A STUDY OF THE RELATIONSHIP BETWEEN A PERSONAL TRAUMA HISTORY AND LEVEL OF VICARIOUS TRAUMATIZATION

by

Cheryl Lynn Green

A THESIS

SUBMITTED TO THE FACULTY OF GRADUATE STUDIES

IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE

DEGREE OF

MASTER OF SOCIAL WORK

FACULTY OF SOCIAL WORK

UNIVERSITY OF MANITOBA

WINNIPEG, MANITOBA

ISBN 0-612-16143-9

Name

Dissertation Abstracts International and *Masters Abstracts International* are arranged by broad, general subject categories. Please select the one subject which most nearly describes the content of your dissertation or thesis. Enter the corresponding four-digit code in the spaces provided.

VICARIOUS TRAUMATIZATION

SUBJECT TERM

0452

SUBJECT CODE

UMI

Subject Categories

THE HUMANITIES AND SOCIAL SCIENCES

COMMUNICATIONS AND THE ARTS

Architecture 0729
Art History 0377
Cinema 0900
Dance 0378
Fine Arts 0357
Information Science 0723
Journalism 0391
Library Science 0399
Mass Communications 0708
Music 0413
Speech Communication 0459
Theater 0465

EDUCATION

General 0515
Administration 0514
Adult and Continuing 0516
Agricultural 0517
Art 0273
Bilingual and Multicultural 0282
Business 0688
Community College 0275
Curriculum and Instruction 0727
Early Childhood 0518
Elementary 0524
Finance 0277
Guidance and Counseling 0519
Health 0680
Higher 0745
History of 0520
Home Economics 0278
Industrial 0521
Language and Literature 0279
Mathematics 0280
Music 0522
Philosophy of 0998
Physical 0523
Psychology 0525
Reading 0535
Religious 0527
Sciences 0714
Secondary 0533
Social Sciences 0534
Sociology of 0340
Special 0529
Teacher Training 0530
Technology 0710
Tests and Measurements 0288
Vocational 0747

LANGUAGE, LITERATURE AND LINGUISTICS

Language
- General 0679
- Ancient 0289
- Linguistics 0290
- Modern 0291

Literature
- General 0401
- Classical 0294
- Comparative 0295
- Medieval 0297
- Modern 0298
- African 0316
- American 0591
- Asian 0305
- Canadian (English) 0352
- Canadian (French) 0355
- English 0593
- Germanic 0311
- Latin American 0312
- Middle Eastern 0315
- Romance 0313
- Slavic and East European 0314

PHILOSOPHY, RELIGION AND THEOLOGY

Philosophy 0422
Religion
- General 0318
- Biblical Studies 0321
- Clergy 0319
- History of 0320
- Philosophy of 0322

Theology 0469

SOCIAL SCIENCES

American Studies 0323
Anthropology
- Archaeology 0324
- Cultural 0326
- Physical 0327

Business Administration
- General 0310
- Accounting 0272
- Banking 0770
- Management 0454
- Marketing 0338

Canadian Studies 0385
Economics
- General 0501
- Agricultural 0503
- Commerce-Business 0505
- Finance 0508
- History 0509
- Labor 0510
- Theory 0511

Folklore 0358
Geography 0366
Gerontology 0351
History
- General 0578
- Ancient 0579
- Medieval 0581
- Modern 0582
- Black 0328
- African 0331
- Asia, Australia and Oceania 0332
- Canadian 0334
- European 0335
- Latin American 0336
- Middle Eastern 0333
- United States 0337

History of Science 0585
Law 0398
Political Science
- General 0615
- International Law and Relations 0616
- Public Administration 0617

Recreation 0814
Social Work 0452
Sociology
- General 0626
- Criminology and Penology 0627
- Demography 0938
- Ethnic and Racial Studies 0631
- Individual and Family Studies 0628
- Industrial and Labor Relations 0629
- Public and Social Welfare 0630
- Social Structure and Development 0700
- Theory and Methods 0344

