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GENDER DIFFERENCES IN IMPACT AND COGNITIONS
AMONG CLINICIANS PROVIDING TRAUMA THERAPY

BY

PAMELA JACKSON

A Thesis
Submitted to the Faculty of Graduate Studies
in Partial Fulfillment of the Requirements for the Degree of

MASTER OF SOCIAL WORK

Faculty of Social Work
University of Manitoba
Winnipeg, Manitoba

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**Gender Differences in Impact and Cognitions Among Clinicians Providing Trauma
Therapy**

BY

Pamela Jackson

**A Thesis/Practicum submitted to the Faculty of Graduate Studies of The University
of Manitoba in partial fulfillment of the requirements of the degree**

of

MASTER OF SOCIAL WORK

PAMELA JACKSON©1999

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Abstract

The issue of the effect on therapists of providing therapy focused on helping clients resolve their trauma experiences is a relatively new area of interest and research. Further, while some attention has been paid to the emotional effects of providing therapy services in the burnout literature, and behavioural effects in the secondary traumatic stress literature, little attention has been paid to cognitive disruptions that may occur as a result of providing trauma focused therapy. The purpose of the present study was to examine gender differences in trauma therapists' beliefs or cognitive schema regarding self and others, and additionally, to develop a further understanding of the impact on therapists of providing trauma therapy. To this end, two hundred and forty-three therapists from across Canada completed the Impact of Event Scale (IES), the Traumatic Stress Institute Belief Scale (TSI), and a questionnaire requesting descriptive data. While no relationship was found between the IES and the provision of trauma therapy, some disruptions in cognitive schema were found as measured by the TSI Belief Scale. Further, women were found to be more disrupted in regards to their beliefs about their own safety, while men were found to be more disrupted in regards to their self esteem. Additionally, while therapists who had experienced childhood trauma reported more cognitive disruptions in self safety than did therapists without a childhood trauma history, therapists who experienced trauma in adulthood reported more cognitive disruptions in control, intimacy, safety and trust than did therapists without a history of trauma in adulthood. Further research is clearly required to come to a fuller understanding of the impact of providing trauma focused therapy.

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Introduction

In the past two decades, mental health professionals have shown an unprecedented interest in the psychological aftermath of victimization (Briere, 1984, 1988, 1989; Figley, 1985, 1988; Herman, 1992). However, less attention has been focused on the enduring psychological consequences for the therapist of exposure to the traumatic experiences of survivor clients. Working with survivors of abuse often poses a risk to therapists' emotional and psychological health and well being (Dutton, 1994; Herman, 1992; McCann, Sakheim, & Abrahamson, 1988; Williams & Sommer, 1994). Trauma, in and of itself, is contagious (Herman, 1992). One of the critical roles of the therapist is to bear witness to the atrocities that victims experience. It has been suggested that the therapist then "...experiences, to a lesser degree, the same terror, rage and despair as the patient" (Herman, 1992, p. 140).

Effects of the Provision of Trauma Therapy on Therapists

A review of the literature shows that a variety of concepts have been explored to examine the impact on therapists of providing therapy services, including burnout, secondary traumatic stress disorder, counter-transference and vicarious trauma. These concepts will be briefly reviewed and compared.

A significant amount of research has been done in the area of burnout (e.g., Beck, 1987; Deutsch, 1984; Farber & Heifetz, 1982; Freudenberger & Robbins, 1979; Garden, 1987; Hagen, 1989; Pines, Aronson, & Kafry, 1981; Rotter, 1954; Sze & Ivker, 1986). The causative factors of burnout have usually focused on the situation, with the work

defined as too demanding, too difficult or too unrewarding. Pines and Aronson (1988) have defined burnout as "a state of physical, emotional and mental exhaustion, caused by long term involvement in emotionally demanding situations" (Pines & Aronson, 1988, p. 9). Figley (1995) argues that emotional exhaustion is a key factor in burnout and further, that burnout has been defined as a collection of symptoms that are associated with emotional exhaustion. Although the burnout literature has not specifically addressed the impact of working with trauma survivors, the concepts are clearly relevant. However, as Danieli (1981) and Haley (1974) point out, the potential effects of working with trauma survivors are distinct from those working with other difficult populations because the therapist is exposed to the horrible images and suffering that are characteristic of serious trauma.

Secondary Traumatic Stress Disorder (STSD) is defined as the natural, consequent behaviours and emotions resulting from knowledge about a traumatizing event experienced by a significant other (Figley, 1995). Figley (1995) states that STSD is a natural and predictable consequence of working with clients who have experienced traumatic events. He suggests that it is the stress that occurs from helping or wanting to help a traumatized person. STSD is based on a diagnostic conceptualization of Post-traumatic Stress Disorder (PTSD; Figley, 1995) and is described as a syndrome of behavioral symptoms that are identical to PTSD except that exposure to a traumatizing event experienced by one person becomes a traumatizing event for the second person (Figley, 1995). Consistent with the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV; American Psychiatric Association, 1994), STSD focuses on

observable behavioral symptoms some of which include: sleep difficulties; irritability; difficulty concentrating; exaggerated startle responses; physiologic reactivity to cues; re-experiencing the traumatic event through dreams, recollections or experiencing sudden reminders; physiologic amnesia; detachment; and efforts to avoid thoughts, feelings, activities and situations.

The counter-transference literature has also provided some useful insights into the impact on therapists of providing therapy. Freud (1959) cited in Figley (1995) states that counter-transference is the distortion of judgment on the part of the therapist due to the therapist's life experiences and is associated with her or his unconscious, neurotic reaction to the client's transference. More recently, Corey (1991) defined counter-transference as the process of seeing oneself in the client, of over-identifying with the client, or of meeting emotional needs through the client. Hence, counter-transference has focused on weaknesses within the individual therapist, and refers to the activation of the therapist's unconscious or unresolved conflicts (Farber, 1985; Haley, 1974) Counter-transference then is viewed as a negative consequence of therapy and one that should be prevented or eliminated. As such, it has been postulated that there are particular therapist qualities that are helpful in managing counter-transference effectively including anxiety management, self-insight and self-integration (Hayes, Gelso, VanWagoner, & Diemer, 1991).

McCann and Pearlman (1990a) introduced the concept of vicarious trauma to describe the effect of trauma work on helpers. This theoretical framework has since been elaborated elsewhere (Newman & Gamble, 1995; Pearlman & Mac Ian, 1995; Pearlman

& Saakvitne, 1995a, 1995b; Rosenbloom, Pratt, & Pearlman, 1995; Saakvitne, 1991, 1995). Vicarious trauma is defined as a transformation that occurs within the therapist's inner experience that results from empathic engagement with clients' trauma material (Pearlman & Saakvitne, 1995a). Vicarious trauma results in cognitive disruptions in therapists' frames of reference, including their sense of identity, world view, and spirituality, as well as their self capacities, ego resources, central cognitive schema, and sensory and imagery systems. The central cognitive schema that are most affected by vicarious trauma are beliefs and psychological needs regarding safety, trust, control, esteem and intimacy (Pearlman & Saakvitne, 1995a). The changes experienced by the therapist parallel those experienced by trauma survivors (Pearlman & Saakvitne, 1995a; Rosenbloom et al., 1995) and result from direct exposure to working with trauma survivors, or indirectly through exposure to graphic descriptions of violence or victimization in supervision, readings or professional presentations (Pearlman & Saakvitne, 1995a; Rosenbloom et al., 1995).

The literature emphasizes that vicarious trauma is a normal response to providing trauma therapy, suggesting that vicarious trauma is an inevitable consequence of providing this type of therapy. As well, there are several common features of vicarious trauma. These include the effects being: cumulative; permanent, in that the effects may result in lasting changes in the way that therapists may think and feel about themselves, others and the world around them; and modifiable, in that there are actions that therapists can take to minimize and ameliorate the negative impact of engaging in trauma work (Neumann & Gamble, 1995; Pearlman & Saakvitne, 1995a; Rosenbloom et al., 1995).

Although burnout, STSD, counter-transference, and vicarious trauma all focus on the effects on therapists of providing therapy services, there are some distinctions between these concepts, especially when considering the impact of providing trauma services. Some of these differences have also been demonstrated empirically. Pearlman and Saakvitne (1995b) argue that burnout is related to the work situation and does not incorporate the interaction of the situation with the individual, which is central to vicarious trauma and STSD. Further, burnout is related to issues of emotional exhaustion while STSD is related to behavioral symptoms, and vicarious trauma is related to disruptions in cognitive schema. Two recent studies have empirically validated a distinction between burnout and vicarious trauma or STSD. In her study examining the impact on therapists of working with clients dealing with sexual trauma, Kassam-Adams (1995) found specific effects of providing trauma therapy on therapists that were similar to the intrusion and avoidance phenomena of post-traumatic responses in trauma survivors and which were distinct from burnout or occupational stress. She found that general occupational stress was not related to working with sexually traumatized clients. Further, in their study examining the effects on counsellors of working with sexual violence survivors, Schauben and Frazier (1995) found that counsellors with a higher percentage of sexual violence survivors as clients reported more disruptions in their basic cognitive schema about themselves and others, consistent with the experience of vicarious trauma. However, there was no relationship to measures of burnout. Neumann and Gamble (1996) argue that vicarious trauma, while a separate construct from burnout, may be a precursor to burnout. They state that vicarious trauma may set the stage for

emotional exhaustion, depersonalization, and reduced feelings of personal accomplishment, which they state are the three components of burnout.

Vicarious trauma also differs from secondary traumatic stress disorder (STSD) in focus and context. Pearlman and Saakvitne (1995b) state that, consistent with the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV; American Psychiatric Association, 1994), STSD focuses on observable symptoms and does not integrate less objective factors such as context and etiology. They argue that, while the two approaches are not diametrically opposed, there is a difference in focus. While STSD only examines behavioral symptoms, vicarious trauma encompasses the self of the individual in a larger context of human adaptation. While STSD focuses on specific, short-term, external manifestations of trauma effects, vicarious trauma focuses on permanent changes in the internal structure of the individual, including changes in the individual's beliefs about self, others, and the world (Pearlman & Saakvitne, 1995a). Further, these changes occur in a unique way in each affected individual, given that individual's unique history and experience in the world. As well, while STSD occurs as a result of one particular traumatizing event, vicarious trauma occurs as a result of on-going exposure to trauma material. Consequently, vicarious trauma is a result of changes that occur and evolve over time (Pearlman & Saakvitne, 1995a).

The empirical evidence is, at this point, unclear in elucidating the differences between vicarious trauma and STSD. In a recent study, Simonds' (1996) empirical research supported Pearlman and Saakvitne's (1995a) view. In her study of vicarious trauma in therapists treating sexual abuse survivors, Simonds (1996) found that no

participants exhibited psychological disruptions at a severity level that is consistent with secondary traumatic stress disorder, but found that a significant number of participants reported negative changes in world view, consistent with vicarious trauma. She concluded that the results of her study illustrated that the vicarious trauma model fit the pattern of her sample's reaction significantly better than the secondary traumatic stress model. However, Kassam-Adams (1995) found empirical support for the notion of secondary trauma in therapists working with sexual abuse survivors, when using a measure of PTSD. However, she did not use a measure to examine vicarious trauma.

Pearlman and Saakvitne (1995b) and Figley (1995) argue that counter-transference is related to a therapist's response to a particular client and what that client represents to the therapist, given the therapist's unresolved issues. Consequently, counter-transference is related to the therapists' personal issues rather than related to the nature of the services being provided. STSD is related to the impact of a particular traumatizing event, while vicarious trauma refers to the cumulative impact of trauma material on the therapist across clients. Neither of these concepts are related to the therapist's unresolved issues. However, Pearlman and Saakvitne (1995b) and Neumann and Gamble (1995) state that there is an interaction between counter-transference and vicarious trauma. Neumann and Gamble (1995) state that unaddressed vicarious trauma can make the processing of counter-transference material much more difficult, while Pearlman and Saakvitne (1995b) state that vicarious trauma can increase the therapist's susceptibility to some counter-transference responses. A review of the literature revealed no empirical research examining these definitional and theoretical distinctions.

In considering the above review, it can be argued that while the concepts of burnout, STSD, counter-transference and vicarious trauma may be related to each other, they are different in focus, potential effects, and context. Further it can be argued that vicarious trauma is quite unique when compared to the other concepts. The uniqueness of the concept of vicarious trauma seems to stem from a few critical features. Firstly, vicarious trauma occurs as a result of a cumulative process and on-going exposure to trauma material as opposed to effects of a demanding work environment (burnout) or responses to an individual event (STSD) or person (counter-transference). Secondly, vicarious trauma results in permanent internal, structural changes in the individual's belief systems and view of themselves, others and the world. Burnout and STSD refer to more transient effects. Further, the concept of vicarious trauma includes the incorporation of the self and how the self and the psychological schema interact with the trauma material. Consequently, vicarious trauma is a unique experience for each affected individual that is informed by that individual's life experiences and constructed reality. This is very different from the concept of STSD, in that STSD is a specific set of proscribed symptoms and short-term, behavioural manifestations of traumatic effects. Further, it can be argued that the concept of vicarious trauma is unique in regards to its focus. Vicarious trauma is conceptually unique as it focuses on disruptions in cognitive schema that may occur as a result of providing trauma therapy. Certainly, attention has been paid to the emotional or the behavioral effects of providing therapy. Burnout focuses on emotional effects, while STSD focuses primarily on behavioral effects. Vicarious trauma focuses on internal, structural changes in the individual's belief

systems and view of themselves, others and the world and is the only concept to focus on these cognitive disruptions. This unique focus on cognitive effects explores an aspect of the provision of trauma therapy that has not yet been examined. It can clearly be argued that exploring the cognitive disruptions that may occur as a result of providing trauma therapy would be quite useful in furthering our understanding in the area of the effects of the provision of trauma therapy. This present research will draw from the vicarious trauma literature in focusing specifically on the cognitive disruptions that may occur in providing trauma therapy.

Theoretical Overview of Vicarious Trauma

As stated earlier, vicarious trauma is defined as a transformation that occurs within the therapist's inner experience that results from empathic engagement with clients' trauma material (Pearlman & Saakvitne, 1995a). Vicarious trauma results in cognitive disruptions in therapists' frames of reference, including their sense of identity, world view, and spirituality, as well as their self capacities, ego resources, central cognitive schema, and sensory and imagery systems. Vicarious trauma is based on the Constructivist Self-Development Theory (CSDT; McCann & Pearlman, 1990c), which is a theory of personality development that describes the impact of trauma on an individual's development and sense of self. The CSDT blends object relations, self-psychology and social cognition theories (McCann & Pearlman, 1990c). It is founded on a constructivist view of trauma, in which the individual's unique history shapes his or her experiences of traumatic events and defines the adaptation to trauma. A constructivist perspective implies that human beings actively create and construct their own personal

realities or representational models of the world. This becomes the framework from which individuals order and assign meaning to new experiences (Mahoney, 1982). Traumatic events then can only be understood within the context of the survivor's unique meaning system (McCann & Pearlman, 1990c). A fundamental premise of CSDT is that trauma disrupts cognitive schema, or beliefs and assumptions about self, others, and the world. These disruptions occur in six core areas, including frame of reference, safety, trust, esteem, control, and intimacy (McCann & Pearlman, 1990c, 1992a, 1992b; Pearlman & Saakvitne, 1995a, 1995b).

