-hypothesized relationship between a predictor and outcome variable. Participants who had a history of SA, and who also received

Table 9

T-Test Analyses of Staff/Volunteer Status and MBI Scores

Measure	Group	n	Mean (SD)	t value
MBI-SUM:	Staff	52	35.94 (19.28)	5.34*
	Volunteer	33	15.47 (12.58)	
MBI-EE:	Staff	52	15.79 (8.24)	5.10*
	Volunteer	33	7.3 (6.10)	
MBI-DP:	Staff	52	3.83 (4.39)	3.03*
	Volunteer	33	1.64 (2.25)	
MBI-PA:	Staff	52	40.85 (5.14)	2.97*
	Volunteer	33	33.51 (13.59)	

*p < .01.

Table 10

T-Test Analyses of Race and Outcome Variables

Measure	Group	n	Mean (SD)	t value
CFST-SUM:	Non-Whites	13	55.15 (10.098)	-2.27*
	Whites	76	65.02 (15.09)	
TSI-BSL	Non-Whites	15	158.97 (39.98)	.00
	Whites	76	158.98 (32.35)	
MBI-SUM:	Non-Whites	14	15.38 (11.6)	-3.18**
	Whites	76	27.75 (20.51)	
MBI-EE	Non-Whites	13	8.21 (6.15)	-1.78
	Whites	76	12.82 (8.95)	
MBI-DP:	Non-Whites	13	1.30 (1.25)	-3.25**
	Whites	76	3.24 (4.21)	
MBI-PA	Non-Whites	13	35.80 (10.88)	-1.37
	Whites	76	39.37 (8.25)	
GSI:	Non-Whites	15	.25 (.23)	-2.12*
	Whites	76	.41 (.28)	

*p < .05. **p < .01.

counseling related to the SA, spent more hours per average week (in the past month) counseling other trauma clients (M = 13.71, SD = 13.74), in comparison to participants who had a history of SA, but no personal counseling (M = 6.67, SD = 6.51), $t(35.01) = -2.17, p = .04$.

T-tests indicated that personnel with a history of SA and/or DV victimization had significantly higher CFST-SUM, CFST-CF, CFST-BO, TSI-BSL, and SCL-90-R GSI scores, as shown in Table 11. Personnel with only a history of sexual assault trauma, compared to personnel without a SA history, had significantly higher CFST-SUM and CFST-CF scores, but no other outcome variables (refer to Table 12). Personnel with only a history of domestic violence trauma, compared to personnel without a DV history, had significantly higher CFST-SUM, CFST-CF, CFST-BO, TSI-BSL, and SCL-90-R GSI scores (refer to Table 13). There were no significant findings for personnel with a history of either SA or DV, or both, regarding any of the MBI scores.

Table 11

T-Tests of Sexual Assault and/or Domestic Violence Trauma History and Outcome Variables

Group 1: Absence of SA or DV History
Group 2: Presence of SA or DV History

MEASURE/Group	<u>n</u>	Mean (SD)	<u>t</u> value	point-biserial <u>r</u> ^a
CFST-SUM				
Absence of SA or DV	40	57.91 (11.54)	-3.80*****	.35****
Presence of SA or DV	57	68.51 (15.96)		
CFST-CF				
Absence of SA or DV	40	30.68 (6.48)	-5.08*****	.45*****

Presence of SA or DV	58	38.80 (9.32)		
CFST-BO				
Absence of SA or DV	41	27.09 (5.82)	-2.01**	.17*
Presence of SA or DV	59	31.38 (14.80)		
TSI-BSL				
Absence of SA or DV	40	153.66 (31.96)	-1.72*	.18*
Presence of SA or DV	59	165.72 (35.54)		
SCL-GSI				
Absence of SA or DV	41	.33 (.27)	-2.00**	.19*
Presence of SA or DV	60	.46 (.35)		

* $p < .10$. ** $p < .05$. *** $p < .01$. **** $p < .001$, 2-tailed.

^aN's range from 97 to 101; CFST = Compassion Fatigue Self-test for Psychotherapists; CF = Compassion Fatigue sub-scale; BO = Burnout sub-scale.

Table 12

T-Tests for Independent Samples of Sexual Assault Trauma History and the CFST

Group 1: Absence of SA History
Group 2: Presence of SA History

MEASURE/Group	<u>n</u>	Mean (SD)	<u>t</u> value	point-biserial <u>r</u> ^a
CFST-SUM				
Absence of SA History	67	61.45 (12.94)	-2.37**	.27**
Presence of SA History	30	70.13 (18.09)		
CFST-CF				
Absence of SA History	68	33.52 (7.64)	-2.96***	.33***
Presence of SA History	30	39.96 (10.79)		
CFST-BO				
Absence of SA History	69	29.36 (13.30)	-.36	.03
Presence of SA History	30	30.19 (9.06)		

* $p < .10$. ** $p < .05$. *** $p < .01$, 2-tailed.

^aN's range from 97 to 101.

Table 13.

T-Tests for Independent Samples of Domestic Violence Trauma History and Outcome Variables

Group 1: Absence of DV History Group 2: Presence of DV History				
MEASURE/Group	<u>n</u>	Mean (SD)	<u>t</u> value	point-biserial <u>r</u> ^a
CFST-SUM				
Absence of DV History	54	58.71 (12.02)	-4.15****	.40****
Presence of DV History	43	70.96 (16.08)		
CFST-CF				
Absence of DV History	54	31.42 (6.59)	-5.37****	.49****
Presence of DV History	44	40.48 (9.5)		
CFST-BO				
Absence of DV History	55	27.19 (6.14)	-2.10**	.22**
Presence of DV History	45	32.59 (16.34)		
TSI-BSL				
Absence of DV History	54	154.82 (31.04)	-1.93*	.19*
Presence of DV History	45	168.07 (37.29)		
SCL-90-R: GSI				
Absence of DV History	55	.34 (.28)	-2.31**	.23**
Presence of DV History	46	.49 (.36)		

* $p < .10$. ** $p < .05$. *** $p < .01$. **** $p < .001$, 2-tailed.

^aN's range from 97 to 101.

Measurement Validity Analyses

Part of the purpose of this research entailed providing validity evidence for the two instruments which measure vicarious and secondary trauma: Figley's Compassion Fatigue Self-test for Psychotherapists (CFST) and Pearlman and McCann's TSI Belief Scale, Revision L (TSI-BSL). These measures were correlated with well-researched and

validated measures, the Symptom Checklist 90, Revised (SCL-90-R) and the Maslach Burnout Inventory (MBI), and with each other to address the issues of convergent and discriminant validity. As the correlation regarding the SCL-90-R GSI with the SCL-90-R CR-PTSD, $r(101) = .96$, $p = .000$, indicated that these scores were almost identical, only the SCL-90-R GSI is used in further analysis. For the purpose of the validity analyses, correlations of .01 to .20 will be considered "small" or low, correlations of .21 to .40 are considered "medium," and correlations of .41 and above are considered "large," strong, or high (Cohen, 1992).

Tests of Concurrent Validity

1. Prediction: The CFST (SUM, CF, and BO scores), TSI-BSL (total score), and MBI (SUM, EE and DP scores) were predicted to correlate with the SCL-90-R (GSI score) at medium to high levels.

Outcome: Analyses indicated significant strong correlations of the CFST-SUM, CFST-CF, TSI-BSL, and MBI-EE with the GSI (.41 to .65; refer to Table 14).

Significant medium correlations of the CFST-BO and MBI-SUM (.27 and .38) with the GSI were demonstrated. A marginally significant small correlation was found between the MBI-DP and GSI, $r(96) = .19$, $p < .10$.

2. Prediction: The CFST-SUM and CFST-CF were predicted to correlate with the TSI-BSL (total score) strongly.

Outcome: Analysis indicated strong significant relationships, $r(95) = .59$, $p < .001$, and $r(96) = .58$, $p < .001$, respectively.

3. Prediction: The CFST-BO was predicted to correlate with the MBI (SUM, EE and

DP) at medium high to high levels and with the MBI-PA at small or negative levels.

Outcome: Although the relationships were statistically significant, the correlations between the CFST-BO and MBI-SUM and MBI-DP were medium to small (.25 and .22 respectively). There was no significant correlation between the CFST-BO and the MBI-EE, or MBI-PA.