Transportation 0709
Urban and Regional Planning 0999
Women's Studies 0453

THE SCIENCES AND ENGINEERING

BIOLOGICAL SCIENCES

Agriculture
- General 0473
- Agronomy 0285
- Animal Culture and Nutrition 0475
- Animal Pathology 0476
- Food Science and Technology 0359
- Forestry and Wildlife 0478
- Plant Culture 0479
- Plant Pathology 0480
- Plant Physiology 0817
- Range Management 0777
- Wood Technology 0746

Biology
- General 0306
- Anatomy 0287
- Biostatistics 0308
- Botany 0309
- Cell 0379
- Ecology 0329
- Entomology 0353
- Genetics 0369
- Limnology 0793
- Microbiology 0410
- Molecular 0307
- Neuroscience 0317
- Oceanography 0416
- Physiology 0433
- Radiation 0821
- Veterinary Science 0778
- Zoology 0472

Biophysics
- General 0786
- Medical 0760

EARTH SCIENCES

Biogeochemistry 0425
Geochemistry 0996
Geodesy 0370
Geology 0372
Geophysics 0373
Hydrology 0388
Mineralogy 0411
Paleobotany 0345
Paleoecology 0426
Paleontology 0418
Paleozoology 0985
Palynology 0427
Physical Geography 0368
Physical Oceanography 0415

HEALTH AND ENVIRONMENTAL SCIENCES

Environmental Sciences 0768
Health Sciences
- General 0566
- Audiology 0300
- Chemotherapy 0992
- Dentistry 0567
- Education 0350
- Hospital Management 0769
- Human Development 0758
- Immunology 0982
- Medicine and Surgery 0564
- Mental Health 0347
- Nursing 0569
- Nutrition 0570
- Obstetrics and Gynecology 0380
- Occupational Health and Therapy 0354
- Ophthalmology 0381
- Pathology 0571
- Pharmacology 0419
- Pharmacy 0572
- Physical Therapy 0382
- Public Health 0573
- Radiology 0574
- Recreation 0575
- Speech Pathology 0460
- Toxicology 0383

Home Economics 0386

PHYSICAL SCIENCES

Pure Sciences

Chemistry
- General 0485
- Agricultural 0749
- Analytical 0486
- Biochemistry 0487
- Inorganic 0488
- Nuclear 0738
- Organic 0490
- Pharmaceutical 0491
- Physical 0494
- Polymer 0495
- Radiation 0754

Mathematics 0405
Physics
- General 0605
- Acoustics 0986
- Astronomy and Astrophysics 0606
- Atmospheric Science 0608
- Atomic 0748
- Electronics and Electricity 0607
- Elementary Particles and High Energy 0798
- Fluid and Plasma 0759
- Molecular 0609
- Nuclear 0610
- Optics 0752
- Radiation 0756
- Solid State 0611

Statistics 0463

Applied Sciences

Applied Mechanics 0346
Computer Science 0984
Engineering
- General 0537
- Aerospace 0538
- Agricultural 0539
- Automotive 0540
- Biomedical 0541
- Chemical 0542
- Civil 0543
- Electronics and Electrical 0544
- Heat and Thermodynamics 0348
- Hydraulic 0545
- Industrial 0546
- Marine 0547
- Materials Science 0794
- Mechanical 0548
- Metallurgy 0743
- Mining 0551
- Nuclear 0552
- Packaging 0549
- Petroleum 0765
- Sanitary and Municipal 0554
- System Science 0790

Geotechnology 0428
Operations Research 0796
Plastics Technology 0795
Textile Technology 0994

PSYCHOLOGY

General 0621
Behavioral 0384
Clinical 0622
Developmental 0620
Experimental 0623
Industrial 0624
Personality 0625
Physiological 0989
Psychobiology 0349
Psychometrics 0632
Social 0451

Nom _____

Dissertation Abstracts International est organisé en catégories de sujets. Veuillez s.v.p. choisir le sujet qui décrit le mieux votre thèse et inscrivez le code numérique approprié dans l'espace réservé ci-dessous.