A major concept that informs CSDT is Piaget's (1971) theory of assimilation and accommodation. Assimilation refers to the process by which new information is integrated into existing schema and the existing belief or schema is then supported by this new information. However, when new information is received that is quite divergent from existing schema, the schema or beliefs will change to accommodate the new information (Piaget, 1971). McCann and Pearlman (1990c) argue that trauma, by its very nature, requires an accommodation in core cognitive schema about the self and the world. Further, they state that events are traumatic to the extent that the individual perceives them to be traumatic and to the extent that the trauma disrupts the individual's central psychological needs and related cognitive schema about self, others and the world (McCann & Pearlman, 1990c, 1992a, 1992b).

The last fundamental concept underlying CSDT, as outlined by McCann and Pearlman (1990c), is that the self is the core of one's identity and inner life and that the self develops over one's lifetime. Thus, the individual self is in a constant process of

change and development, informed by the unique experiences of that individual. McCann and Pearlman (1990c) further state that the individual's unique psychological adaptation to trauma can be understood as a complex interplay among three dimensions: the self; the traumatic memories; and the psychological needs and related cognitive schema.

Review of Empirical Research

The examination of cognitive disruptions as a result of providing trauma therapy, and more generally, vicarious trauma, is a relatively new area of study. However, there is some recent research. The empirical research to date has focused on two major areas of examination. The first area of study that has been examined is whether there are, in fact, effects of providing trauma therapy. This has been examined by determining whether there are differences between the impact of providing trauma therapy and the impact of providing non-trauma therapy. The second major focus of study has been examining whether the therapist's own experiences of trauma affect the impact of providing trauma therapy. In addition, three studies have examined gender differences and vicarious trauma as secondary research questions. These three areas of study will be reviewed.

The impact of trauma vs. non-trauma work. Bober (1996) found that trauma therapy had a significantly greater impact on therapists than did non-trauma therapy. Bober (1996) used both the Impact of Event Scale (IES; Horowitz, Wilner, & Alvarez, 1979) and the Traumatic Stress Institute Belief Scale (TSI Belief Scale; Pearlman & Mac Ian, 1993) to measure the impact on therapists of providing trauma therapy. The IES (Horowitz et al., 1979) is designed to measure acute behavioral, emotional, and psychological reactions on the dimensions of avoidance and intrusion. The TSI Belief

Scale (Pearlman and Mac Ian, 1993) is designed to measure cognitive schema related to self, others, and the world. Bober (1996) conducted a mail out survey and received a 40% response rate for a total of 281 respondents. Bober (1996) defined trauma therapy as providing therapy to clients who had experienced sexual or physical abuse and assault as children and/or adults, violent crimes, workplace accidents, and unexplained or sudden death related to accidents or illness. Bober (1996) found a significant positive correlation between the number of hours therapists engaged in trauma work and a negative impact on the therapists. This positive correlation was found with both the IES (Horowitz et al., 1979) as well as the TSI Belief Scale (Pearlman & Mac Ian, 1993). On the TSI Belief Scale (Pearlman & Mac Ian, 1993), Bober (1996) found the most significant correlations with disruptions in the cognitive schema related to the areas of safety, self esteem and intimacy.

Gamble, Pearlman, Lucca, and Allen's (1996) findings were similar to those of Bober (1996) in identifying different impacts of providing trauma therapy and non-trauma therapy. They examined whether there are specific aspects of therapy with trauma survivors which differ from therapy with non-traumatized clients, in order to distinguish trauma and non-trauma oriented therapies and set the stage for the phenomenon of vicarious trauma. To examine this question, they developed a measure they called the Trauma Work Questionnaire (TWQ), which is designed to measure subjective levels of distress in response to a variety of client behaviours. They mailed a survey to 650 therapists and received responses from 123 participants for a 19% response rate. They defined trauma clients as "individuals who were struggling with the effects of sexual or

physical abuse or interpersonal violence (including war)" (Gamble et al., 1996, p. 16). They asked each therapist to complete the questionnaire twice. Therapists were asked to complete one questionnaire in regards to their work with trauma survivors and complete a second questionnaire in regards to their work with clients who had not experienced trauma. They found that their sample of therapists experienced their work with trauma clients as distinctly different and more distressing than their work with non-traumatized clients. The data indicated that therapy with trauma clients involved significantly more frequent episodes of stressful client behaviours including flashbacks, dissociation, self destructive behaviours and hostile acting out. As well, the results showed that therapists experienced a number of events to be significantly more distressing when occurring with trauma clients versus non-trauma clients, including self destructive behaviours, self-injury, hospitalization, and clients being in danger. Additionally, they found that therapists reported significantly more stress in working with trauma clients compared with non-trauma clients, even when the frequency of distressing behaviours was held constant. Gamble et al. (1996) concluded that these situation variables, and possibly others still to be identified, may set the stage for vicarious trauma, although they did not specifically investigate particular elements of the therapists' distress or specific manifestations of their distress. They suggested that a valid measure of vicarious trauma has yet to be developed.

Battley (1996) examined the effects on therapists of working with trauma clients, attempting to determine whether vicarious trauma is an empirically verifiable phenomenon. Battley (1996) used the World Assumptions Scale (Janoff-Bulman, 1989)

and an adapted version of the Modified Post Traumatic Stress Disorder Symptom Scale (Falsetti, Resick, Resnick, & Kilpatrick, 1992) to test her assumptions. Battley (1996) did not indicate how she defined trauma clients, stating that the therapists responding to her survey identified whether they worked with a trauma clientele. There were 88 participants in her study, although she did not report a response rate. Battley (1996) found no significant differences in therapists' cognitive schema related to world view based on whether their caseload included trauma clients. However, she reported that therapists working with trauma clients did report significantly higher levels of post-traumatic stress-related symptomology than therapists without trauma clients. She further noted that symptomology was positively correlated with a trauma clientele caseload and negatively correlated with therapist age.

Kassam-Adams (1995) examined the risks of treating sexual trauma. Sexually traumatized clients were defined as clients who presented this issue in therapy. She conducted a mail out survey and received a 37% response rate for a total of 100 participants. Kassam-Adams (1995) used the IES (Horowitz et al., 1979), and the Personal Strain Questionnaire of the Occupational Stress Inventory (PSQ; Osipow & Spokane, 1981). The PSQ (Osipow & Spokane, 1981) is designed to measure general work-related stress and psychological distress. Participants were asked about the personal impact of various client issues and diagnoses, including depression, schizophrenia, personality disorders, and working with sexually traumatized clients, and about therapists' exposure to these difficult issues. Therapists were asked both about their current exposure as well as their cumulative exposure over their career.

Kassam-Adams (1995) found that therapist disruption, as measured by the IES (Horowitz et al., 1979), was significantly associated with both the current and cumulative level of exposure to sexually traumatized clients. PTSD symptoms were not related to exposure to the other client problems or diagnoses. As well, these symptoms were distinct from burnout or occupational stress. In comparing the impact of working with sexually traumatized clients as opposed to other client groups, sexual trauma issues and personality disorders had the highest impact rating.

Schauben and Frazier (1995) examined the impact on female counsellors of working with sexual violence survivors. In order to address this question, the researchers used five quantitative measures as well as two open-ended qualitative questions. The quantitative measures included: five sub-scales from the TSI Belief Scale (Pearlman & Mac Ian, 1993); a symptom checklist developed by the researchers, based on the DSMIII-R (American Psychiatric Association, 1987) to measure intrusion, avoidance, and arousal, seen as symptomatic of PTSD; a self rating scale developed by the researchers to measure the extent that the participants felt that they were experiencing vicarious trauma; four sub-scales from the Brief Symptom Inventory (BSI; Derogatis, 1977) to examine negative affect; and the Maslach Burnout Inventory (MBI; Maslach & Jackson, 1986) to measure levels of burnout. They conducted a mail out survey and received a 42% response rate for a total of 148 participants. Schauben and Frazier (1995) found that counsellors who had a higher percentage of sexual violence survivors as clients reported more disruptions in their basic cognitive schema regarding self and others, more symptoms of PTSD, and more self reported vicarious trauma. Working with survivor

clients was not related to negative affect or burnout.

In regards to the qualitative data, Schauben and Frazier (1995) found that the greatest negative effects of working with survivors was reported to be emotional distress and changes in beliefs. In examining the most difficult aspects of the work, they found that some of the most reported difficulties included: concerns regarding therapy management, including difficulty establishing boundaries and trust; dealing with clients' emotions regarding the abuse, including fear, anger, and pain; and dealing with their own emotions regarding their clients' abuse experiences.

Simonds (1996) explored the relationship between vicarious trauma and therapist exposure to specific aspects of trauma therapy. Simonds (1996) examined only therapists who had worked with at least one adult survivor of childhood sexual abuse within the previous year. She gave measurement packages to participants at trauma conferences and received a response rate of 28% for a total of 138 respondents. Consistent with Pearlman and Saakvitne's (1995b) definition of vicarious trauma, exposure included exposure to clients' graphic trauma material and exposure to stories of people's intentional cruelty. In addition, Simonds' (1996) study also examined the relationship between a number of variables and vicarious trauma, including length of time working as a therapist, and percentage of sexual abuse clients on a therapist's caseload.

Measures used for this study included a Therapist's Information Questionnaire, selected sub-scales of the TSI Belief Scale (Pearlman & Mac Ian, 1993) and the Secondary Traumatization Questionnaire (STQ) a measure developed by Simonds (1996). This questionnaire was based on all of the criteria of PTSD except that exposure

was defined as knowledge of the traumatizing event. As well, participants were asked to identify if symptoms were a result of their work with adult survivors. Further, an open ended question asked participants to describe reactions to their work with survivors.

Simonds (1996) found that exposure to clients' traumatic experiences was significantly related to post-traumatic reactions as measured by the STQ, and disruptions in cognitive schema as measured by the TSI Belief Scale (Pearlman & Mac Ian, 1993), most notably the schema regarding other-safety. Simonds (1996) also found that the therapists' most commonly cited negative changes occurred in their self capacities and world views. Simonds (1996) concluded that providing trauma therapy to adult survivors is an important predictor of indirect trauma. Percentages of adult survivors of childhood abuse in a therapist's caseload was not found to be a predictor of indirect trauma, while percentage of sexually abused children and adult sexual assault clients were significant predictors. Simonds (1996) concluded that the exposure to children's trauma and recent trauma has a strong impact on therapists. Further, she found that, for therapists working with adult survivors of childhood abuse, the degree of exposure predicted vicarious trauma as opposed to the percentage of clients seen. As well, Simonds (1996) found that the severity of post-traumatic symptomology was low, with no participants exhibiting a severity level consistent with secondary traumatic stress as a disorder. However, participants did report negative changes in world view, consistent with the experience of vicarious trauma. Simonds (1996) concluded that the impact of working with sexual abuse survivors on the therapists in her sample was consistent with vicarious trauma and not consistent with secondary traumatic stress disorder.

In considering the above research, a number of difficulties stand out. One of the first difficulties with these studies pertains to measurement issues. While Bober (1996), Schauben and Frazier (1995), and Simonds (1996) used the TSI Belief Scale (Pearlman & Mac Ian, 1993), to measure the impact of working with trauma clients, Gamble et al. (1996), Battley (1996), and Kassam-Adams (1995) used a variety of other scales to measure the impact of working with trauma clients. Some of these other measures had established psychometric properties and some measures were created for that particular study, thus having no established reliability or validity. The use of measures that have no established reliability or validity makes the meaning of the results of these studies uninterpretable. It may also be argued that, given the use of such a variety of measures, it is unclear whether in fact the same construct is being measured across these studies.

A second difficulty with these studies is definitional issues. While both Bober (1996) and Gamble et al. (1996) used explicit and broad definitions of trauma, Battley (1996) allowed the participants to self-define whether or not they worked with trauma clients. The remainder of the researchers examined the impact of working with clients who were sexually abused or assaulted as adults or as children. Further, none of the studies gave a specific definition for the term “trauma work”. While in some studies, trauma work was defined in terms of specific events that the clients had experienced (e.g., physical or sexual abuse), it is not made clear in any of these studies to what extent the trauma was the focus of the therapeutic work. Clearly, there are many individuals in therapy who have a history of trauma but direct trauma work might never occur. It is unclear whether these types of situations also came under the rubric of “trauma work”

within these studies.

A further shortcoming of the above noted studies is the response rates. The response rates vary from 19% to 42% across these studies. This presents great difficulty in the generalizability of any of the studies. As well, because of the low response rate, one is left to wonder whether the participants who responded to the surveys are different from those who did not respond to the surveys. The conclusions from these studies must therefore be seen as tentative at best.

Despite these issues, all of these studies were similar in finding a general negative impact on therapists who engaged in trauma work. As well, this impact was differentiated from the impact of working with non-trauma clients. Further, Gamble et al. (1996) were able to explicate some of the more distressing aspects of working with trauma survivors, and further found that even when the frequency of distressing behaviours was held constant, therapists were still more negatively impacted when working with trauma clients as compared to non-trauma clients.

In considering cognitive disruptions specifically, four of the above noted six studies examined this issue, with three studies finding a positive correlation between cognitive disruptions and provision of trauma therapy (Bober, 1996; Schauben & Frazier, 1995; Simonds, 1996) and one study finding no effect (Battley 1996). While Bober (1996), Schauben and Frazier (1995) and Simonds (1996) used the TSI Belief Scale (Pearlman and Mac Ian, 1993) to measure cognitive disruptions, Battley (1996) used the World Assumptions Scale (Janoff-Bulman, 1989) to measure disruptions. The use of different measures, possibly measuring different constructs, may account for the

differences in findings.

Therapist trauma history and vicarious trauma. Pearlman and Mac Ian (1995) found that therapists who reported a trauma history were more negatively affected by engaging in trauma work than therapists without a trauma history. They examined vicarious trauma in 188 self identified trauma therapists reflecting a 32% response rate to their survey. Trauma was not defined by the researchers, and therapists were asked to complete questionnaires if they identified themselves as trauma therapists. The measures used for this study included: a revised version of the TSI Belief Scale (Pearlman & Mac Ian, 1993); the IES (Horowitz et al., 1979); the Symptom Checklist-90 (SCL-90; Derogatis, 1977); and the Marlowe-Crowne Social Desirability Scale (Crowne & Marlowe, 1964).

Although the authors found a very low mean score on the TSI Belief Scale (Pearlman & Mac Ian, 1993) for the entire sample, they found a significant difference between the mean score of therapists with a trauma history compared to therapists without a trauma history, with the therapists with a trauma history reporting a much higher mean score. As well, therapists with a trauma history showed more disruptions on the IES (Horowitz et al., 1979) and on the SCL-90 (Derogatis, 1977). Further, Pearlman and Mac Ian (1995) found that therapists with their own trauma history were also more affected by the length of time they have been doing the work and, to a lesser degree, by the percentage of survivors on their caseload. However, they also found that the newest therapists in the trauma history group were experiencing the most difficulties, while the more experienced survivor therapists showed significantly less general distress.

However, therapists without a trauma history who had been doing trauma work longer, experienced some cognitive disruptions on some sub-scales of the TSI Belief Scale (Pearlman & Mac Ian, 1993), most notably in self-intimacy and other-esteem. As well, utilizing a multiple regression, Pearlman and Mac Ian (1995) found that trauma history predicted vicarious trauma.

Green (1995) also examined whether there was a relationship between personal trauma history and level of vicarious trauma. The 53 participants in her study were asked for demographic information including number of years as a trauma therapist and whether they were a survivor of physical, emotional or sexual trauma. The 53 respondents reflect a 64% response rate. Trauma was left to the participants to self-define. The TSI Belief Scale (Pearlman & Mac Ian, 1993) was used to measure vicarious trauma. Almost one half of the participants identified themselves as having experienced physical, emotional or sexual abuse. Green (1995) found that therapists with a personal trauma history exhibited no differences in cognitive schema compared to participants without a personal trauma history.