Tests of Discriminant Validity

1. Prediction: The TSI-BSL (total score) was predicted to correlate with the MBI (SUM, EE, DP, PA) at low or negative levels.

Outcome: Although analyses indicated significant relationships among all variables; the correlations were medium or negative (.30, .31, .32, -.22, respectively).

2. Prediction: The CFST-CF was predicted to correlate with the MBI (SUM, EE, DP, PA) at low levels.

Outcome: The CFST-CF sub-scale correlated significantly at medium levels with the MBI-SUM, MBI-EE and MBI-DP sub-scales (.32, .34, and .22 respectively).

As predicted, there was no significant correlation of the CFST-CF with the MBI-PA sub-scale.

3. Prediction: The MBI-PA was predicted to correlate with the CFST-SUM, CFST-BO, and GSI at low or negative levels.

Outcome: There was a marginally significant negative relationship between the MBI-PA and the CFST-BO, $r(96) = -.19$, $p = .07$, and GSI, $r(96) = -.19$, $p = .07$. There were no significant relationships between the MBI-PA and the CFST-SUM and GSI.

Table 14

Validity Correlations Among Outcome Variables

	CFST-SUM	CFST-CF	CFST-BO	TSI-BLSUM	MBI-SUM	MBI-EE	MBI-DP	MBI-PA	SCL-90 GSI
CFST-SUM	1.00								
CFST-CF	.93***	1.00							
CFST-BO	.89***	.65***	1.00						
TSI-BLSUM	.59***	.58***	.25**	1.00					
MBI-SUM	.53***	.32**	.25*	.30**	1.00				
MBI-EE	.53***	.34**	.24*	.31**	.97***	1.00			
MBI-DP	.37***	.22*	.20*	.32**	.77***	.58***	1.00		
MBI-PA	-.09	-.13	-.19	-.22*	.17	.20*	.05	1.00	
SCL-90 GSI	.65***	.60***	.27**	.64***	.38***	.41***	.19	-.08	1.00

Note: Ns range from 93 to 101.

* $p < .05$. ** $p < .01$. *** $p < .001$, 2-tailed.

Summary of Validity Analyses

To understand the convergent and discriminant validity among these measures, it is useful to examine in further detail patterns of association and shared variance among various scales. Summarizing correlations and percentages of shared variances between the four total scores (CFST-SUM, TSI-BSL, MBI-SUM, SCL-90-R: GSI), all correlational relationships were significant, with medium to large positive correlations (.30 to .65). The largest correlation (and shared variance) belonged to the CFST-SUM and the SCL-90-R GSI, which shared 42% of their variance. The TSI-BSL and MBI-

SUM had the lowest (but still significant and medium) correlation (with a shared variance of 9%).

Regarding correlations between the SCL-90-R GSI, the instrument measuring general psychological distress, and other measures, the largest significant correlations involved the two instruments measuring secondary and vicarious trauma (the CFST-SUM, .65, and TSI-BSL, .64). There was a medium correlation between the GSI and the scale measuring burnout (MBI-SUM, .38).

Upon examining correlations between the two instruments which tap into different aspects of a similar phenomenon, one's vicarious assimilation of another person's trauma (secondary and vicarious trauma, CFST and TSI-BSL, respectively), the largest associations supporting concurrent validity involved the high correlations of the CFST-SUM and CFST-CF with the TSI-BSL (.59 and .58, sharing 34% and 33% variance, respectively). However, the CFST-SUM, CFST-CF, and TSI-BSL also correlated even more strongly with the GSI (with 36% to 42% shared variances), suggesting that these scales of secondary/vicarious trauma have no more in common with each other than they have in common with general distress.

Regarding the two scales which measure burnout (CFST-BO and MBI), the medium correlation, $r(96) = .25$, while statistically significant, did not reach the large level predicted. Both the CFST-SUM and the CFST-CF, rather than the CFST-BO, correlated more strongly with the MBI (.53 and .32, respectively), undermining the CFST-BO's validity as a sub-scale specifically designed to measure BO. The MBI-EE and MBI-DP also correlated more strongly with the CFST-SUM, CFST-CF, and TSI-

BSL scores than with the CFST-BO scores. This suggests that although there were significant associations between those scores, the CFST-BO is not an adequate measure of burnout (the MBI-EE also correlated more strongly with the GSI than with the CFST-BO). The CFST-SUM and CFST-CF, rather than the expected CFST-BO, appear to provide a better assessment of burnout, raising questions about concurrent validity regarding the CFST-BO and MBI. The TSI-BSL correlated negatively with the MBI-PA (i.e. lower negative cognitive disruptions [TSI-BSL] were associated with more positive aspects of working with clients [MBI-PA]), providing support for construct validity.

The best discriminant validity evidence involved correlations between the MBI-PA and all other scales (CFST-SUM, CFST-CF, CFST-BO, GSI): these correlations were all negative or non-significant. However, the TSI-BSL, while predicted to correlate at low levels with the MBI-SUM, MBI-EE, and MBI-DP, correlated at medium levels (.30 range) with those scales. These correlations, while suggesting some discrimination, provide only adequate (rather than robust) support for discriminant validity. Similar adequate discriminant validity was demonstrated regarding the correlations between the CFST-CF and the MBI-SUM, MBI-EE, and MBI-DP (medium correlations from .22 to .34). Tangentially, the MBI-PA surprisingly correlated positively and significantly with the MBI-EE, suggesting that participants with a higher sense of personal accomplishment also had greater emotional exhaustion.

In summary, associations among most measures were highly significant, often ranging from medium to large. The general pattern among scales shows appropriate associations with general psychological distress (SCL-90-R GSI) for the CFST, TSI-BSL,

and MBI, evidence of good concurrent validity for the CFST-CF and TSI-BSL, but inadequate evidence for clear-cut concurrent validity regarding measures of burnout (CFST-BO and MBI). The clearest example of questionable discriminant validity is that the measure of general distress, the GSI, shows quite similar associations with the CFST-SUM and TSI-BSL, measures of secondary/vicarious trauma. Indeed, the observed association between the CFST-SUM and TSI-BSL matched the predicted association (strong); however, if this association were noticeably stronger than the SCL-90-R associations, convergent and discriminant validity would be more strongly supported. Additionally, the unexpected findings regarding the CFST-BO (which was expected to correlate more strongly with the MBI, compared to the CFST-SUM and CFST-CF, and especially the TSI-BSL and SCL-90-R) further raise questions about its concurrent validity. Discriminant validity regarding the MBI-PA was supported, as the MBI-PA was non-significantly, or negatively, associated with all the other measures.

Hypothesis-testing Analyses

Hypothesis 1

Greater exposure to adult sexual assault and/or domestic violence survivors is correlated with higher rates of secondary traumatic stress, vicarious traumatization, burnout, and general distress symptomatology (measured by the CFST, TSI-BSL, MBI, and SCL-90-R, respectively) in sexual assault and/or domestic violence agency personnel.

Method of Analysis. Pearson correlations examined and compared rates of

secondary traumatic stress, vicarious traumatization, burnout, and general distress with various types of exposure to trauma clients.

Findings. Hours counseling clients and numbers of clients in an average week were both significantly and positively related to the MBI-SUM, MBI-EE and MBI-PA scores, but not the MBI-DP score. The MBI-DP score correlated significantly with the number of weeks at the center. An unexpected negative relationship between number of clients and TSI-BSL total score approached significance ($p = .06$). A negative relationship between MBI-PA sub-scale and days since last contact also approached significance ($p = .07$), as shown in Table 15. No other relationships between predictor and outcome variables were significant.

Table 15

Hypothesis 1: Associations Among Predictor and Outcome Variables

Outcome:	CFST-SUM	CFST-CF	CFST-BO	TSI-BSL	MBI-SUM	MBI-EE	MBI-DP	MBI-PA	SCL-90-R GSI
Predictor:									
Days	.02	.00	-.02	.09	-.03	.01	-.15	-.19*	.16
Hours	-.01	-.06	-.05	-.11	.24**	.23**	.13	.34***	-.03
Clients	.01	.01	-.08	-.19*	.28***	.29***	.17	.33***	-.03
Weeks	-.02	-.03	-.05	.06	.17	.12	.21**	.12	.06

* $p < .10$. ** $p < .05$. *** $p < .01$, 2-tailed.