_____ ☐☐☐ U·M·I

SUJET — CODE DE SUJET

Catégories par sujets

HUMANITÉS ET SCIENCES SOCIALES

COMMUNICATIONS ET LES ARTS
Architecture 0729
Beaux-arts 0357
Bibliothéconomie 0399
Cinéma 0900
Communication verbale 0459
Communications 0708
Danse 0378
Histoire de l'art 0377
Journalisme 0391
Musique 0413
Sciences de l'information 0723
Théâtre 0465

ÉDUCATION
Généralités 515
Administration 0514
Art 0273
Collèges communautaires 0275
Commerce 0688
Économie domestique 0278
Éducation permanente 0516
Éducation préscolaire 0518
Éducation sanitaire 0680
Enseignement agricole 0517
Enseignement bilingue et multiculturel 0282
Enseignement industriel 0521
Enseignement primaire. 0524
Enseignement professionnel 0747
Enseignement religieux 0527
Enseignement secondaire 0533
Enseignement spécial 0529
Enseignement supérieur 0745
Évaluation 0288
Finances 0277
Formation des enseignants 0530
Histoire de l'éducation 0520
Langues et littérature 0279
Lecture 0535
Mathématiques 0280
Musique 0522
Orientation et consultation 0519
Philosophie de l'éducation 0998
Physique 0523
Programmes d'études et enseignement 0727
Psychologie 0525
Sciences 0714
Sciences sociales 0534
Sociologie de l'éducation 0340
Technologie 0710

LANGUE, LITTÉRATURE ET LINGUISTIQUE
Langues
- Généralités 0679
- Anciennes 0289
- Linguistique 0290
- Modernes 0291

Littérature
- Généralités 0401
- Anciennes 0294
- Comparée 0295
- Médiévale 0297
- Moderne 0298
- Africaine 0316
- Américaine 0591
- Anglaise 0593
- Asiatique 0305
- Canadienne (Anglaise) 0352
- Canadienne (Française) 0355
- Germanique 0311
- Latino-américaine 0312
- Moyen-orientale 0315
- Romane 0313
- Slave et est-européenne 0314

PHILOSOPHIE, RELIGION ET THÉOLOGIE
Philosophie 0422
Religion
- Généralités 0318
- Clergé 0319
- Études bibliques 0321
- Histoire des religions 0320
- Philosophie de la religion 0322

Théologie 0469

SCIENCES SOCIALES
Anthropologie
- Archéologie 0324
- Culturelle 0326
- Physique 0327

Droit 0398
Économie
- Généralités 0501
- Commerce-Affaires 0505
- Économie agricole 0503
- Économie du travail 0510
- Finances 0508
- Histoire 0509
- Théorie 0511

Études américaines 0323
Études canadiennes 0385
Études féministes 0453
Folklore 0358
Géographie 0366
Gérontologie 0351
Gestion des affaires
- Généralités 0310
- Administration 0454
- Banques 0770
- Comptabilité 0272
- Marketing 0338

Histoire
- Histoire générale 0578
- Ancienne 0579
- Médiévale 0581
- Moderne 0582
- Histoire des noirs 0328
- Africaine 0331
- Canadienne 0334
- États-Unis 0337
- Européenne 0335
- Moyen-orientale 0333
- Latino-américaine 0336
- Asie, Australie et Océanie 0332

Histoire des sciences 0585
Loisirs 0814
Planification urbaine et régionale 0999
Science politique
- Généralités 0615
- Administration publique 0617
- Droit et relations internationales 0616

Sociologie
- Généralités 0626
- Aide et bien-être social 0630
- Criminologie et établissements pénitentiaires 0627
- Démographie 0938
- Études de l' individu et de la famille 0628
- Études des relations interethniques et des relations raciales 0631
- Structure et développement social 0700
- Théorie et méthodes. 0344
- Travail et relations industrielles 0629