Kassam-Adams (1995), in her previously mentioned study, found that therapists' personal trauma history was a significant predictor of the level of PTSD. As well, Battley (1996), also found that therapists who reported having their own trauma history obtained significantly higher scores on a PTSD measure, and were less positive in their views of themselves and the world. However, Schauben and Frazier (1995) found that counsellors with their own trauma history were not more distressed than counsellors without a trauma history. As well, Simonds (1996) found no relationship between therapists' own

trauma history and any measure of indirect trauma.

While Battley (1996), Kassam-Adams (1995), and Pearlman and Mac Ian (1995) found greater disruptions in therapists with a trauma history, Schauben and Frazier (1995), Green (1995), and Simonds (1996) did not find this difference. There are several possible explanations for this. Firstly, there was little consistency in how impact was measured across studies. The only overlap in measures was between Pearlman and Mac Ian (1995) and Green (1995) both using the TSI Belief Scale (Pearlman & Mac Ian, 1993), although it is unclear whether they each used the same version of this scale. Schauben and Frazier (1995) and Simonds (1996) used some sub-scales of the TSI Belief Scale (Pearlman & Mac Ian, 1993) along with a variety of other measures. Some of these other measures have established psychometric properties and some measures were created for that particular study. Kassam-Adams (1995) used the IES (Horowitz et al., 1979) along with other scales, only one of which was not standardized. Given the use of a variety of different outcome measures, it is unclear whether the same construct was being measured across these studies. Further, the fact that a number of the researchers used measures that had no established psychometric properties calls into question the reliability and validity of the measures and may further account for the differences in the findings across these studies.

Secondly, while all of the studies were examining the impact of providing trauma therapy, three of the studies allowed participants to self-define if they were trauma therapists, without trauma being defined (Battley, 1996; Green, 1995; and Pearlman & Mac Ian 1995). Further, Schauben and Frazier (1995) looked exclusively at the impact of

working with sexual assault survivors, Simonds (1996) examined the impact of working with childhood sexual abuse survivors, and Kassam-Adams (1995) examined the impact of working with sexually traumatized clients, but did not define this term further. This lack of a clear definition of trauma can certainly account for the differences in findings across these studies. Clearly, trauma may mean different things to different individuals. That each individual within each study was left to decide their own definition of trauma, whether in regards to their definition of themselves as trauma therapists or as trauma survivors, results in a lack of clarity regarding what is being examined. Consequently, it becomes unclear, within each study as well as between studies, whether the same variable or sample is being examined.

Gender differences and vicarious trauma. Pearlman and Mac Ian (1995), in their previously mentioned study, used a multiple regression analysis with a number of predictor variables, including gender, to predict vicarious trauma. They found that gender did not predict vicarious trauma. Green (1995) found no significant differences between gender and level of vicarious trauma in her sample. However, when she examined gender differences within a sub-group of therapists who had a trauma history she found a significant correlation between gender and vicarious trauma. She found that women had higher levels of vicarious trauma within this sub-group than did men. However, she recommended further study of the relationship between gender and vicarious trauma. Sample size, the number of male participants in general, and the number of males in her trauma subgroup were very limited. Kassam-Adams (1995) found that in addition to personal trauma history, gender (female) was a significant predictor of the therapists'

levels of PTSD. Kassam-Adams (1995) recommended that a further examination of the role of gender in understanding vicarious trauma is warranted.

The above mentioned studies illustrate that the findings regarding gender and vicarious trauma are inconsistent and consequently inconclusive. Pearlman and Mac Ian (1995) found that gender did not predict vicarious trauma, while Green (1995) and Kassam-Adams (1995) did find some gender effects. However, the examination of gender in relation to vicarious trauma was not a primary focus in any of these studies. As well, the above noted measurement issues and definitional issues may also explain the differences in the findings regarding gender and vicarious trauma.

Critique and Conclusions

A fundamental difficulty in both the theoretical and empirical literature is that vicarious trauma has not yet been validated as a construct or as a theory. All of the research to date has focused on determining if effects of vicarious trauma can be found. However, the theory of vicarious trauma has yet to be clearly defined and the process of the development of vicarious trauma has yet to be specified. This leaves a number of conceptual questions unanswered. Further, none of the empirical literature has focused on examining the validity of the concept of vicarious trauma in regards to criterion-related or construct validity. However, the literature regarding the concept of vicarious trauma has highlighted its uniqueness in focusing on fundamental changes in cognitive schema and beliefs. Further, the empirical literature has indicated a relationship between certain types of cognitive schema and the experience of providing trauma therapy. This unique focus on cognitive effects explores an aspect of the provision of trauma therapy

that has not yet been examined. As cited earlier, the burnout literature has focused on emotional effects while the secondary traumatic stress literature has focused on behavioral effects. It can clearly be argued that exploring the cognitive effects of providing trauma therapy would therefore be quite useful in furthering our understanding in this area.

It is apparent from a review of the literature, both theoretical and empirical, that the concept of vicarious trauma is quite new, such that there is only a small body of literature and research in the area. As well, current research is still very much in the exploratory stage. Because of the exploratory nature, researchers have used a wide variety of measures to explore the cognitive impact of working with trauma clients, including developing a number of measures themselves. While this allows for the possibility of exploring all of the complexities of the issue, because of the use of a variety of measures, including self-developed measures, the research is quite disparate in its findings. Further, given that a number of measures that were used had no established psychometric properties, the results can be questioned. It may also be argued that, given the use of such a variety of measures, it is unclear, whether in fact the same construct is being measured across these studies.

A further difficulty when examining this research, is that the researchers often used different definitions of trauma work, or allowed the participants to define trauma work themselves. While Pearlman and Mac Ian (1995) argue that a constructivist perspective requires that the participant rather than the researcher define what is traumatic, it certainly leads to confusion when attempting to draw conclusions about the

construct and challenges the construct validity of the research. That individuals within most studies were left to decide their own definition of trauma, results in a lack of clarity regarding what is being examined. Consequently, it becomes unclear, within each study as well as between studies, whether the same variable is being examined.

A further limitation of the current research is the generally low response rate in each study. The response rates vary from 19% (Gamble et al., 1996) to 64% (Green, 1995) with the remainder of the response rates in the 30% to 40% range. Given the self-selected nature of respondents it may be argued that their responses would qualitatively differ from those individuals not responding, leading to a potential bias in the results.

As is evident from a review of the empirical research, gender and its relationship to the concept of vicarious trauma has not been a variable that has been closely examined to date. While this author found three studies reporting information on gender effects (Green, 1995; Kassam-Adams, 1995; Pearlman & Mac Ian, 1995), exploring gender differences were secondary aspects of each of these studies. As well, results were inconsistent, with Pearlman and Mac Ian (1995) finding no gender effect, and Green (1995) and Kassam-Adams (1995) finding gender effects. In fact, all of the studies recommended further examination of the impact of gender on vicarious trauma.

Gender Differences in Social and Cultural Experiences

The potential for finding gender differences in relation to vicarious trauma has clear precedent in a cumulation of theory and research. There is extensive literature documenting gender differences in stress and coping (Aneshensel & Pearlin, 1987; Hamilton & Fagot, 1988; Marino, 1986; Ptacek & Dodge, 1994; Ptacek, Smith, & Zanas.

1992; Sigmon, Stanton, & Snyder, 1995) and gender differences in rates of depression and psychological distress (Belle & Goldman, 1988; Kessler, Brown, & Beaman, 1981; Weissman & Klerman, 1985). There is also extensive literature on gender differences in psychological development (Gilligan, 1982; Kaschak, 1992; Miller, 1973, 1976, 1984). Clearly, it has been argued that women experience the world differently than do men, due to the patriarchal nature of our society and the inherent sexism and male violence that women experience (Brownmiller, 1975; Cook, 1993; Dworkin 1976; Kaschak, 1992; Kitter, 1993; MacKinnon, 1987; Pearlman & Saakvitne; 1993). Brown and Gilligan (1992) argue that women's psychological development within a patriarchal society is inherently traumatic. Cook (1993) states that women are systemically devalued and/or violated and this differentiation by gender is pervasive enough that it can be argued that women and men live in two different worlds. Saakvitne and Pearlman (1993) further argue that violence against women is an endpoint of a continuum of messages about gender that begins with the pervasive devaluation of women. Kaschak (1992) states that women are constantly at risk of violation and abuse, within both their public and private realms. She further states that part of early female training and socialization involves learning of the danger with which women must contend, and thus fear and mistrust become an integral part of women's identity.

Certainly, current statistics support the notion that most women experience at least one form of violence in their lives. In a survey, Russel (1986) found that 24% of women reported at least one incident of sexual assault, and a further 31% of women reported an attempted sexual assault. Koss, Gidycz, and Wisniewski (1987) found that

27% of women in their sample reported that they had experienced sexual assault or attempted sexual assault as an adult, and a further 14% of women report a sexual assault by their husbands. Kaschak (1992) found that one third of all females sampled were sexually abused in childhood by a family member while Russel (1986) found that almost 20% of women experienced childhood sexual abuse by a family member, with a further 31% of women reporting sexual abuse by a non-family member before the age of 18. These findings support Herman's (1981) analysis of data from five surveys undertaken since 1940 that found that 20% to 33% of all women reported at least one experience of sexual abuse as a child by an adult male. In regards to domestic violence Strauss, Gelles, and Steinmetz (1980) found that 28% of women reported violence at some point in their marriage while Finkelhor and Yllo (1985) found that 11% to 15% of women reported being sexually assaulted by their husbands. Further, Koss (1990) found that 28% to 33% of married women experience violence at some point in their relationship. Koss (1990) also found that 50% of women in dating relationships reported violence within the relationship. In more recent research by Nolen-Hoeksema (1990), the estimates of violence against women are even greater. Ritter (1993) cites Nolen-Hoeksema (1990) as finding that up to 37% of female children experience childhood sexual abuse, up to 50% of women are assaulted by their husbands and up to 46% of women are sexually assaulted as adults. Finally, The New York Times (1984) found that 85% of working women reported sexual harassment at their jobs.

Given the high incidence of violence against women and girls, it can be argued that women's social and cultural contexts are very different than those of men, regardless

of whether women have experienced violence or abuse first hand. Women are shaped by the experience of being abused, living with the threat of abuse, and knowledge that they are at high risk of being abused at any point in their lives. As Kaschak (1992) points out, all women learn at a very young age that they are at risk of being violated and abused, and consequently, fear and mistrust become a part of women's psychology and identity. From a Constructivist Self Development perspective, this gender difference regarding social and cultural contexts may result in women's cognitive schema about self, safety, trust, esteem, intimacy and control being different than those of men. The foundation of the CSDT is based on the notion that each individual's unique history shapes her or his experiences of traumatic events and defines the adaptation to trauma. A fundamental premise of CSDT is that trauma disrupts cognitive schema in a number of core areas including schema regarding safety, trust, control, esteem and intimacy. Given that all women live with the experience of violence or threat of violence, one would anticipate that women's schema or beliefs in these core areas would be different than those of men. It would therefore be consistent to expect that there would be gender differences among therapists working with trauma survivors.

Cerney (1995) postulates that there may be gender differences in the impact of working with trauma survivors because women may relate to their own feelings of vulnerability and fear while males may respond by feelings of guilt or needing to prove that they are "good" men. Herman (1988) also states that male and female therapists differ in their responses to their work with survivors. She suggests that female therapists often experience feelings of helplessness, despair or rage, while male therapists may

identify with the offender and may have difficulty with the survivor's anger. Further, Pearlman and Saakvitne (1995b) state that engaging in trauma work is disruptive to the therapist because therapists become more aware of the reality of abuse and more aware of the potential for trauma in their own lives. While Pearlman and Saakvitne (1995b) suggest that the impact of trauma work may thus be more disruptive for trauma therapists who have their own trauma history, the arguments of Cerney, (1995), Kaschak (1992), Cook (1993), and Brown and Gilligan (1992) suggest that all women, and not simply women who have a trauma history, are aware of the reality of abuse and the potential for abuse and violence in their own lives. Consequently, one might anticipate that all women therapists may experience different effects than male therapists when engaging in trauma work.

Present Study

The present study examined gender differences in trauma therapists' beliefs, or cognitive schema regarding self and others. The purpose of the present study was to extend the research by examining the relationship between gender and disruptions in cognitive schema among trauma therapists. Given the newness of this field and given the minimal focus of the research to date on gender differences, it was the hope that this study would further develop the understanding of the experiences of males and females doing this work. In addressing this issue, attention was given to several methodological issues which have been limitations in previous research.

The preceding review of the research has identified inconsistencies in the

definition of trauma work. This has included the inclusionary criteria regarding an objective definition, and whether or not trauma is objectively or subjectively defined. When examining the current research, one finds that the researchers use different definitions of trauma work. Some of the studies look exclusively at the impact of working with sexual assault survivors, others examine the impact of working with childhood sexual abuse or sexually traumatized clients exclusively while still others define trauma as interpersonal violence including violent crimes, as well as accidents, and sudden death due to accidents or illness. Further, there are a number of studies that allow participants to self-define trauma. While allowing participants to self-define trauma is in keeping with a Constructivist perspective, it can be argued that this tendency only serves to make any findings ambiguous at best, can certainly lead to confusion when attempting to draw conclusions about the concept of vicarious trauma, and may challenge the validity of the research. Consequently, this present study defined trauma as physical or sexual abuse as an adult or a child. Although there are certainly other types of trauma one can experience, it was believed that using an expanded definition of trauma would only serve to muddy the waters.

All of the studies reviewed to date regarding vicarious trauma have allowed therapists to define for themselves if they are trauma therapists, again in keeping with the constructivist model. As argued earlier, allowing participants to self-define if they are trauma therapists has led to very unclear findings, including a lack of clarity regarding what is being examined. It is questionable, given the use of self-definition of trauma, whether in fact, the same sample is being examined within each study as well as between

each study. Further, it was not clear in any of the studies to what extent the trauma was the focus of the therapeutic work. For the purpose of this study, an individual was considered a trauma therapist if at least 20% of her or his direct client service work was involved in helping clients resolve traumatic experiences, as defined above. As there is no evidence in the literature to suggest a definition of a trauma therapist, the definition for this study was perhaps arbitrary. However, given that it is argued that vicarious trauma is an inevitable consequence of providing trauma therapy, it can be argued that there should be some effect, if at least 20% of a therapist's direct client service work involves helping clients resolve trauma experiences. Further, this researcher did not want to compromise sample numbers by making the cut off point so high as to exclude a high number of therapists providing trauma services.

The studies that have been reviewed regarding vicarious trauma often use very divergent measures to measure vicarious trauma, including a number of measures that were created for particular studies and which did not have established psychometric properties. For the purposes of this study, both the IES (Horowitz et al., 1979) and the TSI Belief Scale (Pearlman & Mac Ian, 1993) were used to measure the impact of providing trauma therapy. The IES (Horowitz et al., 1979) was used to measure generalized impact because of its strong psychometric properties. The TSI Belief Scale (Pearlman & Mac Ian, 1993), while not as well established a measure as the IES (Horowitz et al., 1979), is the only known scale to measure the cognitive schema that were hypothesized to be affected by providing trauma therapy.