Note: Ns range from 92 to 101. Only participants who have had at least one meaningful contact with a client within the past 90 days are included. Days = number of days since last client contact; Hours = number of hours in an average week spent counseling clients; Clients = number of clients counseled in average week; Weeks = number of weeks associated with agency.

To test these findings for consistency between staff and volunteers, separate correlational matrices of predictor and outcome variables were produced for staff and for volunteers. Upon examining a "staff only" correlation matrix, staff with more counseling hours per average week had higher MBI-PA scores, $r(52) = .27, p = .05$. No other correlations were significant regarding only staff. Investigation of a "volunteers only" correlation matrix yielded several significant correlations. Volunteers with greater hours spent counseling per average week had higher scores on the MBI-SUM, $r(33) = .55, p = .001$, MBI-EE, $r(33) = .51, p = .002$, MBI-DP, $r(33) = .40, p = .02$, and MBI-PA, $r(33) = .56, p = .001$. Volunteers with more clients in an average week also had higher MBI-PA scores, $r(31) = .51, p = .003$. T-tests, however, had previously indicated that staff, in general, scored higher on several outcome scores (MBI) than volunteers.

Hypothesis 2

Personnel with: (a) a history of sexual assault and/or domestic violence (measured by the TSI Life Event questionnaire) and (b) no or minimal history of obtained counseling (related to victimization) will have higher levels of secondary traumatic stress, vicarious traumatization, burnout, and general distress (measured by the CFST, TSI-BSL, MBI and SCL-90-R, respectively) compared to personnel with (a) a history of SA and/or DV and (b) counseling received in relation to their trauma history.

Method of Analysis: T-tests and correlations were used to compare victimized volunteers/staff with non-victimized staff/volunteers on all levels of symptomatology.

Findings: Among those with a history of either SA or DV, or both combined, there were no significant correlations between personal therapy usage (comparing people

who had received counseling to people who had not received counseling) and any of the outcome measures. However, participants who only had a history of sexual assault, and who had received counseling for the SA trauma, had higher TSI-BSL and GSI scores, when compared to participants who had a SA history but no personal therapy usage history (Table 16 below). This finding was opposite to the direction predicted.

Participants who only had a history of domestic violence, but who had not received any counseling, had higher CFST-BO scores, when compared to participants with a history of DV who received counseling for the DV (refer to Table 17), a finding in the predicted direction. No other correlations between outcome measures and SA/DV and therapy history were significant.

Table 16

Hypothesis 2: T-Tests of Personal Sexual Assault and Counseling History with the TSI BSL and SCL-90-R

Group 1: Presence of personal sexual assault history, no counseling received
 Group 2: Presence of personal sexual assault and counseling (for SA) history

MEASURE/Group	n	Mean	SD	t value
TSI-BSL				
No therapy usage	16	150.50	23.361	-2.62*
Therapy usage	23	177.59	36.447	
SCL-90-R: GSI				
No therapy usage	16	.3619	.241	-2.24*
Therapy usage	24	.5662	.307	

*p < .05.

Table 17

Hypothesis 2: T-Tests of Personal Domestic Violence and Counseling History with the CFST

Group 1: Presence of personal domestic violence history, no counseling received
 Group 2: Presence of personal domestic violence and counseling (for DV) history

MEASURE/Group	n	Mean	SD	t value
CFST-SUM				
No therapy usage	21	73.10	17.87	.78
Therapy usage	24	69.25	14.67	
CFST-CF				
No therapy usage	21	39.71	8.62	-.47
Therapy usage	24	41.06	10.22	
CFST-BO				
No therapy usage	21	37.60	22.43	1.99*
Therapy usage	24	28.21	5.51	

*p < .05.

CHAPTER IV

DISCUSSION

Introduction/Summary

This study was conceived to investigate empirically the presence of secondary traumatic stress, vicarious trauma, burnout, and, to a lesser extent, general distress in paid staff and unpaid volunteer counselors who work with sexual assault and/or domestic violence survivors. One goal of this investigation was to provide convergent and discriminant validity regarding the newer instruments which measure the constructs of secondary traumatic stress (CFST) and vicarious trauma (TSI-BSL), by comparing those instruments with each other and with more established measures of burnout (MBI) and general distress (SCL-90-R). The major aspects of convergent and discriminant validity for the CFST and TSI-BSL were supported, however, the equivalent correlations among measures of secondary and vicarious trauma (CFST and TSI-BSL) and general distress (SCL-90-R), rather than indicating a stronger association between secondary and vicarious trauma measures, raise questions about their expected discriminant validity. This may reflect gaps between the conceptualization of these constructs and their measurement, or may indicate that despite their assumed similarities, these constructs are rather different in practice. Hypothesis One investigated symptomatology pattern manifestations (burnout, secondary trauma, vicarious trauma) relating to client exposure in SA/DV staff and volunteer counselors. Burnout aspects of Hypothesis One were

supported in the data while the secondary and vicarious trauma aspects were not. Hypothesis Two investigated counselors' own sexual assault/domestic violence and counseling history, examining how these two experiences may influence levels of burnout, secondary traumatic stress, vicarious trauma, and general distress. Supporting this hypothesis, participants with a history of DV and no counseling had greater compassion fatigue-related burnout than those with a history of DV who have received personal counseling for it. Contrary to the predicted results, participants with a SA and counseling history had greater vicarious trauma (TSI-BSL) and general distress (SCL-90-R) than participants with a history of SA and no history of personal counseling.

Measurement Validity

Regarding the validity aspects of the present study, while some evidence was found in support of concurrent validity and discriminant validity, more evidence was found which raises doubts about convergent validity among the four instruments used (CFST, TSI-BSL, MBI, SCL-90-R). The CFST-SUM and TSI-BSL, designed to measure aspects (albeit different ones) of the same phenomena, secondary/vicarious trauma, should possess the strongest association. Although they did share a strong association, their even higher associations with the SCL-90-R GSI suggest that the scales of secondary/vicarious trauma have more in common with general distress than with each other, raising questions about true concurrent validity. This possibly reflects the distinctions between the observed phenomena (trauma contagion), the two separate constructs of STS and VT, and their measures. Although the observed phenomena entails the same concept of assimilating another person's traumatic material, STS and VT

conceptualize this assimilation somewhat differently; these distinctions are reflected in their respective measurement construction. However, for both conceptualizations general distress occupies a considerable component of symptom manifestation. Burnout (measured by the MBI-SUM) occupies a smaller role in the constructs and measurement of STS and VT, as evidenced by the lower correlations, compared to the higher SCL-90-R GSI with the CFST-SUM and TSI-BSL.

Indeed, the CFST-SUM, compared to the TSI-BSL, correlated most highly with the MBI-SUM. The TSI-BSL, although predicted to demonstrate a low association with the MBI-SUM, correlated at the medium level, failing to demonstrate a robust distinction. These correlations, despite the stronger association between the CFST-SUM and MBI-SUM, compared to the association between the TSI-BSL and MBI-SUM (suggesting some dissimilarity), provide only adequate support for discriminant validity.

Looking at the sub-scales and scales specifically designed to measure secondary and vicarious trauma (CFST-CF and TSI-BSL), a strong correlation was demonstrated implying concurrent validity. However, the strength of this correlation still falls short of the correlation between the CFST-CF and SCL-90-R, making true concurrent validity judgment problematic.

Additionally, a further concurrent validity disappointment involved the relationship between the two scales which were constructed to measure burnout (CFST-BO and MBI): the medium correlation, while significant, did not reach the strong level predicted. In fact, the CFST-BO correlated at the same or better medium level with the two other major scales (TSI-BSL, SCL-90-R), undermining the CFST-BO's validity as an

adequate measure of burnout. Almost any other measure score (such as the CFST-SUM and CFST-CF) appears to provide a more convergent assessment with MBI scores, raising questions about the fitness of the CFST-BO scale. Conversely, evidence for discriminant validity was strong regarding the associations between the MBI-PA and all other scales (CFST, TSI-BSL, SCL-90-R).

The findings related to the CFST encourage a reformulation of its conceptual structure. The CFST-SUM does not appear to measure a unitary construct, and while the CFST-CF and CFST-BO sub-scales appear to measure somewhat separate constructs, they do not appear to robustly measure what they purport to measure, particularly the CFST-BO. The CFST-BO appears to measure a more work-related general distress, rather than work-related burnout. However, adequate discriminant validity was demonstrated regarding the medium correlations between the CFST-CF and the MBI-SUM, MBI-EE, and MBI-DP (the associations were predicted to be low).