Transports 0709
Travail social 0452

SCIENCES ET INGÉNIERIE

SCIENCES BIOLOGIQUES
Agriculture
- Généralités 0473
- Agronomie. 0285
- Alimentation et technologie alimentaire 0359
- Culture 0479
- Élevage et alimentation 0475
- Exploitation des pâturages 0777
- Pathologie animale 0476
- Pathologie végétale 0480
- Physiologie végétale 0817
- Sylviculture et faune 0478
- Technologie du bois 0746

Biologie
- Généralités 0306
- Anatomie 0287
- Biologie (Statistiques) 0308
- Biologie moléculaire 0307
- Botanique 0309
- Cellule 0379
- Écologie 0329
- Entomologie 0353
- Génétique 0369
- Limnologie 0793
- Microbiologie 0410
- Neurologie 0317
- Océanographie 0416
- Physiologie 0433
- Radiation 0821
- Science vétérinaire 0778
- Zoologie 0472

Biophysique
- Généralités 0786
- Medicale 0760

SCIENCES DE LA TERRE
Biogéochimie 0425
Géochimie 0996
Géodésie 0370
Géographie physique 0368
Géologie 0372
Géophysique 0373
Hydrologie 0388
Minéralogie 0411
Océanographie physique 0415
Paléobotanique 0345
Paléoécologie 0426
Paléontologie 0418
Paléozoologie 0985
Palynologie 0427

SCIENCES DE LA SANTÉ ET DE L'ENVIRONNEMENT
Économie domestique 0386
Sciences de l'environnement 0768
Sciences de la santé
- Généralités 0566
- Administration des hôpitaux 0769
- Alimentation et nutrition 0570
- Audiologie 0300
- Chimiothérapie 0992
- Dentisterie 0567
- Développement humain 0758
- Enseignement 0350
- Immunologie 0982
- Loisirs 0575
- Médecine du travail et thérapie 0354
- Médecine et chirurgie 0564
- Obstétrique et gynécologie 0380
- Ophtalmologie 0381
- Orthophonie 0460
- Pathologie 0571
- Pharmacie 0572
- Pharmacologie 0419
- Physiothérapie 0382
- Radiologie 0574
- Santé mentale 0347
- Santé publique 0573
- Soins infirmiers 0569
- Toxicologie 0383

SCIENCES PHYSIQUES
Sciences Pures
Chimie
- Généralités 0485
- Biochimie 487
- Chimie agricole 0749
- Chimie analytique 0486
- Chimie minérale 0488
- Chimie nucléaire 0738
- Chimie organique 0490
- Chimie pharmaceutique 0491
- Physique 0494
- PolymÈres 0495
- Radiation 0754

Mathématiques 0405
Physique
- Généralités 0605
- Acoustique 0986
- Astronomie et astrophysique 0606
- Électronique et électricité 0607
- Fluides et plasma 0759
- Météorologie 0608
- Optique 0752
- Particules (Physique nucléaire) 0798
- Physique atomique 0748
- Physique de l'état solide 0611
- Physique moléculaire 0609
- Physique nucléaire 0610
- Radiation 0756

Statistiques 0463

Sciences Appliqués Et Technologie
Informatique 0984
Ingénierie
- Généralités 0537
- Agricole 0539
- Automobile 0540
- Biomédicale 0541
- Chaleur et thermodynamique 0348
- Conditionnement (Emballage) 0549
- Génie aérospatial 0538
- Génie chimique 0542
- Génie civil 0543
- Génie électronique et électrique 0544
- Génie industriel 0546
- Génie mécanique 0548
- Génie nucléaire 0552
- Ingénierie des systèmes 0790
- Mécanique navale 0547
- Métallurgie 0743
- Science des matériaux 0794
- Technique du pétrole 0765
- Technique minière 0551
- Techniques sanitaires et municipales 0554
- Technologie hydraulique 0545