A number of studies reviewed were limited by the number of participants in their

sample. This study attempted to include a large sample of therapists and included a cross Canada mail out survey to a large number of agencies. In order to determine the sample size that was necessary to decrease the potential of committing a Type II error, a power analysis was performed. An expected effect size of $r = .30$ was calculated based on the mean r value found in three studies, all of which used the IES (Horowitz et al., 1979) and the TSI Belief Scale (Pearlman and Mac Ian, 1993) to determine the impact of providing trauma therapy. Cohen (1977), as cited in Rubin and Babbie (1993), argues that the maximum probability of committing a Type II error should be no more than .20, suggesting a statistical power of .80. Alternatively, it was suggested as ideal to reduce the probability of committing a Type II error to that of the probability of committing a Type I error. In this situation, statistical power would then have to be .95. It was determined that the sample size necessary to obtain a statistical power of .80, with an estimated effect size of $r = .30$, was 84 cases. To obtain a statistical power of .95, with an estimated effect size of $r = .30$, a sample size of 140 cases was necessary. It was anticipated that, given the number of agencies that were being contacted to participate in this study, the sample size would meet at least the minimum criteria of 84 cases, for adequate power.

In examining the return rates of the reviewed studies regarding vicarious trauma, it was found that return rates were quite low ranging from 19% to 64%, with the majority of return rates in the 30% to 40% range. This presents great difficulty when considering the generalizability of any of these studies. Further, given the self-selected nature of respondents it can be argued that their responses would qualitatively differ from those individuals not responding, leading to a potential bias in the results. It is unclear whether

any of these researchers sent out any reminders or follow up mailings. In order to maximize the power of this study, every effort was made to achieve a responses rate of at least 50%. This was accomplished by utilizing a minimum of two follow-up mailings as well as the use of a small incentive.

The present study examined gender differences in regards to the impact of providing trauma therapy. More specifically, this study examined whether there are gender differences regarding disruptions in cognitive schema as a result of providing trauma therapy. Given that women's social and cultural contexts are very different than those of men, including women's experiences and knowledge of violence and abuse, it was anticipated that women would be significantly more affected than men in regards to cognitive disruptions as a result of providing trauma therapy. The hypotheses for this study included:

- H₁: The impact of providing trauma therapy, as measured by the IES, will be positively correlated with the amount of direct therapy provided which is focused on helping clients resolve trauma experiences.**
- H₂ Disruptions in cognitive schema, as measured by the TSI Belief Scale, will be positively correlated with the amount of direct therapy provided which is focused on helping clients resolve trauma experiences.**
- H₃ Women therapists will score significantly higher on measures of avoidance and intrusion than will male therapists.**

H₄: Women therapists will score significantly higher on measures of disruptions of cognitive schema than will male therapists.

Method

Participants

Participants were selected from a variety of sources. The Family Services Centres of Canada were identified as agencies who provided a significant amount of therapy to clients who had experienced trauma, and employed both male and female therapists to provide direct services to this population. The Director of Family Services Canada was contacted and forwarded a mail list of all Family Services Agencies across Canada. Each province had a minimum of two Family Service agencies, with the larger provinces having over ten Family Service agencies, totaling 85 Family Service agencies across Canada. As a number of Community Health Centres also provided trauma therapy, a mailing list of Community Health Centres across Canada was also obtained. There were approximately eight Community Health Centres across Canada. The number of Community Health Centres in each province was quite small, with a number of provinces having no Community Health Centres. The International Society for Traumatic Stress Studies Membership Directory was also acquired by this researcher. Eighty members of this organization were identified as living and working in Canada. All members, along with their addresses, were identified by the populations to whom they provided direct services. All agencies and individuals who returned completed questionnaires and thereby agreed to participate in this study were included in the study.

Measures

The questionnaire (see Appendix A) mailed to potential respondents consisted of a variety of questions related to demographics and to other variables identified in the

vicarious trauma literature as being related to changes in cognitive schema (e.g., education, number of years providing trauma therapy). In addition, two scales, the IES (Horowitz et al., 1979) and the TSI Belief Scale (Pearlman & Mac Ian, 1993) were included to assess the impact of providing trauma therapy. Participants were asked to respond to the measures based on their work helping clients resolve their experiences of trauma. The measures were counter-balanced in the questionnaires, with one half of the questionnaires having the TSI Belief Scale (Pearlman & Mac Ian, 1993) as the first measure and the other half of the questionnaires having the IES (Horowitz et al., 1979) as the first measure, to account for any potential order effects.

Dependent Measures

The Impact of Event Scale. The Impact of Event Scale (IES; Horowitz et al., 1979) was developed to measure the degree of subjective distress experienced as a result of a specific event. The IES (Horowitz et al., 1979) is a self report measure that can be anchored to any specific life event. In their research leading to the development of the IES (Horowitz et al., 1979), Horowitz and his associates (1979) found that two major response sets or psychological responses were common among people experiencing stressful life events. This was found through both interviews with distressed individuals, as well as through a review of the stress and coping literature (Horowitz et al., 1979). The two most common responses that were found were avoidance and intrusion. Avoidance refers to consciously recognized avoidance of certain ideas, feelings or situations, and intrusion refers to intrusive ideas, images, feelings or bad dreams. The IES (Horowitz et al., 1979) measures these two specific categories of experiences in

response to stressful life events.

The IES (Horowitz et al., 1979) is comprised of 15 items which are rated according to how frequently the intrusive or avoidance reactions occur. Responses are scored on a four point scale with higher scores reflecting more stressful impact. A cut off point of 26 is suggested with scores higher than 26 indicating moderate to severe impact.

The IES (Horowitz et al., 1979) is a good measure of subjective impact of stressful life events, with good psychometric properties. The split half reliability of the total scale was reported as high ($r = 0.86$; Horowitz et al., 1979). Internal consistency of the intrusion and avoidance sub-scales was shown to be high during the construction of the measure (Horowitz et al., 1979) and was confirmed by follow-up analysis (Zilberg et al., 1982). Internal consistency of the sub-scales was calculated using Cronbach's Alpha and was also reported as high (intrusion = 0.78, avoidance = 0.82). A correlation of the two sub-scales was 0.42 ($p < 0.0002$) indicating that the two sub-scales are associated but do not measure identical dimensions. The test-retest reliability for the whole scale was found to be 0.87, and 0.89 and 0.79 for the intrusion sub-scale and the avoidance sub-scale respectively. As well, in both Horowitz's study (1979) as well as Zilberg's study (1982), factor analysis demonstrated clear factor structures that supported the two sub-scales of avoidance and intrusion. Perkins and Tebes' (1984) findings from their study regarding simulated versus genuine responses on the IES (Horowitz et al., 1979) supported the construct validity of the measure. As well, the sensitivity of the measure was supported by a number of researchers, both in terms of discriminating between different populations that had experienced different levels of stress (Horowitz et al, 1979;

Johnsen, Eid, Lovestad, & Michelsen, 1997), as well as sensitivity to therapeutic intervention (Johnsen et al., 1997; Zilberg et al., 1982).

In considering any potential weaknesses of the IES (Horowitz et al., 1979), a few issues were found. Horowitz (1979) stated that the measure was useful with populations from diverse cultural and ethnic backgrounds, suggesting that diverse populations understand the items and are comfortable with it. However, Velsen, Gorst-Unsworth, and Turner (1996), in their research on survivors of torture, had some difficulty with using the IES (Horowitz et al., 1979) with their sample population and discontinued its use. Velsen et al. (1996) stated that the IES (Horowitz et al., 1979) was difficult to use partly due to problems in translating colloquialisms. Because the measure had to be translated to the participants, the authors became aware of difficulties the participants were experiencing in understanding the meaning of some of the items. This suggests that some caution may need to be applied when using this measure with participants not well versed in the English language or colloquialisms.

A second reason that Velsen et al. (1996) gave for discontinuing the use of the IES (Horowitz et al., 1979) in their study was that they had some difficulty in pinpointing a single trauma with which to measure the severity of stress. Although Horowitz et al. (1979) initially suggested that the IES (Horowitz et al., 1979) be used to determine the impact of a single event, later research suggests that the measure has been successfully used for more than one specific event. Perrin, Hasselt, Basilio, and Hersen (1996) used the IES (Horowitz et al., 1979) to assess the effects of violence on women in battering relationships, and Alexander (1993) used the IES (Horowitz et al., 1979) to assess the

effects of childhood sexual abuse. Although Perrin et al. (1996) did not provide information on the number of assaultive events that each participant experienced, one can anticipate, given the nature of domestic violence, that more than one incident of domestic violence occurred. Alexander (1993), in her study with sexual abuse survivors, stated that the average duration of abuse occurred over a seven year time span. It is unclear then, why Velsen et al. (1996) felt it necessary to use the IES (Horowitz et al., 1979) only in terms of one specific event.

Another concern with the IES (Horowitz et al., 1979) is the sex differences that were found in the initial study and development of the scale. In his study, Horowitz et al. (1979) found that the sexes differed significantly in their degree of endorsement of three of the initial 20 items, with women indicating a higher level of endorsement than men. Horowitz et al. (1979) further stated that all of the more frequently endorsed items were in the avoidance sub-scale. However, he did not state whether these items were kept when the scale was revised to 15 items.

Notwithstanding the above noted issues regarding language difficulties and potential sex differences found with the IES (Horowitz et al., 1979), this measure is a well validated and reliable measure of stressful life events, having good psychometric characteristics. The IES (Horowitz et al., 1979) is an accurate measure of the impact of stressful life events, and has been used in a number of diverse situations with diverse populations. For example, a review of the literature showed that the IES (Horowitz et al., 1979) has been used for assessing the impact of natural disasters (Dalglish, Joseph, Thrasher, Tranah, & Yule, 1996; Kenardy, Webster, Lewin, Carr, Hazell, & Carter, 1996;

Marmar, Weiss, Metzler, Ronfeldt, & Foreman, 1996; Steinglass & Gerrity, 1990), the impact of patient suicides on therapists (Kleespies, Becker, & Smith, 1990), the impact of violence on women in abusive relationships (Perrin et al., 1996), responses following motor vehicle accidents (Bryant & Harvey, 1996), stress reactions among women victims of assault and rape (Dancu, Riggs, Hearst-Ikeda, Shoyer, & Foa, 1996), stress reactions of fire fighters (Bryant & Harvey, 1996), responses of medical personal and mental health workers after a shooting incident (Sloan, Rozensky, Kaplan, & Saunders, 1994), and the effects of childhood sexual abuse (Alexander, 1993). This review of the literature shows a consistent pattern of results that supports both the theoretical underpinnings of the scale and its reliability and validity

The Traumatic Stress Institute Belief Scale. The TSI Belief Scale (Pearlman & Mac Ian, 1993) measures disrupted cognitive schema. The scale is based on CSDT and assesses disruptions in psychological need areas that are hypothesized to be sensitive to traumatic experiences. It is an 80 item, 6-point Likert scale that measures cognitive disruptions regarding safety, trust, intimacy, esteem and control. Within each area, the scale contains items intended to assess disruptions related to self and to other. Pearlman and Mac Ian (1996) report the following sub-scales and their internal consistencies as measured by Cronbach's alpha.

1. **Self-safety:** (the belief that one is reasonably invulnerable to harm inflicted by self or others) alpha = .83.
2. **Other-safety:** (the belief that valued others are reasonably protected from harm inflicted by oneself or others) alpha = .73.

3. Self-trust: (the belief that one can trust one's judgment) $\alpha = .87$.
4. Other-trust: (the belief that one can rely upon others) $\alpha = .86$.
5. Self-esteem: (the belief that one is valuable) $\alpha = .87$.
6. Other-esteem: (the belief that others are valuable) $\alpha = .75$.
7. Self-intimacy: (the belief that time spent alone is enjoyable) $\alpha = .79$.
8. Other-intimacy: (the belief that one is close and connected to others) $\alpha = .86$.
9. Self-control: (the need to be in charge of one's own feelings and behaviours)
 $\alpha = .82$.
10. Other-control: (the need to manage interpersonal situations) $\alpha = .73$.

Pearlman and Mac Ian (1995) reported that the internal consistency reliability of the entire scale, as measured by Cronbach's alpha, was .93.

Procedures

The Executive Directors of each of the above noted agencies were contacted by telephone to provide information regarding this study, to determine whether their clinical staff qualified for this study, and to assess if they were willing to have their clinical staff involved in this study. If the Directors were willing to have the staff of the agency participate, they were asked about the number of clinical staff at their agency and were asked to identify one administrative person to take responsibility for distributing information regarding this study. A package of said number of sealed measurement packages was sent to the identified administrative person in each agency who was asked to distribute the packages to each clinician within the agency in a confidential and

anonymous manner (i.e., placing a measurement package in each clinician's mail folder). This was to ensure that the staff regarded this study as independent from their agencies and did not perceive any threats to their confidentiality or anonymity. Identified members of the International Society for Traumatic Stress Studies who work with trauma clients, as identified above, were also contacted by mail and sent a questionnaire.

The questionnaire included a cover letter (see Appendix B) explaining the nature and purpose of the study, how individuals were selected for the study, the importance of their responses, and the confidentiality and anonymity of their responses. To increase the response rate, an incentive was utilized. Each participant was invited to write their first name only and a telephone number where they could be contacted on a slip of paper that they inserted in a small envelope that was provided. They were informed that the envelopes would be separated from the measurement package upon receipt and kept until the data collection period was completed. A draw then occurred and the winner received a \$20.00 gift certificate for a self-care package of their choice. Participants were informed that the self care package may include a gift certificate for their favorite book store, bath shop or music store. Individuals were informed that the return of a completed measurement package would be regarded as their informed consent to participate in this study. Individuals were also informed that a summary of the results would be sent to each of the participating agencies. Also included with the questionnaire was a stamped, self-addressed return envelope.

Two weeks following the initial mailing, a reminder letter was sent to all individuals in the same manner as the initial measurement package was sent. This letter

briefly explained the nature of the research, the importance of their response, and thanked those that have already responded. Three weeks after the reminder letter, a second reminder letter was sent to all participants in the manner described above. Along with this mailing, approximately ten additional sealed measurement packages were sent to the identified administrative person in case any participants required an additional package. The administrative person was asked to make these packages available in a common area, where participants were able to help themselves to another package if necessary.

Results

Data Analysis

Due to the exploratory nature of this study, a .05 significance level was used in all analyses. Although the potential for a Type I error was recognized, it seemed appropriate at this early stage in the research to allow for exploration and understanding. Non-parametric statistics were used for analyses as data was considered to be ordinal in nature and random sampling procedures were not used.

In order to determine if there were any differences on the dependent measures in relation to a variety of the demographic variables, Kruskal-Wallis tests were performed. In order to determine if the effects of providing trauma therapy, both general effects as measured by the IES (Horowitz et al., 1979) and disruptions in cognitive schema as measured by the TSI Belief Scale (Pearlman and Mac Ian, 1993), were positively correlated with the amount of direct service provided to trauma survivors Spearman's Rank-Order Correlation Coefficient was used. To determine if there were gender differences regarding the impact of providing trauma therapy, Mann-Whitney U tests were performed. Glass rank biserial correlation tests were used to determine the strength of any significant relationships that were found. Further, a hierarchical multiple regression analysis was performed in an exploratory manner, to examine the role of a variety of variables in accounting for variance.

Participants

A total of 525 questionnaires were mailed across Canada. Of these, 299 (57%) were sent to Family Service Agencies, 71 (13%) to the Canadian members of the

International Society for Traumatic Stress Studies (ISTSS), 34 (6%) to Community Health Clinics, and 125 (24%) to agencies identified by Family Service Directors as agencies which provide a substantial amount of trauma services in their geographic area. A total of 251 responses were received for a response rate of 48%. Of those responding, 172 (71%) of the respondents were from Family Service agencies or Community Health Clinics, 48 (20%) were from other agencies and 23 (9%) were members of ISTSS. Eight questionnaires were spoiled or incomplete, leaving the total number of participants in this study as 243. Kruskal-Wallis tests identified no differences between participants from the various referral sources on the IES or the TSI Belief Scale.