When examining these validity issues, one must remember other factors which may have affected the patterns of association. The participants' restricted range of SCL-90-R GSI scores, and lower than expected CFST, TSI-BSL, and MBI scores (suggesting a lack of secondary, vicarious, and burnout symptomatology among the group) might have obstructed finer statistical distinctions. A more symptomatic and affected sample might yield different, more distinct, patterns of convergence and discriminance in the directions predicted.

In conclusion, the general pattern among scales shows appropriate associations regarding the SCL-90-R GSI and evidence of good concurrent validity for the CFST-

SUM, CFST-CF, and TSI-BSL. However, the various other inadequate associations (medium associations when small associations were predicted, and vice-versa) did not provide evidence for robust, clear-cut concurrent and discriminant validity regarding the newer measures of secondary and vicarious trauma (CFST, TSI-BSL) and burnout (CFST-BO) when compared to each other and the older, established measure of burnout (MBI) and general distress (SCL-90-R). This pattern of association indicates that the constructs and instruments of STS (CFST-SUM, CFST-CF), VT (TSI-BSL), and STS-related burnout (CFST-BO) all need further explication and refinement regarding the assumptions of the observed phenomena, concept formulation, and instrument design.

Therapists' Exposure to Trauma Clients

Before summarizing the major findings, it is important to note that this sample, as an average, did not reach significantly clinical levels of symptomatology. For all purposes, this sample appears to not exhibit symptoms of STS, VT, BO, or general distress. Reiterating the major findings regarding Hypothesis 1 (greater exposure to traumatized clients is related to greater symptomatology), counselors (both staff and volunteer) with more exposure to traumatized clients (more hours per average week counseling clients, more clients per average week, in the past month) had significantly higher MBI scores (SUM, EE, and PA) than counselors with less exposure. These counselors had higher rates of burnout (higher total scores, higher emotional exhaustion, and higher personal accomplishment) in comparison to counselors with less client contact. Counselors with reduced personal accomplishment had seen clients less recently. This finding is consistent with the literature; counselors gain personal

accomplishment from utilizing their skills. It is when they do not receive the expected results that personal accomplishment is reduced (Pines, 1993). Counselors who had been with the center longer had higher rates of depersonalization (MBI-DP). This is also an expected finding as previous research has demonstrated that "long-term involvement in emotionally-demanding situations" (such as crisis work) often relate to feelings of depersonalization towards one's clients (Pines, 1993).

The high rates of personal accomplishment manifested in the data were both expected and unexpected. Typically, individuals who manifest burnout have high EE and DP scores, and low PA scores (Maslach and Jackson, 1981). They experience few rewards (low PA scores) and high negative effects (high EE and DP scores) from their work. The counselors in this study with greater client contact also had high PA, suggesting that while they experience some negative effects (high EE), they were still able to experience personal rewards from the work. This also is supported by the finding that counselors who had seen clients less recently had no significant negative effects on any of the measures, with the exception of the MBI-PA. They had significantly lower MBI-PA scores compared to participants who had seen clients more recently, suggesting that recent client contact provides rewards, increasing a sense of personal accomplishment. For this sample, the rewarding work (as evidenced by the high MBI-PA) may provide a buffer against the development of negative effects (secondary/vicarious trauma, burnout, general distress).

Regarding vicarious trauma, counselors who saw more clients in an average week (in the past month) had lower cognitive disruptions/changes (TSI-BSL total score),

inconsistent with previous research which has demonstrated the opposite effect (McCann & Pearlman, 1990; Pearlman & Mac Ian, 1995; Schauben & Frazier, 1995; Cunningham, 1996). This finding did not support the hypothesis that greater exposure is related to greater vicarious trauma (TSI-BSL total score). Additionally, there were no significant findings regarding the measure of secondary traumatic stress (CFST), or the measure of general distress (SCL-90-R) related to amount of client exposure.

There are several possible explanations for this result. Participants were comprised of staff and volunteers, the two groups differing in degree and type of client exposure on a number of factors (agency norms and expectations, client caseload, definition of volunteer shifts/duties, staff job description). Although combining the samples of staff and volunteers in major analyses was a reasonable endeavor (based on the data that 14.5% of the sample both volunteer and receive pay for their work), this may have muddled some of the delineating characteristics of each separate sample, as volunteers and staff tend to spend differing amounts of time engaged in different client activities.

Furthermore, this sample's participants may possess adequate coping mechanisms (not investigated in this study) or work/volunteer at an agency with adequate supportive mechanisms (also not directly investigated). Staff may experience adequate supervision and training (almost all participants underwent training to work with this population, most staff indicated ongoing training and supervision). Likewise, volunteers may not have enough consistent, cumulative exposure to clients to produce vicarious/secondary symptomatology.

Because combining staff and volunteers may have diluted some findings, additional analyses of Hypothesis One examined staff and volunteer responses separately. This changed the results greatly regarding staff and volunteers; only one correlation for staff-only analyses remained significant while several associations for volunteer-only analyses became significant. Investigating staff only, staff with higher MBI-PA scores also had spent more hours per week counseling clients (this correlation actually decreased in value from .34 for the combined staff and volunteer analyses to .27 for the staff-only analysis). Examining volunteers only, volunteers with more counseling hours per week had higher MBI scores (higher SUM, EE, DP, PA). Volunteers with more clients had higher MBI-PA scores. While these particular correlations for volunteers all increased in size upon cutting staff from the analyses, some correlations were no longer significant (MBI-PA was no longer significantly associated with days since last contact; TSI-BSL, MBI-SUM and MBI-EE were no longer associated with number of clients; MBI-DP was no longer associated with weeks at the center) and staff still had higher or virtually equivalent means on most measures (exception; SCL-90-R).

While these results are more dramatic in quantity for volunteers (significant correlations on several MBI scores for volunteers, as opposed to only one significant correlation for staff), several possible explanations exist. The most obvious explanation regards differences in statistical power due to unequal sample sizes. However, if this explanation were true, the results would be reversed. More results regarding the staff would be present, rather than more results for volunteers, because there are more staff than volunteers. As this explanation is not statistically viable, other explanations must be

considered. Indeed, although more statistically significant correlations exist when only analyzing volunteers, staff still manifest higher means on outcome measures. This may indicate that volunteers may be a less homogenous group and more easily affected by different variables (i.e. number of clients per week, etc.) than staff. In other words, while staff may consistently score higher on outcome measures, volunteers' symptom manifestation may easily be influenced by wide variations in exposure-related predictor variables, producing a greater quantity of statistically significant associations.

This conjecture may reflect a number of possible explanations. Volunteers may not have adequate access to support mechanisms in the agency; they may not receive the same degree or kind of institutional support staff receive, nor may they be taken as seriously as staff. Additionally, as they may have less contact with the center, they may also have little contact with staff. This may increase volunteers' vulnerability to negative symptomatology because they lack the support that can occur among daily contact between staff. This daily support can also act as a homogenizing agent; helping to influence consistent outcome results among a group of people (i.e. staff).

Additionally, volunteers may have different patterns of client contact (volunteering a few days a month, carrying a pager for hospital escort duty for a week, or volunteering for a few hours to cover the hotline), they may have inadvertently applied the MBI to their own paid jobs (outside of the volunteer work), or all of their professional work/volunteer. It may have been difficult for some volunteers to remain focused on their volunteer work with questions that imply consideration of employment and work-related aspects, despite clear indications that the study was related to their association

with the center. As the volunteers likely also had some other livelihood (i.e. paid employment or parenthood), the cumulative effects of both their paid employment and/or parenthood and volunteerism may combine to increase significance in burnout symptomatology. They may essentially be taking on a double-load of work and they may not have separated either type of activity in their minds while answering the MBI or other symptomatology questionnaires.

Staff and volunteers also differed significantly on several demographic variables; however, these differences can be derived from logical extrapolation. Workers had greater education and income, had seen clients more recently, had been with the agency longer, and had more client contact. All these aspects are predictable, especially as volunteers typically are not afforded as much agency and responsibility as staff. Additionally, volunteers typically volunteer to gain further experience and increase their future employment viability. Many individuals volunteer while in college or on internship (or as an unpaid internship), and work when they have completed their college or training, hence the datum that workers have more education. Additionally, further education, which the workers have in this sample, generally is equated with greater income.