Mécanique appliquée 0346
Géotechnologie 0428
Matières plastiques (Technologie) 0795
Recherche opérationnelle 0796
Textiles et tissus (Technologie) 0794

PSYCHOLOGIE
Généralités 0621
Personnalité 0625
Psychobiologie 0349
Psychologie clinique 0622
Psychologie du comportement 0384
Psychologie du développement 0620
Psychologie expérimentale 0623
Psychologie industrielle 0624
Psychologie physiologique 0989
Psychologie sociale 0451
Psychométrie 0632

THE UNIVERSITY OF MANITOBA

FACULTY OF GRADUATE STUDIES

COPYRIGHT PERMISSION

A STUDY OF THE RELATIONSHIP BETWEEN A PERSONAL TRAUMA HISTORY AND LEVEL OF VICARIOUS TRAUMATIZATION

BY

CHERYL LYNN GREEN

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

MASTER OF SOCIAL WORK

ABSTRACT

A STUDY OF THE RELATIONSHIP BETWEEN A PERSONAL TRAUMA HISTORY AND LEVEL OF VICARIOUS TRAUMATIZATION

As trauma helpers we are exposed to our client's trauma material on a regular basis. A conceivable result of this work is vicarious traumatization, defined as a "transformation in the helper's inner experience, resulting from empathic exposure to client's trauma material" (McCann & Pearlman, 1990). Pearlman (1994) suggests that a personal trauma history is a risk factor for vicarious traumatization if it is unrecognized, unprocessed or unresolved.

This quantitative study explores the relationship between a personal trauma history with several other variables and level of vicarious traumatization on fifty three front-line trauma helpers employed by Kenora-Patricia Child and Family Services and the Kenora Child Development Centre in March, 1996.

Trauma helpers with a personal trauma history did not show more negative effects from their work than those without a personal trauma history. Levels of vicarious traumatization were statistically significant with level of education attained suggesting that those participants with a high school education were more vulnerable to vicarious traumatization than those in the community college or undergraduate groups.

ACKNOWLEDGEMENTS

I would like to express my sincere thanks and gratitude to a number of people who have participated along with me. To my faculty advisor, Dr. Denis Bracken, thank you for your support and encouragement. Thank you to my internal committee member, Dr. Barry Trute for your patience and assistance. To my external committee member, Dr. John Schallow, thank you for your challenges, they have been very valuable.

Special thanks to Jan Aylward, Lana Hohn, Kati Heinrich, Linda Campbell, and Garry Norris for their encouragement, support, and expertise. To Sylvia and Catherine at the "Norwood Westin", thank you for keeping me safe and grounded.

And finally to my family- Harry, Casey, and Michael, I could not have completed this thesis without your patience and love.

TABLE OF CONTENTS

LIST OF TABLES

CHAPTER I

INTRODUCTION

Vicarious traumatization is a relatively new term, coined in 1990 by McCann and Pearlman from the Traumatic Stress Institute in Connecticut. They define vicarious traumatization as "a transformation in the helper's inner experience, resulting from empathic exposure to client's trauma material" (McCann & Pearlman, 1990).

McCann and Pearlman propose that vicarious traumatization is an inevitable result of trauma work. Vicarious traumatization results in disruptions to the trauma helper's sense of identity, worldview, ability to tolerate strong affect, spirituality, and central cognitive schemas (i.e. core beliefs about safety, trust, esteem, control, and intimacy).

The effects of vicarious traumatization will be unique in each trauma helper depending on his or her personality, defensive style, and resources. Pearlman et al. propose that vicarious traumatization can affect anyone who engages empathically with trauma survivors (e.g. journalists, police, shelter staff, clergy, researchers, etc.).

Vicarious traumatization differs from burnout and countertransference. Burnout focuses on the situation and is

the result of unrealistic expectations in a difficult and unrewarding job. Burnout may relate to any type of job. Several studies have differentiated empirically between vicarious traumatization and burnout (Gamble, Pearlman, Lucca, & Allen, 1994; Monroe, 1991; & Schauben & Frazier, 1995). However, vicarious traumatization may be a precursor to burnout (Neumann & Gamble, 1995).