Participants were 196 females (81%) and 47 males (19%) from across Canada. Seventy-one (29%) of the participants were from Ontario, 49 (20%) from British Columbia, 38 (16%) from Alberta, with the remainder scattered across the remaining provinces. Participants ranged in age from 23 to 74 years with a mean age of 44 ($SD = 8.9$). The majority of participants worked in the field of Social work (46%) or Psychology (16%) and had Master's degrees (64%) in their field of study. Participants had been working in their current position an average of seven years ($SD = 6.09$) with a range from less than one year to 40 years. Participants had been working with trauma survivors an average of 11 years ($SD = 7.00$), with a range from one year to 38 years. These participants reported spending a weekly average of 21 hours ($SD = 8.53$) providing therapy, with a weekly average of 12 hours ($SD = 7.92$) spent providing trauma therapy. A variable was created to compute the percentage of working hours spent providing trauma therapy. The percentage of trauma therapy hours ranged from 5 % to 100%, with

a mean of 54% ($SD = 27.46$).

Dependent Measures

Table 1 shows the medians and the quartile ranges (QR) for each of the sub-scales of both measures. Medians and quartile ranges were calculated due to the ordinal level of the data. An examination of the data indicates that the medians of all sub-scales appear quite low. In order to examine this further and to draw comparisons to published research in the area, the means, standard deviations, and the internal consistencies, as measured by Cronbach's alpha, for each of the sub-scales of both measures were also calculated and are detailed in Table 2. The mean TSI Belief Scale score for this sample was 159 ($SD = 33.68$). Pearlman and Mac Ian (1995), in their study of 188 trauma therapists, reported a mean score on the TSI Belief Scale of 184, and note that this is the lowest mean they had found over the past number of years. The mean IES scale score for this sample was 21 ($SD = 16.00$), while the mean on the avoidance and intrusion sub-scales were 11 ($SD = 9.46$) and 10 ($SD = 7.46$) respectively. Horowitz et al. (1979) when calculating mean scores for distressed populations, found the mean for distressed populations to range from 14 ($SD = 12.0$) to 20 ($SD = 11.0$) on the avoidance sub-scale and 21 ($SD = 12.5$) to 23 ($SD = 9.4$) on the intrusion sub-scale, while the total mean for their distressed populations ranged from 35 ($SD = 22.6$) to 44 ($SD = 17.2$). The means found in this present study are lower than the distressed populations in Horowitz's (1979) study and are more closely related to those means that Horowitz et al. (1979) found with a population after the participants had received therapy intervention subsequent to a stressful experience.

Table 1

Range, Median and Quartile Range of Dependent Measures

	Minimum Value	Maximum Value	Median	Quartile Range
TSI Belief Scale	83.00	269.00	156.00	135.50 - 179.00
Safety-self	1.00	3.22	1.67	1.33 - 2.00
Safety-other	1.00	3.78	2.11	1.78 - 2.44
Trust-self	1.00	3.72	2.00	1.71 - 2.29
Trust-other	1.00	3.88	2.00	1.75 - 2.25
Esteem-self	1.00	4.11	1.56	1.22 - 1.89
Esteem-other	1.13	3.50	2.00	1.63 - 2.28
Intimacy-self	1.00	5.43	1.78	1.42 - 2.14
Intimacy- other	1.00	4.13	2.12	1.62 - 2.50
Control-self	1.00	4.75	2.25	1.75 - 2.63
Control-other	1.00	4.43	2.14	1.86 - 2.57
IES Scale	0.00	69.00	17.00	8.00 - 30.00
Avoidance	0.00	38.00	8.00	3.00 - 17.25
Intrusion	0.00	31.00	8.00	4.00 - 14.00

Table 2

Mean, Standard Deviation and Internal Consistency of Dependent Measures

	Mean	Standard Deviation	Cronbach's Alpha
TSI Belief Scale	158.63	33.67	.94
Safety-self	1.72	.45	.73
Safety-other	2.12	.56	.73
Trust-self	2.00	.56	.81
Trust-other	2.03	.55	.78
Esteem-self	1.62	.50	.81
Esteem-other	1.98	.47	.72
Intimacy-self	1.87	.65	.48
Intimacy-other	2.12	.67	.83
Control-self	2.26	.66	.69
Control-other	2.22	.64	.75
IES Scale	20.62	16.00	.93
Avoidance	10.91	9.46	.88
Intrusion	9.67	7.46	.86

Regarding the dispersion of the scores, the majority of the medians of the sub-scales fall below the mid-point of the range, most notably Esteem-self and Intimacy-self, in which 75% of the scores fall below the mid-point of the range. This indicates that a large portion of cases falls to the left of the distribution. The Kurtosis and Skewness were also calculated and an examination of the results showed that while some of the sub-scales are close to symmetric in nature, a few sub-scales are positively skewed, most notably Esteem-self (Skewness = 1.45) and Intimacy-self (Skewness = 3.12), confirming that there are more cases to the left of the distribution. In regards to the proportion of cases falling into the tails of the distributions, an examination of the results showed that the distributions of some sub-scales have positive kurtosis while others have negative kurtosis, with again the largest deviations from a normal distribution occurring with Esteem-self (Kurtosis = 3.15) and Intimacy-self (Kurtosis = 22.05).

It is common to transform data through square root or logarithmic transformations to reduce skewness and kurtosis and to more readily fit the assumptions of parametric measures. However, it was determined that non-parametric procedures should be utilized in this research for a number of reasons. This includes that nonrandom sampling procedures were used to secure participants for this study. Further, the measures in this study may not be regarded as interval in nature. That there is some deviation from normal distribution in regards to the measures certainly supports the decision to utilize non-parametric procedures.

In examining the internal consistencies of the measures, as shown in Table 2, the majority of the sub-scales have adequate internal consistency with the exception of

Intimacy-self and Control-self. Further, on the vast majority of the sub-scales of the TSI Belief Scale the internal consistencies in this study were found to be lower than those reported for this same scale by the authors of the scale (Pearlman & Mac Ian, 1996). The internal consistencies of the sub-scales for the IES found in this study are somewhat higher than those found by Horowitz (1979).

Spearman's Correlation Co-efficient was performed to determine the correlation among and between the dependent measures. Weak but significant positive correlations, ranging from $r_s = .099$ ($p < .05$) to $r_s = .319$ ($p < .001$) were found between the IES and the TSI, suggesting that these two scales may be associated but do not measure the same constructs. Table 3 shows the correlations between the sub-scales of the TSI Belief Scale. Significant positive correlations, ranging from $r_s = .36$ ($p < .001$) to $r_s = .81$ ($p < .001$), were found. A close examination of the table indicates that the highest correlations are found between the sub-scales and the total TSI score, as one would expect. The significant correlations between the sub-scales indicates that the sub-scales are not entirely independent of one another. A significant positive correlation was also found between the Avoidance and Intrusion sub-scale ($W = .571$, $p < .001$) of the IES.

Demographic Variables and the Dependent Measures

A series of Kruskal-Wallis tests were performed to determine if there were any differences on the dependent variables based on level of education or professional discipline. No differences were found between either of the dependent measures and

professional discipline. Upon examination of the education variable, it was noted that there were only a few cases in each of the categories below a university education. Consequently, a new variable was created in which these categories were grouped into one category named 'no degree'. Kruskal-Wallis tests were performed with this new variable. The tests between education and some sub-scales of the TSI were significant, specifically, Intimacy-other ($H = 16.570, p < .01$) and Control-self ($H = 8.406, p < .05$), as well as TSI total ($H = 8.008, p < .05$). Significant results were also found on the tests on Avoidance ($H = 13.261, p < .01$), Intrusion ($H = 12.948, p < .01$), and IES total ($H = 13.167, p < .01$). To further specify between which groups these differences were located, all possible pair-wise post-hoc comparisons were computed for each of the sub-scales comparing all of the education level groups using Protected rank-sum tests (z). Table 4 illustrates only those comparisons between groups that were found to be significant. As the table illustrates, the majority of differences were found between the group of individuals having no degree and the other degree groups. An examination of the results indicates that those participants with no degree have higher scores on the sub-scales in question as well as higher scores on both the total TSI and IES.

Spearman's Correlation Coefficient (r_s) was performed to determine whether there were any significant relationships between age and the dependent measures. The results, shown in Table 5, indicate a weak but significant negative correlation between age and the TSI Belief Scale total score as well as most of the sub-scales of this measure. No relationships were found between age and the total IES score or on either of the sub-scales of this measure.

Table 4

Post-Hoc Comparisons on Education Level and Dependent Measures

	Group Differences	<u>z</u> value
TSI Total	No degree - Master	2.08*
	No degree - Doctorate	1.97*
Control-self	No degree - Master	2.52*
	No degree - Doctorate	2.00*
Intimacy-other	No degree - Master	2.09*
	Bachelor - Master	3.75**
IES Total	No degree - Bachelor	2.36*
	No degree - Master	3.18**
	No degree - Doctorate	2.90**
Avoidance	No degree - Bachelor	2.74**
	No degree - Master	3.36**
	No degree - Doctorate	3.07**
Intrusion	No degree - Master	2.76**
	No degree - Doctorate	2.49*
	Bachelor - Master	2.28**

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

Table 5

Correlation Between Age and the TSI Belief Scale

Measure	Age
TSI Total	-.231***
Control-other	-.185**
Control-self	-.240***
Esteem-other	-.202**
Esteem-self	-.115
Intimacy-other	-.153*
Intimacy-self	-.237***
Safety-other	-.182**
Safety-self	-.206**
Trust-other	-.124
Trust-self	-.150*

Note. N = 240

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

Tests of Hypotheses

Impact of Providing Trauma Therapy

The first hypothesis predicted that the impact of providing trauma therapy, as measured by the IES, would be positively correlated with the amount of direct therapy provided which is focused on helping clients resolve trauma experiences. In order to test this hypothesis, a number of variables were examined using Spearman's Correlation Coefficient (r_s).

There were no correlations found with regards to the number of hours of providing trauma therapy and the IES. Further, no correlations were found in regards to the percentage of trauma therapy hours and the IES. However, weak but significant negative correlations were found regarding the number of years of experience providing trauma therapy and Avoidance, $r_s = -.186$, $p < .01$, Intrusion, $r_s = -.169$, $p = .01$, and the total IES scale, $r_s = -.204$, $p < .01$. These results indicate that as the number of years of experience providing trauma therapy increased, Avoidance, Intrusion, and total distress decreased.

The effects of providing trauma therapy on cognitive schema. The second hypothesis predicted that disruptions in cognitive schema, as measured by the TSI Belief Scale, would be positively correlated with the amount of direct therapy provided which is focused on helping clients resolve trauma experiences. In order to test this hypothesis, a number of variables were examined using Spearman's Correlation Coefficient (r_s). There were no significant correlations between the number of hours of providing trauma

therapy and the TSI Belief Scale. However, as expected, a weak but significant positive correlation was found between the percentage of trauma therapy hours and Safety-self $r_s = .181, p < .01$, indicating that as the percentage of current trauma therapy hours increased, so too did disruptions in regards to Safety-self.

In order to examine the effects of cumulative exposure on disruptions in cognitive schema, the relationships between years of experience providing trauma therapy and the TSI sub-scales were examined. Weak but significant negative correlations were found between the number of years of experience providing trauma therapy and Safety-other, $r_s = -.124, p < .05$, Safety-self, $r_s = -.150, p = .01$, and Intimacy-self, $r_s = -.117, p < .05$. Contrary to expectation, these findings indicate that as the number of years of experience providing trauma therapy increased, disruptions in regards to Safety-other, Safety-self and Intimacy-self decreased.

The effects of trauma history on trauma therapists. To further explore the results regarding the impact of providing trauma therapy, Mann-Whitney U Tests were performed to determine if there was a mean rank difference on either the IES or the TSI Belief Scale between those respondents who had experienced physical or sexual abuse as a child and those respondents who did not experience abuse as a child. No differences were found on the IES total score or on either of the sub-scales of this measure. A significant difference was found on the Safety-self sub-scale of the TSI Belief Scale, $U = 5415.5, p < .01$. Those individuals who had experienced abuse as a child had higher Safety-self scores ($Mdn = 1.78, QR = 1.56, 2.11; M = 1.81, SD = .47$) than did those individuals who did not experience abuse as a child ($Mdn = 1.56, QR = 1.33, 1.89; M =$

1.65, $SD = .43$). No differences were found on the remaining TSI Belief Scale sub-scales or the total TSI.

Mann-Whitney U Tests were also performed to determine whether there was a mean rank difference on either the IES or the TSI Belief Scale between those respondents who had experienced abuse as an adult and those who did not experience abuse as a adult. No significant differences were found on the IES total score or on either of the sub-scales of this measure. Significant differences were found on the TSI Belief Scale in regards to cognitive disruptions in the areas of Control-other, $U = 4686.0$, $p < .05$; Intimacy-other, $U = 4246.5$, $p < .01$; Safety-other, $U = 4446.0$, $p < .01$; Safety-self, $U = 4403.5$, $p < .01$; Trust-other, $U = 4629.0$, $p < .05$ and TSI total, $U = 4169.5$, $p < .01$.

The medians, quartile range, means and standard deviations found on each of these sub-scales for those participants who did experience abuse as an adult and for those participants who did not experience abuse as an adult can be found in Table 6.

Participants who had experienced abuse as an adult had higher scores on all of these sub-scales indicating greater disruption. Glass rank biserial correlation tests were computed to determine the strength of the relationship between group membership and ranking on these sub-scales. Weak relationships were found between experiencing abuse as an adult and Control-other, $r_G = .150$, Intimacy-other, $r_G = .242$, Safety-other, $r_G = .197$, Safety-self, $r_G = .210$, Trust-other, $r_G = .173$, and TSI total, $r_G = .207$, indicating that although there are differences between those individuals who had experienced abuse as an adult and those individual who had not experienced abuse as an adult on each of the above-noted sub-scales of the TSI Belief Scale, these differences are quite weak.

Table 6

Descriptive Statistics on TSI Sub-scales for Those Who Experienced Abuse and Those Who Did Not Experience Abuse

	Control- Other	Intimacy- Other	Safety- Other	Safety- Self	Trust- Other	TSI Total
Experienced Abuse as an Adult						
Mean	2.35	2.32	2.24	1.84	2.17	166.60
Standard Deviation	.69	.68	.57	.47	.58	34.50
Median	2.28	2.25	2.22	1.78	2.00	164.00
Quartile Range	2.00 2.86	1.78 2.75	1.71 2.57	1.56 2.11	1.87 2.34	147.00 186.00
Did not Experience Abuse as an Adult						
Mean	2.18	2.05	2.08	1.68	1.99	155.77
Standard Deviation	.63	.65	.55	.45	.55	33.23
Median	2.14	2.00	2.00	1.67	2.00	153.00
Quartile Range	1.71 2.57	1.50 2.37	1.67 2.39	1.33 2.00	1.63 2.25	133.00 176.00

Gender differences

The third hypothesis predicted that women therapists would score significantly higher on measures of avoidance and intrusion than would male therapists. In order to test this hypothesis, Mann-Whitney U tests were performed. No significant gender differences were found in regards to measures of avoidance or intrusion.