The datum that workers spend more time with clients and had a longer history with the agency, when compared to volunteers, can also be related to the result that workers had higher MBI scores than volunteers. Greater work responsibilities and longer affiliation to a particular place (especially if one is engaged in long hours or continuous, direct contact with clients) increase the likelihood of burnout (Maslach, 1976).

Another interesting finding involves the percentage of work titles. Almost a third of the staff occupied some managing or directing role. This finding is typical of the way many non-profit agencies work. Many non-profit agencies (the agencies in this sample were all non-profit) have limited funds and therefore limited paid personnel, leading personnel to often occupy directorships or management roles, in addition to the daily services they were hired to perform. People in management, compared to staff, might be more likely to fill out a research questionnaire, particularly if the results might help managers encourage employee retention, longevity, and productivity. Additionally, managers and directors might see filling out a research questionnaire as part of their responsibilities in promoting positive public relations. They may be accustomed to interacting on a give-and-take level with people from outside the agency, to better promote the agency's services. Furthermore, people in management will likely have further education, enabling them to see the value of practical research, as well as the effort involved in research. They may be more sympathetic to researchers, particularly someone conducting research for their graduate requirements.

The difficulties in assessing volunteers (particularly those who may not spend many hours in volunteer activities or may volunteer infrequently) with work-related constructs is apparent in the absence of previous research addressing burnout in volunteers. This research at least provides an introduction from which other research on one of society's most valuable commodities (volunteers) can commence.

Trauma History

Before comparing the symptomatology pattern of participants who have received counseling for their trauma history to those who have not received counseling, it is useful to first examine the relationships between presence of any trauma history and symptomatology.

Participants with any history of trauma (SA and/or DV) had significantly higher secondary traumatic stress (CFST-SUM, CFST-CF, CFST-BO), vicarious trauma (TSI-BSL), and general distress (SCL-90-R: GSI). Participants with only a history of sexual assault had significantly higher secondary traumatic stress (CFST-SUM, CFST-CF, and SCL-90-R). Participants with only a history of domestic violence had significantly higher secondary traumatic stress (CFST-SUM, CFST-CF, CFST-BO), vicarious trauma (TSI-BSL), and general distress (SCL-90-R). Burnout symptomatology (MBI) was not related to a history of trauma.

These results of higher vicarious and secondary trauma are consistent with previous research (Cunningham, 1996; Follete, Polusny, & Milbeck, 1994; Kassam-Adams, 1995; Pearlman & Mac Ian, 1995), demonstrating that individuals who score higher on measures of trauma and distress (whether measuring vicarious/secondary effects or PTSD-like effects) are likely to have a history of sexual assault. The traumatized individuals in this sample also had scores indicating high and deleterious levels of secondary and vicarious symptomatology, in comparison to established group norms.

In discussing these results, it is worth noting the high rates of trauma in this sample. More than half had some form of SA or DV trauma history; almost half of the sample had a history of DV. These high rates are certainly not unexpected, as people who have a history of trauma are probably more likely to be drawn to this field. Although there has been no previous research investigating the relationship between counselors' history of DV and symptomatology, the numerous significant findings can be hypothesized based on other research regarding DV. Domestic violence, tending to occur throughout the course of a relationship (not just once), often includes sexual assault (Pagelow, 1992; AMA, 1995). In fact, the prevalence of marital rape among battered women extends from 33% to 50% (Pagelow, 1988) and one out of every two U.S. women is battered by an intimate partner sometime during her life, making DV even more prevalent than SA. This evidence of pervasiveness and accumulation makes it likely that DV, in comparison to SA, might affect more indices of trauma.

Additionally, the differences in patterns of symptomatology between SA and DV survivors possibly provides support for construct validity in the form of criterion-related validity regarding the measures of secondary traumatic stress (CFST) and vicarious trauma (TSI-BSL). Sexual assault tends to occur as an isolated incident, with results similar to the DSM-IV PTSD effects of other single-episode traumatic events. This PTSD-like symptom manifestation in secondary victims is what Figley has traditionally examined. This is reflected in the construction of his measure, the CFST, which taps into more overt, tangible effects of exposure to trauma, and in the results of this particular study. The effects of SA have traditionally been viewed in terms of PTSD

symptomatology and theory. Only the CFST reflected significant differences when comparing participants with a history of sexual assault to participants without this history. As PTSD is one construct underlying the CFST, it makes sense that participants with SA history would only have elevated CFST scores, particularly an elevated CFST-CF (compassion fatigue) score and CFST-SUM (total score), and not an elevated CFST-BO (burnout) score.

Pearlman and McCann's measurement of vicarious trauma, the TSI-BSL, has a more theoretical, cognitive-based approach, and reflects their orientation to the long-term (rather than sudden) process of becoming vicariously traumatized. They view vicarious traumatization as a cumulative process, occurring over time and resulting from exposure to multiple traumatized clients, unlike Figley's construct of secondary traumatic stress (a reaction pattern that can result from a single, isolated exposure to trauma). This difference in underlying construct is further reflected in the DV history data. Participants with a history of DV also had significantly higher TSI-BSL scores, in addition to the elevated CFST scores. The significant TSI-BSL scores possibly reflect the evidence that domestic violence is often pervasive, cumulative (multiple events), and cognition-altering. The effects of DV can be more insidious, covert, pervasive, and harder to recognize and measure. These aspects of trauma are what the TSI-BSL purports to investigate, and this appears to be reflected in the results.

The additional finding of the significant CFST-BO score (and non-significance of the MBI) has a number of implications for domestic violence survivors who are also counselors. Clearly, the CFST-BO is tapping into some different symptoms of "burnout"

than the MBI. These symptoms also appear to have a more overt relationship with domestic violence. Additionally, it is more difficult to reverse or ameliorate the negative effects/symptoms of domestic violence compared to sexual assault. This can possibly lead to a greater propensity for developing vicarious trauma and a greater susceptibility to compassion fatigue-related burnout among counselors who are DV survivors compared to counselors who are SA survivors.

Furthermore, DV also often includes SA, a more “sudden” trauma. The significant finding that counselors with a history of DV and/or SA, compared to counselors with only a history of SA, have symptom manifestations on more measures reflects these inclusive and pervasive aspects of DV.

Examining the relationship between trauma history and demographics, non-married participants had higher rates of SA/DV trauma, compared to married participants. This is perhaps somewhat expected as it can be speculated that a history of trauma might negatively affect various aspects of intimacy and interaction (trust, self-worth, safety, etc.). A traumatized individual might not deem themselves worthy of an intimate relationship, or they might have a difficult time developing trust, leading to problems in relationship involvement. Survivors of assault often develop rigid boundaries meant to keep others at a distance, particularly if the assault occurred at younger ages. Conversely, survivors can react in the opposite manner and maintain very loose boundaries, giving up on the belief that they can have a say in what happens to them (AMA, 1995). They may have many relationships over the course of their lives, but most may be unsatisfying and short-term.

There was an additional interesting finding regarding participants' personal history of sexual assault and counseling. Participants with a history of SA, and SA-related counseling, spent more hours per average week counseling other trauma clients, compared to participants with a history of SA, but no history of personal counseling. This finding suggests that individuals who have been assaulted, and who received counseling for that assault, have more motivation for or tolerance of working with other SA survivors. Because they have possibly received the benefits within themselves of receiving counseling, they may seek out a greater caseload counseling other survivors. Since they may have dealt with much of the negative ramifications of SA, they may be in a better position to help other SA survivors. Counselors who had been assaulted, but who did not receive counseling, may somehow, consciously or unconsciously, limit their caseload due to their own unresolved reactions. Or, perhaps they do not possess as many counseling skills, compared to the participants who received counseling for the SA; this may lead to a diminished client load over time. There are any number of hypotheses regarding this result; these are but a few.

Associations Between Trauma and Counseling History and Symptomatology

There were several significant t-test results supporting Hypothesis Two (history of trauma and personal counseling is related to level of trauma symptomatology). It was hypothesized that participants with a history of trauma, and who had received counseling for the trauma, would manifest lower levels of symptomatology. For sexual assault survivors, the opposite of the expected relationship was found. Counselors with a history

of sexual assault and a history of personal counseling received explicitly for the sexual assault had higher TSI-BSL and SCL-90-R GSI scores. However, for counselors with a history of domestic violence, the counselors with no history of DV-related counseling had significantly higher CFST-BO scores. No other results were significant.

There are several possible explanations for these findings. The obvious explanation, or rather, problem with this finding is the small number of individuals per group, in the t-test comparisons. For the sexual assault comparison, the two groups compared contain 16 (presence of SA history, absence of counseling) and approximately 24 (presence of SA, presence of counseling) members. For the DV comparison, the two groups have 21 and 24 members, respectively. The small numbers of group members do not bode well for generalizability of results, and indicate a weak effect with low statistical power. Future research should increase group membership and should analyze in further detail the aspects related to counseling received. Even though the current study asked questions about counseling regarding length of time and chronology, the lack of subjects in these categories rendered these responses difficult to analyze. Future studies (with larger groups) should also address therapeutic techniques utilized, why therapy was terminated, and in depth questions about satisfaction, etc.

Additionally, sexual assault can be more difficult to treat and counsel, due to its sudden, shame-producing nature, tending to produce more dramatic, PTSD-like effects which may be difficult to ameliorate (Roth & Newman, 1995). Often survivors do not seek counseling, or seek counseling at a later date, allowing internalization of negative reactions. The effects of SA can linger for many years (Kilpatrick, Saunders, Veronen,

Best, & Von, 1987), and tend to produce both cognitive changes and greater general distress effects, similar to the general distress measured by the SCL-90-R (Kilpatrick, Vernonon, & Resick, 1979).

The SA history and counseling relationship was hypothesized to occur in the opposite direction of the findings. However, as the groups in the comparison were too small to analyze other available information (how long counseling was received, when, satisfaction with counseling, etc.), the results of this analysis should be regarded as inconclusive. Interpretations can be made tentatively and hypothetically, but generalizations cannot be made in good conscience.

This same rationale can be stated for the DV history and counseling results. Despite the significant finding that participants with a history of DV, and no DV-related counseling, had higher CFST-BO scores, which was in the direction hypothesized, this result also lacks generalizability. However, one can still pose very provisional explanations about what this datum means. Without receiving counseling for a DV history, DV survivors may not develop adequate mechanisms to help them cope with various facets of life, such as work. While trauma-like symptoms may not be apparent (lack of significance on the other measures), these individuals may still be more susceptible to compassion fatigue-related burnout. They may have a difficult time developing support systems at work that would help ameliorate burnout. However, these hypothetical explanations need to be further assessed in future research. Future research should assess for support mechanisms available at work and at home, analyzing patterns of coping and utilization.

Other Demographic, Predictor, and Outcome Variable Analyses

Several other non-validity and non-hypothesis-related aspects merit extrapolation. Particularly, unexpected associations between some demographic and outcome variables, the extreme range of predictor variables (participants' exposure to clients), and low outcome measure scores all receive further discussion below.

Looking at relationships between demographics and outcome variables, older participants had higher MBI-SUM and MBI-EE scores, a finding in opposition to most burnout literature which maintains that younger people tend to score higher on the MBI (Farber, 1990; Price & Spence, 1994). This sample may be comprised of older participants who only recently began working with these populations (most participants had not been working with survivors very long). Working with trauma survivors may affect levels of burnout; this study may discriminate inadequately between the relationships and interactions regarding trauma and burnout (multiple regression studies may be more precise and explanatory).

Another association between demographic and outcome variable worth exploring regards the datum that participants with greater years of education had lower TSI-BSL scores. This suggests that more knowledge and experience provides a broader perspective on human behavior. As these people have ascended in academics and experience, they may see more possibilities and more positive behaviors around them. Because they may have a better life, and are possibly doing something they enjoy and worked toward, their outlook may be more positive. The fact that they also have higher MBI-SUM, MBI-EE, and MBI-PA scores is not unexpected. As their education likely

led them to a job with greater human service contact, they might be more likely to develop burnout symptomatology than those with less education and who may be less dedicated to this line of work (their work at the agencies may simply be a job; they may not have invested much in the work). Those with more education, because they are likely pursuing a field they enjoy, are also in a greater position to develop a higher sense of personal accomplishment. The finding that participants who only work, as opposed to only volunteer, had greater burnout symptomatology (an expected finding) is likely due to the fact that workers have much greater exposure to clients than volunteers.

The predictor variables exhibited extreme variety regarding range of client exposure, deserving further extrapolation. In particular, there was tremendous variation concerning participants' length of weekly involvement with their center. SA and DV volunteers had the same broad ranges of length of involvement. However, SA volunteers had higher standard deviations of involvement length, meaning that they had greater variation in the number of weeks they had been associated with the agency, compared to DV volunteers. SA staff also had greater ranges of involvement length (and higher standard deviations), than DV staff, suggesting a higher turnover in DV staff. In fact, the standard deviations of involvement length were larger than the actual averages, suggesting wide discrepancies in this sample's agency long-term affiliation. This sample was comprised of people from both ends of the spectrum: veterans of agency association and neophytes.

Another type of client exposure predictor variable worth examining further concerns counselors' average weekly amount of hourly exposure to clients. The means

for client contact (10.8 direct exposure hours and 8.3 clients counseled in an average week in the past month, 7.9 days since last client contact) were somewhat lower than expected. However as these means were calculated from both the staff and volunteer data combined, they may be appropriate, when considering that volunteers are expected to have less exposure, by the very nature of their responsibilities, ultimately explaining the lower means.

The outcome measure results of this sample are also worth exploring for a number of reasons. For all measures (CFST, TSI-BSL, MBI, SCL-90-R), this sample scored lower when compared to other similar groups norms (mental health workers, etc.). This is a positive finding for the simple fact these results can be interpreted to mean that this sample, as a whole, is not demonstrating negative effects, on any level, in relation to their contact with survivors. Any of the reasons mentioned above regarding why this sample may or may not manifest symptomatology is applicable here. Participants may receive adequate support, supervision, and/or training from their agencies. Or this sample may have, as a whole, adequate coping mechanisms. They may also perceive many more rewards than dissatisfactions from their affiliation. Any of these possibilities may ameliorate the manifestation of negative symptomatology.

Strengths and Limitations/Recommendations for Future Research

The findings indicate several significant strengths and limitations worth discussing in further detail. In examining the demographic data, this sample appears fairly representative of SA and DV agency staff and volunteers. The number of individuals who are affiliated with a dual-purpose SA/DV agency, almost half of the

sample, is less characteristic of other research on this population. Typically, research (Cunningham, 1996; Pearlman & Mac Ian, 1995; Kassam-Adams, 1995; Schauben & Frazier, 1995) has addressed individuals who do only SA work, not both SA and DV work. This finding is interesting in light of general knowledge that sexual assault and domestic violence services are usually separate and found at different agencies.

Typically, a victim calls a SA hotline or seeks respite at a DV shelter. However, most of the agencies in the Dallas/Fort Worth area appear to recognize the entanglement and overlapping that can occur regarding SA and DV, generally offering services for survivors of either assault type, particularly as DV survivors often also experience SA in the course of the DV. These Dallas/Fort Worth agencies generally have a sexual assault hotline and operate a separate domestic violence shelter. They also, however, generally offer counseling for either SA or DV at their counseling center.

Additionally, the inclusion of volunteers, almost half of the sample, is also uncharacteristic of earlier research in SA counselors (research which has mainly focused on paid professional counselors). The inclusion of volunteers and DV workers are two strengths associated with this study. The limitation of this population inclusion involves the consequence that these results, regarding volunteers and DV, cannot be compared to previous research within these same parameters, as none have been published. However, future research on these populations will now have a foundation from which to expand.

This sample's participants have been affiliated with the agencies for an average of 117 weeks (about 2 years), with a standard deviation of 182 weeks! After breaking down length of association into full or part time, SA or DV counselors, and staff or volunteers,

the lengths of association are even smaller (averaging 1.2 to 13.7 weeks). It is perhaps these low averages of time involvement which might explain this sample's typically non-clinical levels of symptomatology. They may not have had enough time to develop any vicarious/ secondary trauma or burnout symptomatology.