The fourth hypothesis predicted that women therapists would score significantly higher on measures of disruptions of cognitive schema than would male therapists. In order to test this hypothesis, Mann-Whitney U tests were performed. Significant gender differences were found in regards to Safety-self, $U = 3140.0$, $p < .01$, with women reporting more disruptions on measures of Safety-self than did men, thus supporting the hypothesis. The mean score for female participants on the Safety-self sub-scale was $M = 1.76$, ($SD = .43$) and the median score was $Mdn = 1.67$, ($QR = 1.44, 2.00$) while the mean score for male participants was $M = 1.56$, ($SD = .50$) and the median score was $Mdn = 1.44$, ($QR = 1.22, 1.78$). Glass rank biserial correlation indicates that this relationship is weak ($r_G = .158$). However, a contrary result was also found with male participants reporting more disruptions in regards to Esteem-self, $U = 3860.0$, $p < .05$, than women. The mean score for male participants was $M = 1.74$, ($SD = .55$) and the median score was $Mdn = 1.56$, ($QR = 1.33, 2.00$) while the mean score for female participants was $M = 1.59$, ($SD = .49$) and the median score was $Mdn = 1.55$, ($QR = 1.22, 1.89$). Glass rank biserial correlation indicates that this relationship is moderate ($r_G = .315$).

As relationships were found in regards to experiencing abuse as an adult or as a

child and cognitive disruptions, Chi-square tests were performed to determine if there were gender differences in regards to experiencing abuse as a child or as an adult. There were no significant differences in regards to gender and experiencing abuse as a child, $\chi^2(1, N = 239) = .053, p = .41$. Seventeen (36%) of the male therapists reported having experienced abuse as a child while 82 (42%) of the female therapists reported having experienced abuse as a child. However, significant differences were found in regards to gender and experiencing abuse as an adult, $\chi^2(1, N = 239) = .204, p < .01$, with women reporting a higher level of abuse than men. Specifically, 60 (31%) of the female therapists reported physical or sexual abuse as an adult while only 4 (8%) of the male therapists reported physical or sexual abuse as an adult.

A variety of other variables were examined to determine if there were gender differences in this population of therapists. In examining gender differences and level of education, a significant difference was found, $\chi^2(4, N = 243) = .315, p < .001$, with men reporting a higher level of education than women. Specifically, more men than expected reported having a Doctorate degree, while less men than expected have a Bachelors degree or Counselling Certificate. Further, less women than expected have a Doctorate degree while more women than expected have a Bachelors degree or Counselling Certificate.

To determine if there was a mean rank difference between gender and a variety of other variables, Mann-Whitney U tests were performed. Significant gender differences were found in regards to: age, $U = 3052.5, p < .001$, with men being older ($M = 49$) than women ($M = 43$); percentage of hours spent providing trauma therapy, $U = 3379.0, p <$

.05, with women reporting a higher percentage of trauma hours ($\underline{M} = 56$) than men ($\underline{M} = 45$); number of years in current position, $\underline{U} = 2476.0$, $p < .01$, with men reporting a higher number of years in current position ($\underline{M} = 11$) than women ($\underline{M} = 6$); and years of experience, $\underline{U} = 2788.0$, $p < .01$, with men reporting a higher number of years of experience ($\underline{M} = 15$) than women ($\underline{M} = 10$). Glass rank biserial correlation tests were computed to determine the strength of the relationship between group membership and ranking on these variables. Moderate relationships were found between gender and age, $r_G = .33$; percentage of hours spent providing trauma therapy, $r_G = .22$; number of years in current position, $r_G = .46$; and years of experience, $r_G = .38$.

In order to examine the amount of variance accounted for by a number of factors (i.e., age, percentage of trauma hours, years in current position, years of experience) along with gender, exploratory multiple regression analyses were performed on the Safety-self and Esteem-self sub-scales of the TSI Belief Scale. In examining Safety-self, a hierarchical multiple regression was performed in two steps. First, the demographic variables on which gender differences were found, including age, years of experience, years in current position, and percentage of trauma hours, were entered in the first step. An \underline{R}^2 value of .096 for the block of demographic variables was found, indicating that these variables accounted for just over 9% of the variance. In the second step, gender was added to the block of demographic variables and an \underline{R}^2 value of .104 was found, indicating that the demographic variables combined with gender only accounted for 10% of the variance. This result indicates that gender accounted for only an additional 1% of the variance. The difference in variance between step one and step two was found not

significant ($F_{inc} = .40$). A hierarchical regression was also performed with Esteem-self. The same demographic variables of age, years of experience, years in current position, and percentage of trauma hours were entered in the first step. An R^2 value of .027 was found, indicating that these variables accounted for just over 2% of the variance. In the second step, gender was added to the block of demographic variables and an R^2 value of .042 was found, indicating that the demographic variables combined with gender only accounted for 4% of the variance, and gender accounted for only an additional 2% of the variance. The difference in variance between step one and step two was found to be not significant ($F_{inc} = .75$).

Discussion

Overall, varying results in regards to the hypotheses were found in this present study. While no relationships were found between average time spent providing trauma therapy or percentage of trauma hours and measures of avoidance or intrusion, some relationships were found between disruptions in cognitive schema and the percentage of trauma hours. Unexpected results were found in the relationship between years of experience and avoidance, intrusion, and measures of cognitive disruptions. Contrary to expectation, the degree of disruption decreased as years of experience increased. Further, while some differences were found on measures of cognitive schema between those who had experienced abuse as a child and those who had not experienced abuse as a child, many more differences were found on measures of cognitive schema between those who had experienced abuse as an adult and those who had not experienced abuse as an adult. No gender differences were found on measures of avoidance or intrusion, while some gender differences were found regarding disruptions in cognitive schema. While women were found to be more disrupted in regards to self safety, men were found to be more disrupted in regards to self esteem. These results will be discussed and the implications will be explored. As well, the limitations of this study will be reviewed.

Impact of providing trauma therapy

Contrary to other research (Bober, 1996; Gamble et al., 1996; Kassem-Adams, 1995; Schauben & Frazer, 1995; Simonds, 1996), there was no relationship between the amount of therapy provided and general impact of providing trauma therapy in this sample. There may be many reasons for this. First, this current study strictly defined

trauma therapy while other studies used very broad definitions of trauma or allowed participants to self define trauma. This strict definition of trauma may have led to more conservative results. Another factor that needs to be considered however, is that this particular sample had very low means on all of the dependent measures, much lower than published means for therapist populations or distressed populations. This suggests that the sample in this study may in fact be quite different from other samples that have been studied. This may be due to sampling procedures. A number of the published studies obtained their sample from self-selected participants at trauma conferences. It may be that therapists who felt most impacted by their work were more inclined to participate in the research or attend such conferences. It is also possible that the sampling procedure used in this study resulted in more non-distressed therapists responding to the mail-out survey than distressed therapists. It could well be that a mail out design encourages less distressed individuals to respond and discourages more distressed individuals from responding. Further, the vast majority of the published studies were conducted within a limited geographic area, with the number of participants ranging from 88 to 138 participants, while this present research included participants from across Canada.

Disruptions in participants' schema regarding self-safety were found to be weakly correlated with current trauma hours, such that as the percentage of current trauma therapy hours increased, cognitive disruptions in regards to self-safety also increased. These findings are in keeping with the findings of Bober (1996), Schauben and Frazer (1995), and Simonds (1996), all of whom found cognitive schema regarding safety negatively impacted by providing trauma therapy. As trauma therapy is often focused on

exploring situations that expose therapists to stories of clients being hurt by others, it stands to reason that therapists may begin to feel more unsafe in their lives, the more experiences of trauma they are exposed to at any given time. There may be some temptation to argue, given this finding, that therapists should, as much as reasonably possible, avoid asking about or directly exploring clients' traumatic experiences in therapy. The negative therapeutic implications of this solution are apparent. It may be important however, for therapists to spend some time considering ways to protect themselves and their belief systems while providing therapy as well as during their non-work hours. This finding also suggests that it may be helpful for agencies to attend to balancing therapists' client loads regarding trauma and non-trauma clients whenever possible.

Despite this finding, a weak but negative correlation was also found suggesting that as years of experience providing trauma therapy increased, general negative impact decreased and disruptions in cognitive schema decreased. These findings suggest that there may be differences between current impact and cumulative impact of providing trauma therapy. Some research (Kassem-Adams, 1995; Pearlman & Mac Ian, 1995) has examined whether there are differences in this regard. Kassam-Adams (1995) found greater negative disruptions in regards to cumulative exposure as compared to current exposure, while Pearlman and Mac Ian (1995) found contrary results, with those with a trauma history showing less cumulative disruptions and those without a trauma history showing greater cumulative disruptions. That this current study found less general distress and less disruptions in cognitive schema as years of experience increased should

be interpreted cautiously. First, the negative correlations found between cumulative exposure and both measures were very weak and therefore should not be over interpreted. Further, in this study, years of experience was not strictly defined and it is unknown whether this includes full time or part time work. It is also unknown if the work changed in regard to the amount of trauma work provided or if the years of experience were continuous.

However, despite these limitations, this finding is quite interesting and there may be several explanations for this result. It may reflect some self selection, in that persons who find themselves impacted by providing trauma therapy over the years may leave the therapy field or may find employment providing therapy that is not focused on trauma. It may also suggest that therapists who are working with clients who have experienced trauma may have found coping strategies over the years that decrease the impact of providing trauma therapy. There also may be some blunting effect occurring, such that therapists who have been providing trauma therapy may have become desensitized to the exposure to trauma experiences or to the impact of the work. Clearly, more research in this area is needed to come to a fuller understanding of this issue. A longitudinal study of trauma therapists would be helpful in examining some of these issues. This type of study would provide an opportunity to explore therapists' coping styles and strategies over time as well as determine if some therapists are in fact leaving the field as a result of the impact of providing trauma therapy. Further, a longitudinal study would be helpful in determining if there are any changes regarding the impact of providing trauma therapy as a result of time or as a result of changes in the parameters of therapists' working lives

(i.e., full time or part time work, number of trauma hours worked). Alternatively, as longitudinal research is often not possible, qualitative research may also be useful in examining these issues. However, the validity of this research would be dependent on therapists' abilities to remember and distinguish between varying degrees of impact throughout their history as therapists.

When examining the results of the present study in regards to therapist trauma history, some interesting results emerged. No differences were found between therapists who had a history of childhood or adult trauma and general disruptions as measured by the IES. However, this present study found that those therapists who reported childhood physical or sexual abuse reported more disruption in cognitive schema related to self safety than those therapists who had not experienced physical or sexual abuse as a child. More interesting however, is that therapists who reported experiences of physical or sexual abuse as an adult experienced more cognitive disruptions in control, intimacy, safety, and trust than those therapists who had not experienced abuse as an adult. This result suggests that experiencing abuse as an adult may be especially important in understanding a therapist's reaction to doing trauma work.

There has often been an assumption in the literature that a history of childhood abuse, particularly childhood sexual abuse, may have the most negative impact on the adult therapist (Kassam-Adams, 1995; Pearlman & Saakvitne, 1995a; Saakvitne, 1990). Further, the literature has often focused on the potential negative effects on therapists who may have a history of childhood abuse (Saakvitne, 1991). It has been suggested that childhood trauma is more likely to produce personality dynamics and vulnerabilities that

may increase the likelihood of being negatively effected by providing trauma therapy (Pearlman & Saakvitne, 1995a; Kassam-Adams, 1995). However, little attention has been paid to the impact of experiencing physical or sexual abuse as an adult, the assumption being that, as an adult, one has more adequate coping mechanisms that may reduce the potential negative effects of such an experience. The finding in this current research suggests that a closer examination needs to occur regarding the impact of trauma in adulthood. It may not be the potential effects of personality dynamics that cause therapists to be more negatively affected by providing trauma therapy. It may be that the more recent the experiences of trauma, the more the therapist is affected when providing trauma therapy. There may also be a factor of accommodation occurring in regards to history of abuse. It may well be that if one experiences abuse as a child, one has already found methods to incorporate this information and one's schema are changed at a young age in regards to the view of self and the world. Further, an individual who experiences trauma in childhood may have developed well entrenched coping styles and adaptations in order to deal with abusive behaviour in general as well as exposure to abusive behaviour. It may be that those who have not experienced abuse until they are adults do not have the coping strategies or adaptations in place in order to deal with the reality of abusive behaviours and consequently experience greater disruptions in cognitive schema.

The research regarding therapist trauma history is quite contradictory. While three studies did find greater disruptions in therapists who reported a trauma history (Battley, 1996; Kassam-Adams, 1995; and Pearlman and Mac Ian, 1995) there were also

three studies which did not find any differences (Green, 1995; Schauben & Frazier, 1995; and Simonds, 1996). Of all of these studies, only Kassam-Adams (1995) distinguished between experiencing trauma as an adult or as a child and found that those therapists who reported childhood trauma were more negatively impacted when providing trauma therapy. However, her definition of trauma was very broad, including death and natural disasters. The findings of this present study provide some interesting research questions and certainly suggest that more detailed and exacting research be done in this area. This may include further research investigating the impact of abuse history which clearly distinguishes between experiencing trauma as a child and experiencing trauma as an adult. Further, qualitative research may be helpful in exploring, identifying and coming to a fuller understanding of the inter-relationships between trauma history as an adult or as a child, cognitive schema, and the provision of trauma therapy.

Gender differences

That women's social and cultural contexts are different than men has certainly been well documented (Brownmiller, 1975, Cook, 1993; Dworkin, 1976; Kaschak, 1992; Kitter, 1993). As a result of the gender differences in social and cultural contexts, Cerney (1995) and Herman (1988) postulate that there are gender differences in the impact of providing trauma therapy. While this present research did not find gender differences in regards to Avoidance and Intrusion, gender differences were found in regards to cognitive disruptions. Specifically, women reported more disruptions in cognitive schema related to their perceptions of their own safety than did men. This finding is consistent with the literature. Kaschak (1992) argues that, because women learn at a very

young age that they are at risk of being violated and abused, fear and mistrust become a part of women's identity. Cerney (1995) and Herman (1988) suggest that because of women's experiences and knowledge of violence against women, women therapists may relate to their own feelings of vulnerability and fear when providing trauma therapy. It is not surprising therefore, to find that the women trauma therapists in this present study reported feeling more unsafe and more worried about their own safety than did their male counterparts. However, further questions emerge as a result of this finding. For example, it is unclear whether women therapists' disruptions in cognitions of safety result from providing trauma therapy or if similar gender differences regarding feelings of safety would be found in the general population of women. Given the arguments of Cerney (1995), Cook (1993), Kaschak (1992), and Herman (1988) it could very well be that, because of women's experience and knowledge of violence against women and children, and because most female socialization includes learning about this danger and learning how to contend with it, women in general may be justifiably more concerned about their safety in the world and feel less safe than do men. It may be useful for further research to examine this issue more closely and employ the use of control groups of male and female non-therapists to come to a fuller understanding of these questions.

It is interesting to note that males therapists in this sample were found to have more disruptions than female therapists in self esteem. The literature shows that males are more often the perpetrators of violence against women and children (Gilligan, 1992; Herman, 1988; Kaschak, 1992; Koss, 1990; Nolen-Hoeksema, 1990; Russel, 1986). It may be that male therapists struggle with issues of gender guilt or feel less positive about

their male identity when providing trauma therapy, which often includes bearing witness to the effects of male violence. However, it may also be that male therapists who provide trauma therapy are more knowledgeable about issues related to male violence against women and children, and further, are more sensitized regarding these issues. Thus, it is unclear whether the provision of trauma therapy is in fact the causative element of these disruptions in self esteem, or if similar results would be found in the general population of males who are knowledgeable and sensitive to the issues of male violence against women. Again, further research utilizing control groups of male and female non-therapists may be helpful to further explore this issue.