Because the mechanics of vicarious and secondary trauma development are still unknown, a longitudinal study would be highly beneficial. Assessing the development over time of vicarious/secondary symptomatology might enable researchers to determine the time-frame of development. Perhaps vicarious trauma indeed develops slowly and imperceptibly, cognitive changes seeping into one's belief system at a steady, gradual rate, building up until some point when the individual realizes they perceive the world differently. Perhaps there is a development peak, at which point some of the cognitive changes begin to change back, while other changes are more permanent.

A comprehensive longitudinal study, beginning with the comparison of multiple groups with different levels of symptomatology, might yield insight into the mechanism of onset, development, peak(s) (if they exist), and permanence. It would especially be helpful to assess participants who terminated their association with trauma work. Perhaps the passage of time (after last exposure to traumatic material) might ameliorate negative effects, eventually resulting in an absence of vicarious/secondary trauma symptomatology. Understanding why individuals might terminate their involvement would be an essential question. Perhaps those who terminate are the most affected individuals; this may affect any post-work transformations in belief system, especially as higher burnout predicts greater job turnover. Their belief system may begin the path

back to (or towards) “normalcy,” but it may always be more altered, or indicate more negative beliefs, than individuals with no exposure to traumatic material.

Additionally, perhaps these questionnaires were not specific enough to the type of work and interactions these respondents perform. These respondents, particularly the volunteers (a difficult group to assess based on a lack of unification in roles and client exposure) may indeed be suffering negative effects untapped by the measures utilized. The only score approaching a clinical level of symptomatology was the CFST-CF score, indicating that this sample, on average, has a moderate risk of secondary traumatic stress. This sample’s TSI-BSL score was equivalent to other mental health professionals; however, these scores are much lower than clinical in-patients and other groups which have documented inadequate or negative psychological functioning (Mc Cann and Pearlman, 1998). In other words, this sample scored equivalent to, or lower than, other mental health professionals on measures of burnout, vicarious/secondary trauma, and general distress.

Some other recommendations for future research, not already mentioned above, are apparent from the results of this study. Further investigations into secondary and vicarious trauma should entail more research into the instruments purported to measure these concepts, particularly as these two constructs are assumed to refer to the same observable phenomena. However, while both constructs concern therapists’ assimilation of another’s traumatic material, differences regarding assessment manifest during measurement. The developers of these instruments may want to examine the content and face validity of their measures, fine-tuning them to produce instruments which emphasize

the distinctive features of secondary and vicarious trauma and further distinguish secondary and vicarious trauma from general distress. However, this may not be possible if secondary and vicarious trauma are inherently distressing. Figley's BO sub-scale needs re-examination; its lower correlation with the MBI makes questionable whether it measures BO at all, even if he is attempting to measure a more compassion fatigue-related form of BO. Perhaps he should rename this scale to something more suitable such as the "Work Environment" sub-scale or "Work-Related" sub-scale.

Other obvious recommendations included an expanded sample, especially regarding the sub-sample that has been traumatized (resulting in larger comparison groups regarding those who have and have not received counseling). An expanded sub-sample of traumatized individuals who have or have not received counseling would enable researchers to better understand the role of personal counseling in the life of a therapist. This information could double as an outcome study, a look at counseling satisfaction, and an examination of how a therapist's personal counseling affects their relationship with their clients. A larger sample size would also hopefully include increased groups of males, non-Whites, and non-heterosexuals.

One strength of this study includes the use of populations not previously examined (SA volunteers, DV staff/volunteers) on any of the measures of secondary/vicarious trauma and burnout. In fact, studies of burnout in trauma (or many other kinds of volunteers) workers apparently have not been published. Nor were any secondary traumatic stress studies found which examine this phenomenon in SA or DV volunteers

or staff. Only a small number of studies exist which examine vicarious trauma in trauma counselors, and these studies only investigate vicarious trauma in paid counselors.

An additional strength entails the validation nature of this study. To date, no researchers have attempted to examine the two closely linked concepts of secondary traumatic stress and vicarious trauma in a single study. Certainly no other study has utilized each measure of these two concepts (CFST and TSI-BSL) on the same population, providing convergent and discriminant analyses. Nor has any other study included the well-researched MBI in this investigation, attempting to tie in not only theoretical similarities and discrepancies regarding burnout, secondary, and vicarious trauma, but measurement-related discrepancies as well.

Some other strengths include the activist approach of the research procedures. The researcher gave information regarding the topic of this study, after data was gathered, in order to inform the staff and volunteers of the symptoms, prevention, and intervention of secondary/vicarious trauma and burnout. Often a discussion was facilitated in which participants expressed tremendous interest in the topic, making connections between the information provided and their own lives. Realizations of the negative and positive aspects of working with this difficult population were often voiced, leading to greater insight on part of the participants and investigator.

Conclusion

This research study has provided a further, in-depth look at the relatively recently formulated concepts of secondary traumatic stress and vicarious trauma. The findings can be applied to trauma counselors at SA and DV centers, a population not generally

researched, providing one more piece of information regarding the hard, but necessary, work of counseling trauma survivors.

Additionally, this research provides a necessary bridge between secondary traumatic stress, vicarious trauma, and burnout, linking and analyzing these concepts together in an inclusive manner. Research on secondary/vicarious trauma now has unifying data and analyses from which further distinctions can be fine-tuned and similarities elaborated. Hopefully this research can propel investigators in the two, presently disparate fields of secondary and vicarious trauma to join forces in the desire to understand people's secondary/vicarious assimilation of trauma. Everyone has much to gain from such an alliance: researchers, subjects, counselors, and sufferers of secondary/vicarious trauma alike.

APPENDIX A

INVITATION LETTER TO CENTERS AND SHELTERS

University of North Texas
Department of Psychology
P.O. Box 311280
Denton, TX 76201
(940) 565-2671

STAFF/ VOLUNTEER RESEARCH PROJECT

Stephanie Baird, B.S.
Sharon Rae Jenkins, Ph.D., Faculty Advisor

July 29, 1998

Dear Colleague:

Working or volunteering at a domestic violence center/shelter can be very rewarding, especially when a domestic violence survivor's pain has been eased by your services. However, this close contact with another person's trauma can contribute to your own level of stress. It has been noted over time that working closely with clients, either as a counselor, or even through administrative contact, can strongly impact the service provider.

I am writing to invite the staff and volunteers at your agency to participate in a study that will examine how working with domestic violence survivors affects the service provider's stress levels and general well-being. Understanding such effects can help agencies provide appropriate support for service providers such as yourself, thereby likely increasing level of employee/volunteer productivity and retention. I am conducting the present study as my master's thesis in counseling psychology at the University of North Texas.

I will call you next week in order to schedule a meeting with a human resources or volunteer director at your agency in order to further discuss and explain the nature of this study. At the meeting, I would like to present a copy of the questionnaires I am assembling for volunteers/staff to answer. I encourage you to bring to the meeting possible suggestions, input, and ideas you have regarding the stresses you and your colleagues face as you provide services for your clients; this would greatly enhance the nature of this study. If you have any questions in the meanwhile, please contact me at either of the numbers listed below.

Sincerely,

Stephanie Baird

Home: (940) 566-2223*** (**Best number to reach me at)
Office: (940) 565-2671; E-mail: sab0002@jove.acs.unt.edu
APPEMDIX B: Consent Form

APPENDIX B
INFORMED CONSENT FORM

INFORMED CONSENT FORM
for
A STUDY OF WORK/VOLUNTEER-RELATED STRESS

I, _____, agree to participate in a study of stress reactions related to working/volunteering at a sexual assault and/or domestic violence center. Participation includes disclosing personal background information about myself as well as information regarding my reactions to working/volunteering at this sexual assault or domestic violence center. Hopefully, the knowledge gained from this study will help us understand the effects of working with traumatized individuals on general emotional/mental well-being.

I agree to fill out a questionnaire for up to one hour. The questions regard my background history, my counseling experience, my experience working or volunteering at this center, my own history of trauma and victimization, my own personal counseling received, and my responses to working with traumatized individuals. Many questions will address my emotional responses to working with traumatized individuals. The main risk or cost to me is that thinking about these issues may be uncomfortable.

I understand that my confidentiality will be protected by using code-numbers on all research materials instead of my name. My name appears only on this consent form, which will be kept under lock and key separately from my questionnaire. If I wish to obtain a copy of a summary of this study's results I must provide an address where it could be mailed.

A random drawing will be held at the end of the data collection period, with one first prize of \$30.00 and two second prizes of \$15.00 each. To participate in this drawing I will provide a phone number where I can be reached in case of winning a prize.

My participation is voluntary and I can withdraw from the study at any time, without work or volunteer consequences. Additionally, I do not hold this center/agency (where I work and/or volunteer) liable for any consequences resulting from answering this questionnaire. If I have questions, I may contact the researcher or project supervisor directly at:

Stephanie Baird, Counseling Psychology Graduate Student (940-565-2671) **or**
Sharon Rae Jenkins, Ph.D., Project Supervisor (940-565-2671)
University of North Texas
Department of Psychology
P.O. Box 13587
Denton, TX 76203-3587
e-mail: sab0002@jove.acs.unt.edu
sbaird@hotmail.com

_____ Date

_____ Signature of Participant

THIS PROJECT HAS BEEN REVIEWED BY THE UNIVERSITY OF NORTH TEXAS COMMITTEE FOR THE PROTECTION OF HUMAN SUBJECTS (Phone 940-565-3940).

=====

Do you wish to participate in the random drawing? ___No ___Yes

If "**Yes**" please provide a name and phone number where you could be reached:

Name: _____ Area Code: _____ Number: _____

Do you wish to receive a summary of this study's results? ___No ___Yes

If "**Yes**" please provide an address where this can be mailed:

Address: _____

APPENDIX C
QUESTIONNAIRE PART I (DEMOGRAPHICS, ETC.)

Participant: please check, circle, or write your response for each of the following questions. Please indicate a response for each question, skipping none. Thank you for your time.

DEMOGRAPHICS

1. Sex:
 1) female
 2) male
2. Age: _____
3. Current relationship status:
 1) never married
 2) in a committed relationship
 3) living with someone in a committed relationship
 4) married
 5) separated
 6) divorced
 7) widowed
 8) other (please describe): _____
4. Sexual orientation:
 1) mainly heterosexual
 2) mainly homosexual (lesbian or gay man)
 3) mainly bisexual
 4) other (please describe): _____
5. Race and/or ethnic identification: _____
6. Religion:
 0) None
 1) Protestant
 2) Catholic
 3) Jewish
 4) Other (please describe): _____
7. How often do you attend religious services?
 0) never
 1) rarely
 2) 3-6 times a year
 3) every month or two
 4) 1-2 times a month
 5) 3-4 times a month
 6) more than once a week
8. Your highest degree:
 1) HS Diploma or GED
 2) College degree
 3) Master's degree (M.A., M.S., M.Ed., etc.)
 4) Doctorate (Ph.D., M.D., Ed.D., etc.)
9. The discipline of your degree: _____
10. What is your approximate yearly income?
 1) \$10,000 or under 2) \$10,001 to \$15,000
 3) \$15,001 to \$20,000 4) \$20,001 to \$30,000
 5) \$30,001 and above

SEXUAL ASSAULT (SA) AND/OR DOMESTIC VIOLENCE (DV) CENTER/ SHELTER HISTORY

11-12. How long have you been doing any kind of counseling/therapy-related work?

	<i>As a volunteer</i>	<i>As paid staff</i>
11. <i>Full time</i>	_____ years _____ months _____ weeks	_____ years _____ months _____ weeks
12. <i>Part time</i>	_____ years _____ months _____ weeks	_____ years _____ months _____ weeks

13-16. How long have you **specifically** been doing **counseling/therapy-related work** with **sexual assault (SA)** and/or **domestic violence (DV) clients** (please place your answers in the **2 tables** regarding SA survivors and DV survivors **below**):

SA SURVIVORS:

	<i>As a volunteer</i>	<i>As paid staff</i>
13. <i>Full time</i>	_____ years _____ months _____ weeks	_____ years _____ months _____ weeks
14. <i>Part time</i>	_____ years _____ months _____ weeks	_____ years _____ months _____ weeks

DV SURVIVORS:

	<i>As a volunteer</i>	<i>As paid staff</i>
15. <i>Full time</i>	_____ years _____ months _____ weeks	_____ years _____ months _____ weeks
16. <i>Part time</i>	_____ years _____ months _____ weeks	_____ years _____ months _____ weeks

17. How long have you volunteered or worked at this particular center?
 _____ years and _____ months

18. How long ago was your last meaningful contact with a SA or DV survivor?
 _____ months _____ weeks _____ days

19. Is this a sexual assault (SA) or a domestic violence (DV) center/shelter (or both) where you are currently working and/or volunteering?
 _____ (1) SA center
 _____ (2) DV center/shelter
 _____ (3) both

What is your work and/or volunteer title at this SA and/or DV center?

20. Work: _____

21. Volunteer: _____

SA/DV CENTER ACTIVITIES

Thinking of an **average week in the past month**, how many **hours per week** did you spend in each of the following activities, paid and/or unpaid, with SA and/or DV survivors, listed in the table below? If you did not spend any hours in a certain activity, please write in '0' (zero). Please describe or circle the activities, where appropriate. Additionally, please add up the total number of hours for each column.

<i>SA/DV CENTER ACTIVITIES</i>	<i>PAID</i>	<i>UNPAID/ VOLUNTEER</i>
22. Individual therapy with clients		
23. Group therapy with clients		
24. Direct client contact other than therapy (eg. Concrete services <u>only</u> such as scheduling apts., transportation, etc.)		
25. Other counseling (hotline crisis intervention, hospital escort duty, <u>direct</u> work with survivors' <u>family</u> members or <u>friends</u> etc.) <i>*PLEASE describe:</i>		
26. Supervising/counseling staff		
27. Administration (paperwork/clerical/fundraising); meetings with staff ; outreach (education, speaker's bureau, etc.); training staff/volunteers ; developing agency policy. <i>*PLEASE specify (circle which activities) and/or describe:</i>		
28. Other (PLEASE describe):		
29. Other (PLEASE describe):		
30. TOTALS	Total= _____ _hrs	Total= _____ hours

31. Thinking of an average week in the past month, estimate the **individual** number of SA and/or DV clients you counseled. _____

SUPERVISION & TRAINING

32. Did you receive any special training for this job/volunteership at this SA or DV center to work with traumatized clients (special training refers to a specific course, certificate program, series of lectures or some other organized consistent program)?

- _____ 0) no
- _____ 1) yes

33. Please describe this training briefly. _____

Thinking of this past month...

34. what was the **average #** of hours **per week** of client supervision that you received (as a supervisee) _____ hours

APPENDIX D
THERAPY/COUNSELING HISTORY

THERAPY/COUNSELING HISTORY

If you **yourself have experienced** sexual abuse or assault or domestic violence, please answer the following questions (beginning with #20). If you **have not experienced** sexual abuse or domestic violence, please check “**not applicable**” immediately below, leave this page blank, and turn to the next page.

_____ **Not Applicable** (I have **not** experienced sexual abuse or domestic violence)

20. Did you ever obtain counseling specifically relating to the sexual abuse/assault and/or domestic violence, as the initial presenting problem?

A. Sexual abuse/assault:

- _____0) no
- _____1) yes
- _____2) not applicable

B. Domestic violence:

- _____0) no
- _____1) yes
- _____2) not applicable

C. Or did it come up in therapy regarding a different presenting problem?

- _____0) no
- _____1) yes
- _____2) not applicable

21. A. If you answered “yes,” to parts A or C of question I (you received counseling related to **sexual assault/abuse**), please answer the following questions:

1. For how long did you receive counseling?
_____years_____months_____weeks_____days
2. How long after the sexual assault/abuse did you wait to seek counseling?
_____years_____months_____weeks_____days
3. How well were you satisfied with the counseling you received?
_____0) not at all
_____1) a little
_____2) moderately
_____3) quite satisfied

B. If you answered “yes,” to parts B or C of question I (you received counseling related to **domestic violence**), please answer the following questions:

1. For how long did you receive counseling?
_____years_____months_____weeks_____days
2. How long after the domestic violence did you wait to seek counseling?
_____years_____months_____weeks_____days
3. How well were you satisfied with the counseling you received?
_____0) not at all
_____1) a little
_____2) moderately
_____3) quite satisfied

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