While research shows that many more females than males experience abuse as a child or as an adult (Gilligan, 1992; Herman, 1988; Kaschak, 1992; Koss, 1990; Nolen-Hoeksema, 1990; Russel, 1986), the sample of males in this study reported an almost equal rate of experiences of childhood physical or sexual abuse as did the female therapists. This may suggest that the sample of male participants in this study may be somewhat different than the males in the general population. It may well be that males who have experienced violence or abuse as children are more drawn to a profession in the helping field or to the provision of trauma therapy in particular. However, these findings may also be reflective of a measurement issue related to the definition of abuse. The variable exploring abuse as a child asked participants whether they had ever experienced physical or sexual abuse as a child, and participants answered on a “yes” or “no” basis. Therefore, there is no way to distinguish which type of abuse the participants experienced. It may be that the male participants experienced more physical abuse, and

as a result of their education and experiences, may also identify physical abuse more readily than their non-therapist counterparts.

Limitations

While this present study certainly indicated a variety of interesting results and highlighted areas for further exploration and study, there are also a number of limitations of this study. First, the sample used in this study was a selected sample, not a random sample. Therefore, generalizability of the results must be viewed with caution and carefully assessed. Further, this current sample had a much lower mean on both dependent measures than published results with other therapist populations, suggesting that the sample in this study is different from other samples studied, making comparisons with other research tentative. Additionally, while a response rate of almost half of the potential participants may seem to be satisfactory, the respondents are clearly self-selected and their responses may qualitatively differ from those individuals who did not respond, leading to a potential bias in the results. Low response rates have also provided limitations in previous research in this area and clearly needs to be addressed in future research in order to fully explore this field of study.

A second limitation of this study is that a control group with therapists providing non-trauma therapy was not used. The findings should therefore not be interpreted as evidence that male and female therapists experience particular cognitive disruptions as a result of providing trauma focused therapy. Further research utilizing control groups is necessary to explore this further. This study also does not demonstrate a causal relationship between disruptions and the provision of trauma therapy. The correlational

nature of this study means that a causal relationship cannot be implied. It is impossible to determine from the results of this study the directional nature of the correlations that were found.

A further limitation of this study is that of measurement. Although the TSI Belief Scale is the only known scale to measure the specific cognitive disruptions in question, there are certainly some difficulties with this measure. First, it is a long measure containing 80 questions. This certainly could affect participant's willingness to attend carefully to the full measure. Secondly, the internal consistency of the measure appears to be quite variable. In this present study, the internal consistencies found on each of the sub-scales were much lower than the internal consistencies reported by the authors of the scale, with one of the sub-scales having quite low internal consistency. This calls into question the over-all reliability of this measure. Further, in examining the relationships between the sub-scales of this measure, positive correlations varying from weak to moderate were found. This suggests that some of the sub-scales may not be clearly different from each other. There have also been no reported studies regarding criterion-related or construct validity of the TSI Belief Scale. Clearly, as has been suggested in the literature (Gamble et al., 1996), this current study points to the need for further development of the TSI Belief Scale. There are however, some potential benefits of this measure. It is of note that, in this study, although general distress was not related to the amount of trauma therapy provided, disruptions in cognitive schema were found to be related to the amount of trauma therapy provided. This finding lends credence to the notion that there may be different components of self that are variously impacted by

providing trauma therapy, and further, that it is possible to discriminate between these processes. The fact that some effects were found on the TSI Belief Scale, which measures cognitive disruptions, while no effects were found on the IES suggests that there may be some discriminative validity to this measure. McCann and Pearlman (1990c, 1992a, 1992b) and Pearlman and Saakvitne (1995a, 1995b) argue that vicarious trauma is a unique concept as it focuses on cognitive disruptions regarding beliefs about self and the world as a result of providing trauma services, as opposed to external behavioral manifestations including symptoms of avoidance and intrusion, or emotional symptoms of burnout. These present findings are consistent with the notion of vicarious trauma as cognitive disruption. Nonetheless, further development of a model of vicarious trauma is still necessary, both theoretically and empirically. The theory of vicarious trauma has yet to be clearly defined and the process of the development of vicarious trauma has yet to be specified.

Conclusion

The findings in this study highlight some important considerations in regards to the impact of the provision of trauma therapy and gender differences. This study suggests that there may be some aspects of the impact of providing trauma therapy that are gender specific, while others are not. Specifically, this research suggests that while women's beliefs regarding their own safety may be impacted by providing trauma therapy, men's beliefs regarding their self esteem may be negatively impacted by providing trauma therapy. However, further research using control groups is necessary to determine if these gender differences are specific to trauma therapists, or are a reflection of gender

differences in the general population as a result of differences in social and cultural contexts.

The results suggest that gender may be an important variable when examining the impact of providing trauma therapy. Clearly further research is necessary in order to fully explore gender differences in the impact of providing trauma therapy. However, it will be important that further research assess and control for other population characteristics including age and years of experience which were found to be related to gender, when examining gender differences.

In addition to exploring gender differences, this research also highlighted the need to consider the role of other variables in understanding the impact of providing trauma therapy. Abuse history is one such variable that appears to be important. While experiencing trauma in childhood has been explored in relation to the effect this experience may have on the impact of providing trauma therapy, much less attention has been paid to the effect that experiencing trauma as an adult may have on the impact of providing trauma therapy. This research illustrates that trauma history clearly warrants further exploration. It will be important for further research to explore the effects of trauma history while clearly distinguishing between a history of childhood trauma and trauma experienced in adulthood. A qualitative research design may be helpful in exploring more fully the effects of experiencing abuse as an adult on cognitive schema and coping strategies.

References

- Alexander, P. (1993). The differential effects of abuse characteristics and attachment in the prediction of long-term effects of sexual abuse. Journal of Interpersonal Violence, 8, 346-362.
- American Psychiatric Association. (1987). Diagnostic and statistical manual of mental disorders. (3rd ed. rev.). Washington, D.C.: Author.
- American Psychiatric Association. (1994). Diagnostic and statistical manual of mental disorders. (4th ed.). Washington, D.C.: Author.
- Aneshensel, C., & Pearlin, L. (1987). Structural contexts of sex differences in stress. In R. C. Barnett, L. Biener, & G. Baruch (Eds.), Gender and stress (pp. 75-95). New York: Macmillan.
- Battley, S. L. (1996). Vicarious trauma: The effects on psychotherapists of working with trauma victims. In S. Gamble & J. Munroe (Eds.), Trauma's impact on helpers: Research handbook (pp. 3-4). South Windsor, CT: Traumatic Stress Institute.
- Beck, D. (1987). Counsellor burnout in family service agencies. Social Casework: The Journal of Contemporary Social Work, 3-15.
- Belle, D., & Goldman, N. (1988). Patterns of diagnosis received by men and women. In M. Guttentag, S. Salason, & D. Belle (Eds.), The mental health of women (pp. 21-30). New York: Academic Press.
- Black, A., & Pearlman, L. A. (1997). Self esteem as a mediator between beliefs about self and beliefs about others. Journal of Social and Clinical Psychology, 16, 57-76.

Bloom, S. (1994). Developing generic inpatient programs for the treatment of psychological trauma. In M. Williams & J. Sommer (Eds.), Handbook of post-traumatic therapy (pp. 474 - 494). Westport CT: Greenwood Press.

Bober, T. E. (1996). Vicarious trauma and a therapeutic work environment. In S. Gamble & J. Munroe (Eds.), Trauma's impact on helpers: Research handbook (pp. 5-10). South Windsor, CT: Traumatic Stress Institute.

Briere, J. (1984). The effects of childhood sexual abuse on later psychological functioning: Defining a post sexual abuse syndrome. Paper presented at the Third National Conference on Sexual Victimization of Children. Washington, D.C.

Briere, J. (1988). Long-term clinical correlates of childhood sexual victimization. Annals of the New York Academy of Sciences, 582, 327-34.

Briere, J. (1989). Therapy for adults molested as children: Beyond survival. New York: Springer.

Brown, L., & Gilligan, C. (1992). Meeting at the crossroads: Women's psychology and girl's development. Cambridge, MA.: Harvard University Press.

Brownmiller, S. (1975). Against our will: Men, women and rape. New York: Bantam Books.

Bryant, R., & Harvey, A. (1996a). Posttraumatic stress reactions in volunteer firefighters. Journal of Traumatic Stress, 9, 51-62.

Bryant, R., & Harvey, A. (1996b). Initial posttraumatic stress responses following motor vehicle accidents. Journal of Traumatic Stress, 9, 223-234.

Cerney, M. S. (1995). Treating the "heroic treaters". In C. R. Figley (Ed.), Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized (pp. 131-149). New York: Brunner/Mazel.

Cohen, J. (1977). Statistical power analysis for the behavioral sciences. New York: Academic Press, Inc.

Cook, E. P. (1993). Helping women heal: Today and tomorrow. In E. P. Cook (Ed.), Women, relationships and power (pp. 275-291). Alexandria, VA: American Counseling Association.

Corey, G. F. (1991). Theory and the practice of counseling psychotherapy. Belmont, CA.: Brooks Cole.

Crown, D., & Marlowe, D. (1964). The approval motive: Studies in evaluative dependence. Westport, CT: Greenwood Press.

Dalglish, T., Joseph, S., Thrasher, S., Tranah, T., & Yule W. (1996). Crisis support following the herald of free enterprise disaster: A longitudinal perspective. Journal of Traumatic Stress, 9, 833-845.

Daniel, W. (1990). Applied nonparametric statistics. Boston, Mass.: Kent Publishing.

Danieli, Y. (1981). Therapists' difficulties in treating survivors of the Nazi holocaust and their children (Doctoral dissertation, New York University, 1981). Dissertation Abstracts International, 42, 4947-4948.

Danieli, Y. (1994). Countertransference and trauma: Self healing and training issues. In M. Williams & J. Sommer (Eds.), Handbook of post-traumatic therapy (pp. 540 - 550). Westport CT: Greenwood Press.

Dickinson Gibbons, J. & Chakraborti, S. (1992). Nonparametric statistical inference. New York: Marcel Dekker.

Derogatis, L. (1977). Manual for the SCL-90. Baltimore: John Hopkins School of Medicine.

Deutsch, C.J. (1984). Self reported sources of stress among psychotherapists. Professional Psychology: Research and Practice, 15, 833-845.

Duncu, C., Riggs, D., Hearst-Ikeda, D., Shoyer, B., & Foa, E. (1996). Dissociative experiences and posttraumatic stress disorder among female victims of criminal assault and rape. Journal of Traumatic Stress, 9, 253-267.

Dutton, M. (1994). Post-traumatic therapy with domestic violence survivors. In M. Williams & J. Sommer (Eds), Handbook of post-traumatic therapy (pp.146 - 161). Westport, Ct: Greenwood Press.

Dworkin, A. (1976). Our blood: Prophecies and discourses on sexual politics. New York: Harper and Row.

Farber, B.A. (1985). The genesis, development and implications of psychological mindedness among psychotherapists. Psychotherapy, 22, 170-177.

Farber, B.A., & Heifetz, L.J. (1982). The process and dimensions of burnout in psychotherapists. Professional Psychology, 13, 293-301.

Figley, C.R. (1985). Trauma and its wake: The study and treatment of post traumatic stress disorder. New York: Brunner/Mazel.

Figley, C.R. (1988). Toward a field of traumatic stress. Journal of Traumatic Stress, 1, 3-16.

Figley, C. R. (1995). Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized. New York: Brunner/Mazel.

Finkelhor, D., & Yllo, K. (1985). License to rape: Sexual abuse of wives. New York: Holt, Rinehart and Winston.

Freudenberger, H., & Robbins, A. (1979). The hazards of being a psychoanalyst. Psychoanalytic Review, 66, 275-296.

Gamble, S. J., Pearlman, L. A., Lucca, A. M., & Allen, G. J. (1996). Differential therapist stressors in psychotherapy with trauma vs. non-trauma clients. In S. Gamble & J. Munroe (Eds.), Trauma's impact on helpers: Research handbook (pp. 16-19). South Windsor, CT: Traumatic Stress Institute.

Garden, A. (1987). Depersonalization: A valid dimension of burnout? Human Relations, 40, 545-560.

Gilligan, C. (1982). In a different voice: Psychological theory and women's development. Cambridge, MA: Harvard University Press.

Green, C. (1995). A study of the relationship between a personal trauma history and level of vicarious trauma. Unpublished master's thesis, University of Manitoba.

Hamilton, S., & Fagot, B. (1988). Chronic stress and coping styles: A comparison of male and female undergraduates. Journal of Personality and Social Psychology, *55*, 819-823.

Haley, S.A. (1974) When the patient reports atrocities: Specific treatment considerations in the Vietnam veteran. Archives of General Psychiatry, *30*, 191-196.

Hagen, J. (1989). Burnout: An occupational hazard for social workers. In B. Compton & B. Galaway (Eds.), Social Work Processes (pp. 718-726). Belmont, CA.: Wadsworth Publishing Co.

Hayes, J. A., Gelso, C. J., Van Wagoner, S. L., & Diemer, R. A. (1991). Managing countertransference: What the experts think. Psychological Reports, *69*, 138-148.

Herman, J. L. (1981). Father-daughter incest. Cambridge, MA: Harvard University Press.

Herman, J. L. (1988). Father-daughter incest. In F. Ochberg (Ed.), Post-traumatic therapy and victims of violence (pp. 175-195). New York: Brunner\Mazel.

Herman, J. L. (1992). Trauma and recovery. New York: Basic Books.

Horowitz, M., Wilner, N., & Alvarez, W. (1979). Impact of event scale: A measure of subjective stress. Psychosomatic Medicine, *41*, 209-218.

Hossack, A., & Bentall, R. (1996). Elimination of posttraumatic symptomology by relaxation and visual-kinesthetic dissociation. Journal of Traumatic Stress, *9*, 99-110.

Janoff-Bulman, R. (1985). The aftermath of victimization: Rebuilding shattered assumptions. In C.R. Figley (Ed.), Trauma and its wake: The study and treatment of post-traumatic stress disorder (pp. 15-35). New York: Brunner\Mazel.

Johnsen, B., Eid, J., Lovstad, T., & Michelsen, L. (1997). Posttraumatic stress symptoms in nonexposed, victims, and spontaneous rescuers after an avalanche. Journal of Traumatic Stress, 10, 133-140.

Kaschak, Ellyn. (1992). Engendered lives: A new psychology of women's experience. New York: Basic Books.

Kassam-Adams, N. (1995). The risks of treating sexual trauma. In B. H. Stamm (Ed.), Secondary traumatic stress (pp. 37-48). San Francisco, CA.: Sidran Press.

Kenardy, J., Webster, R., Lewin, T., Carr, V., Hazell, P., & Carter, G. (1996). Stress debriefing and patterns of recovery following a natural disaster. Journal of Traumatic Stress, 9, 37-49.

Kessler, R. C., Brown, R.L., & Beaman, C. L. (1981). Sex differences in psychiatric life-seeking. Journal of Health and Social Behavior, 22, 49-64.

Kleespies, P., Smith, M., & Becker, B. (1990). Psychology interns as patient suicide survivors: Incidence, impact, and recovery. Professional Psychology: Research and Practice, 21, 257-263.

Koss, M. P. (1990). The women's mental health agenda: Violence against women. American Psychologist, 45, 374-380.

Koss, M. P., Gidycz, C. A., & Wisniewski, J. (1987). The scope of rape: Incidence and prevalence of sexual aggression and victimization in a national sample of higher education students. Journal of Consulting and Clinical Psychology, 55, 162-170.

Levin, J. & Fox, J. (1993). Elementary statistics in social research. New York: Harper Collins

Litz, B. T., & Weathers, F. W. (1994). The Diagnosis and assessment of post-traumatic stress disorder in adults. In M. Williams & J. Sommer (Eds.), Handbook of post-traumatic therapy (pp. 19 - 37). Westport Ct: Greenwood Press.

Mahoney, M. J. (1982). Psychotherapy and human change process. In J. Harvey & M. Parks (Eds.), Psychotherapy research and behavior change (pp. 73-123). Washington, D.C.: American Psychological Association.

Maslach, C., & Jackson, S. (1986). Maslach burnout inventory manual (2nd ed.) Palo Alto, CA.: Consulting Psychologists Press.

Mainiero, L.A. (1986). Coping with powerlessness. Administrative Science Quarterly, 31, 633-653.

Marmar, C., Weiss, D., Metzler, T., Ronfelst, H., & Foreman, C. (1996). Stress responses of emergency services personnel to the Loma Prieta earthquake, Interstate 880 freeway collapse and control traumatic incidents. Journal of Traumatic Stress, 9, 63-85.

McCann, I. L., & Pearlman, L.A. (1990a). Vicarious traumatization: A framework for understanding the psychological effects of working with victims. Journal of Traumatic Stress, 3, 131-149.

McCann, I. L., & Pearlman, L.A. (1990b). Vicarious traumatization: The emotional costs of working with survivors. The Advisor: Newsletter of the American Professional Society on the Abuse of Children, 3, 34.

McCann, I. L., & Pearlman, L.A. (1990c). Psychological trauma and the adult survivor: Theory, therapy and transformation. New York: Brunner/Mazel.

McCann, I. L., & Pearlman, L. A. (1991). Constructivist self development theory as a framework for assessing and treating victims of family violence. In S. Stith, M. B. Williams, & K. Rosen (Eds.), Violence hits home (pp. 305-329). New York: Springer.

McCann, I. L., & Pearlman, L.A. (1992a). Constructivist self-development theory: A theoretical model of psychological adaptation to severe trauma. In D. K. Dakheim & S.E. Devine (Eds.), Out of darkness: Exploring satanism and ritual abuse (pp. 185-206). New York: Lexington Books.

McCann, I. L., & Pearlman, L.A. (1992b). Constructivist self-development theory: A theoretical framework for assessing and treating traumatized college students. College Health 40, 189-196.

McCann, I. L., & Pearlman, L. A. (1993). Vicarious traumatization: The emotional costs of working with survivors. Treating Abuse Today, 3, (3), 28-31.

McCann, I. L., Sakheim, D., & Abrahamson, D. (1988). Trauma and victimization: A model of psychological adaptation. The Counselling Psychologist, 16, 531-594.

Miller, J. B. (1973). Psychoanalysis and women: Contributions to new theory and therapy. New York: Brunner/Mazel.

Miller, J. B. (1976). Towards a new psychology of women. Boston: Beacon Press.

Miller, J. B. (1984). The development of women's sense of self. Wellesley, MA: Stone Center for Developmental Services and Studies.

Neal, L., Busuttill, W., Rollins, J., Herepath, R., Strike, P., & Turnbull, G. (1994). Convergent validity of measures of post-traumatic stress disorder in a mixed military and civilian population. Journal of Traumatic Stress, 7, 447-455.

Neave, H. & Worthington, P. (1988). Distribution-free tests. Boston: Unwin Hyman.

Neumann, D. A., & Gamble, S. J. (1995). Issues in the professional development of psychotherapists: Countertransference and vicarious traumatization in the new trauma therapist. Psychotherapy, 32, 341-347.

New York Times. (1984). Violent death rate cited as U.S. health concern. November, 28, p. A-14.

Pearlman, L. A. (1995). Self care for trauma therapists: Ameliorating vicarious traumatization. In B. H. Stamm (Ed.), Secondary traumatic stress (pp. 51-64). San Francisco, CA.: Sidran Press.

Pearlman, L., & Mac Ian, P. (1993). The TSI belief scale: Data from four criterion groups. Unpublished manuscript, The traumatic Stress Institute, South Windsor, CT.

Pearlman, L. A., & Mac Ian, P. S. (1995). Vicarious traumatization: An empirical study of the effects of trauma work on trauma therapists. Professional Psychology: Research and Practice, 26, 558-565.

Pearlman, L., & Saakvitne, K. (1995a). Trauma and the therapist. New York: W. W. Norton and Company.

Pearlman, L. A., & Saakvitne, K. (1995b). Treating traumatized therapists. In C.R. Figley (Ed.), Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized (pp. 150-177). New York: Brunner/Mazel.

Perkins, D., & Tebes, J. (1984). Genuine versus simulated responses on the impact of event scale. Psychological Reports, 54, 575-578.

Perrin, S., Van Hasselt, V., Basilio, I., & Hersen, M. (1996). Assessing the effects of violence on women in battering relationships with the Keane MMPI-PTSD Scale. Journal of Traumatic Stress, 9, 805-816.

Piaget, J. (1971). Psychology and epistemology: Toward a theory of self-knowledge. New York: Viking.

Pines, A. M. & Aronson, E. (1988). Career burnout: Causes and cures. New York: Free Press.

Ptacek, J. T., & Dodge, K. L. (1994). Gender differences in coping with stress. Personality and Social Psychology Bulletin, 20, 421-430.

Ptacek, J. T., Smith, R. E., & Zanas, J. (1992). Gender, appraisal, and coping. Journal of Personality, 60, 747-770.

Ritter, K. Y. (1993). Depression in women. In E. P. Cook (Ed.), Women, relationships and power (pp. 139-179). Alexandria, VA.: American Counseling Association.

Rosenbloom, D. J., Pratt, A. C. & Pearlman, L. A. (1995). Helper's responses to trauma work: Understanding and intervening in an organization. In B. H. Stamm (Ed.), Secondary traumatic stress (pp. 65-79). San Francisco, CA.: Sidran Press.

Rotter, J. B. (1954). Social learning and clinical psychology. Englewood Cliffs, N.J.: Prentice Hall.

Rubin, A. & Babbie, E. (1993). Research methods for social work. Pacific Grove, California: Brooks Cole Publishing.

Russell, D. (1984). Sexual exploitation: Rape, child sexual abuse and workplace harassment. Beverly Hills, CA.: Sage.

Russell, D. (1986). The secret trauma: Incest in the lives of girls and women. New York: Basic Books.

Saakvitne, K. W. (1990). Psychoanalytic psychotherapy with incest survivors: Transference and counter-transference paradigms. Paper presented at the annual convention of the American Psychological Association, Boston, MA.

Saakvitne, K. W. (1991). Countertransference in psychotherapy with incest survivors: When the therapist is a survivor of child abuse. Paper presented at the 99th Annual Convention of the American Psychological Association, San Francisco, CA.

Saakvitne, K. W. (1995). Therapists' responses to dissociative clients: Countertransference and vicarious traumatization. In L. Cohen, J Berzoff, & M. Elin (Eds.), Dissociative identity disorders: Theoretical and treatment controversies (pp.467-492). Northvale, NJ.: Jason Aronson.

Saakvitne, K. W., & Pearlman, L. A. (1993). The Impact of internalized misogyny and violence against women on feminine identity. In E. P. Cook (Ed.), Women, relationships, and power (pp.247-275). Alexandria, VA: American Counseling Association.

Schauben, L. J., & Frazier, P. A. (1995). Vicarious trauma: The effects on female counselors of working with sexual violence survivors. Psychology of Women Quarterly, 19, 49-64.

Sheskin, D. (1997). Handbook of parametric and nonparametric statistical procedures. New York: CRC Press.

Sigmon, S., Stanton, A., & Snyder, C. (1995). Gender differences in coping. Sex Roles, 33, 565-587.

Simonds, S. L. (1996). Vicarious traumatization in therapists treating adult survivors of childhood sexual abuse. In S. Gamble & J. Munroe (Eds.), Trauma's impact on helpers: Research handbook (pp. 48-49). South Windsor, CT: Traumatic Stress Institute.

Sloan, I., Rosensky, R., Kaplan, L., & Saunders, S. (1994). A shooting incident in an elementary school: Effects of worker stress on public safety, mental health and medical personnel. Journal of Traumatic Stress, 7, 565-574.

Sprent, P. (1993). Applied nonparametric statistical methods. New York: Chapman Hall.

Strauss, M., Gelles, R., & Steinmetz, S. (1980). Behind closed doors: A survey of family violence in America. New York: Doubleday.

Steinglass, P., & Gerrity, E. (1990). Natural disasters and Post-traumatic stress disorder: Short-term versus long-term recovery in two disaster-affected communities. Journal of Applied Social Psychology, 20, 1746-1756.

Sze, W., & Ivker, B. (1986). Stress in social workers: The impact of the setting and role. Social Casework: The Journal of Contemporary Social Work, 141-148.

Van Wagoner, S. L., Gelso, C. J., Hayes, J. A., & Diemer, R. A. (1991). Countertransference and the reputedly excellent therapist. Psychotherapy: Theory, research and practice, 28, 411-421.

Velsen, C., Gorst-Unsworth, C., & Turner, S. (1996). Survivors of torture and organized violence: Demography and diagnosis. Journal of Traumatic Stress, 9, 181-192.

Weissman, M., & Klerman, G. (1985). Gender and depression. Trends in Neurosciences, 9, 416-420.

White, William L. (1986) Incest in the organizational family: The ecology of burnout in closed systems. The Lighthouse Training Institute, Bloomington, Illinois.

Williams, M., & Sommer, J. (1994). Toward the development of a generic model of PTSD treatment. In M. Williams & J. Sommer (Eds.), Handbook of post-traumatic therapy (pp551-564). Westport, Ct: Greenwood Press.

Zilberg, N., Weiss, D., & Horowitz, M. (1982). Impact of event scale: A cross validation study and some empirical evidence supporting a conceptual model of stress response syndromes. Journal of Consulting and Clinical Psychology, 50, 407-414.

Appendix A

QUESTIONNAIRE

The purpose of this survey is to better understand the impact on therapists who help clients resolve their trauma experiences. Please try and answer each item. Thank you.

For the purposes of this questionnaire, **TRAUMA OR TRAUMA EXPERIENCES IS DEFINED AS PHYSICAL OR SEXUAL ABUSE AS A CHILD OR AS AN ADULT.**

1. How would you best describe your practice setting?
 1. ___ Private Practice
 2. ___ Family Service Agency
 3. ___ Community Health Centre
 4. ___ Abuse Centre
 5. ___ Other - Please describe _____

2. How long have you worked in your current job? _____ years.

3. Including your current job and your previous jobs, how many years have you been providing therapy which is focused on helping clients resolve trauma experiences? _____ years.

4. On average, approximately how many hours per week do you spend providing direct client services\therapy to clients? _____ hours

5. Although many clients may have experienced trauma in their lives, therapy may not be focused on these experiences. On average, approximately how many hours per week do you provide therapy which is focused on helping clients resolve their trauma experiences? _____ hours.

6. On average, how many therapy clients are on your caseload at any given time?
_____ clients.

7. On average, how many of your clients are:

1. adult females _____	4. adult males _____
2. adolescent females _____	5. adolescent males _____
3. female children _____	6. male children _____

8. On average, how many of your clients with whom you are currently working to help resolve trauma are:

1. adult females _____	4. adult males _____
2. adolescent females _____	5. adolescent males _____
3. female children _____	6. male children _____

9. a) How many hours per month, on average, do you spend receiving clinical supervision? _____hours

b) How many hours of this supervision, on average, focuses on clients with whom you are working to help resolve their trauma experiences? _____hours

10. a) How many hours per month, on average, do you spend providing clinical supervision? _____hours

b) How many hours of this supervision, on average, focuses on therapy with clients to help resolve their trauma experiences? _____hours

11. Are you female or male? 1. _____Female 2. _____Male

12. What province do you live in? _____

13. What is your current age? _____years

14. What is the highest level of education that you have completed? (Please mark only one category)

1. _____Less than high school

2. _____Completed high school

3. _____Counseling certificate

4. _____Bachelors degree (specify discipline _____)

5. _____Master's degree (specify discipline _____)

6. _____Doctorate degree (specify discipline _____)

15. Have you ever attended a workshop or training on vicarious trauma?

1. _____yes 2. _____no

16. Have you read any books or articles on vicarious trauma?

1. _____yes 2. _____no

17. Have you ever experienced physical or sexual abuse

as a child? 1. _____yes 2. _____no

as an adult? 1. _____yes 2. _____no

Appendix B

LETTER TO PARTICIPANTS

Dear Colleague;

As a component of my M.S.W. Program at the University of Manitoba, I am conducting a study on the effects of providing trauma services. I am interested in examining the impact on therapists of working with clients to resolve their trauma experiences.

I have received permission from the Director of your agency to include the staff at your agency in this study. However, neither your director nor anyone else at your agency will know of your participation in this study. Therapists from across Canada, working in a variety of different agencies are being contacted to participate in this study. Your participation in this study is completely voluntary and confidential. You will not be required to identify yourself in any way. Your completion and return of the enclosed measurement package will be considered your informed consent for participation in this study.

The data compiled from your responses will be solely used for my research. A summary of the results will be mailed to each of the participating agencies. The results and summary should be ready by the end of April, 1999.

Your participation in this study is very important. Please take a few minutes and fill out the questionnaire. I am very interested in your candid responses. This survey has been pre-tested and should take you approximately fifteen to twenty minutes to complete. I understand that your work time is very valuable and I decided that a small incentive might make this task a little more appealing. Consequently, you will notice that in this package is a small slip of paper and a small white envelope. Should you wish to do so, on this slip of paper, please print your first name only and a telephone number (with the area code) where a message can be left for you and seal it inside the small white envelope provided. You can then return this envelope with the completed questionnaire in the self-addressed, stamped envelope provided. The envelope with your first name written inside will be kept separately until all of the completed questionnaires are returned and I begin to code the data. At that time, a draw will occur and the winner will receive a \$20.00 gift certificate for a self-care package of their choice. This may include a gift certificate for your favorite book store, bath shop or music store. Please return your completed questionnaire as soon as possible as your response is very important. Should you require any further information, please contact me at (204) 284-7525. Thank you for your participation in this study.

Sincerely,

Dear Colleague;

As a component of my M.S.W. Program at the University of Manitoba, I am conducting a study on the effects of providing trauma services. I am interested in examining the impact on therapists of working with clients to resolve their trauma experiences.

I have acquired your name through membership directory of the International Society for Traumatic Stress Studies. Therapists from across Canada, working in a variety of different agencies as well as in private practice are being contacted to participate in this study. Your participation in this study is completely voluntary and confidential. You will not be required to identify yourself in any way. Your completion and return of the enclosed measurement package will be considered your informed consent for participation in this study.

The data compiled from your responses will be solely used for my research. A summary of the results will be mailed to each of the participating agencies or individuals. The results and summary should be ready by the end of April, 1999.

Your participation in this study is very important. Please take a few minutes and fill out the questionnaire. I am very interested in your candid responses. This survey has been pre-tested and should take you approximately fifteen to twenty minutes to complete.

I understand that your work time is very valuable and I decided that a small incentive might make this task a little more appealing. Consequently, you will notice that in this package is a small slip of paper and a small white envelope. Should you wish to do so, on this slip of paper, please print your first name only and a telephone number (with the area code) where a message can be left for you and seal it inside the small white envelope provided. You can then return this envelope with the completed questionnaire in the self-addressed, stamped envelope provided. The envelope with your first name written inside will be kept separately until all of the completed questionnaires are returned and I begin to code the data. At that time, a draw will occur and the winner will receive a \$20.00 gift certificate for a self-care package of their choice. This may include a gift certificate for your favorite book store, bath shop or music store.

Please return your completed questionnaire as soon as possible as your response is very important. Should you require any further information, please contact me at (204) 284-7525. Thank you for your participation in this study.

Sincerely,

Pamela Jackson