Countertransference focuses on the individual and relates to all psychotherapy. It refers to the activation of the trauma helper's unconscious or unresolved conflicts and its effects are specific to the therapy relationship (Wilson & Lindy, 1994).

Vicarious traumatization focuses on the interaction between the situation and the trauma helper and relates specifically to trauma therapy (McCann & Pearlman, 1992). When trauma helpers allow themselves to share in the experience of survivors, their own assumptions about the nature of the world may also be damaged (Bloom, 1994). It is important to stress that vicarious traumatization is a normal response to doing the hard work of trauma therapy and does not necessarily reflect the trauma helper's competence (Neumann & Gamble, 1995).

THEORETICAL FRAMEWORK

Vicarious traumatization is based on Constructivist Self Development Theory (CSDT). This theory of trauma and adaptation blends contemporary psychoanalytic theories with social cognition theories to provide a developmental framework for understanding the experiences of survivors of traumatic life events (Pearlman & MacIan, 1995).

CSDT identifies the specific ways in which working with trauma victims can disrupt the trauma helper's schema or beliefs and assumptions about self and world (McCann & Pearlman, 1990; McCann, Pearlman, Sakheim, & Abrahamson, 1988; McCann, Sakheim, & Abrahamson, 1988). McCann & Pearlman propose that these disruptions occur in the following seven core areas: frame of reference, safety, trust/dependency, esteem, independence, power, and intimacy. They believe that these fundamental human needs are most vulnerable to disruption by trauma.

Painful feelings, as well as changes in interpersonal relationships, can result from disruptions to these schema. CSDT proposes that disruptions in imagery are a hallmark of vicarious traumatization and that helpers may also experience transient and sometimes permanent changes in their memory systems (McCann & Pearlman, 1993).

CSDT is based on the following assumptions: Individuals construct and construe their own realities (Constructivist); and the self develops over the life-span within a particular social and cultural context (Developmental) (McCann & Pearlman, 1992). These schemas are developed through the processes of assimilation and accommodation. They may operate within or outside of our conscious awareness, and may be positive or negative, and generalized or specific. Schemas are associated with various feelings, thoughts, and behaviours. When one experiences a traumatic event, one's core schemas about self and the world may be disrupted. Trauma often produces negative, overgeneralized schemas, disrupting one's identity, one's emotional and interpersonal life outside of the traumatic environment, and one's ability to meet central psychological needs (McCann & Pearlman, 1992).

CSDT offers a conceptualization of the client and his or her resources that is nonpathologizing and therefore esteem-enhancing (Pearlman & Saakvitne, 1995). CSDT provides a framework to understand the complex and individual ways in which we adapt to trauma and victimization. By exploring the disturbances in each of the schema areas, therapeutic strategies can be developed that respect individual differences.

Disturbed schemas are frequently related to specific traumatic experiences. The traumatic imagery that is most distressing for an individual often reflects that individual's central schema areas. McCann & Pearlman (1992) propose that individuals will experience greater emotional distress related to disruptions in their more central need areas. The degree of disruption or importance of the different need areas to each person may depend in part on the level of the individual's psychological development when various traumatic events occurred (McCann & Pearlman, 1992).

From a CSDT perspective, the schemas may have developed in order to protect the client from being overwhelmed by painful feelings. Thus the survivors's symptoms can be viewed as adaptive strategies that were developed to manage feelings and thoughts that threaten the integrity and safety of the self (Pearlman & Saakvitne, 1995). Even the most disturbed schema served some protective or defensive function in the client's past.

CSDT also provides a framework for understanding the impact of trauma work on the trauma helper. As trauma helpers, a CSDT perspective can be utilized to assess our own changes in our beliefs about ourselves and others. By acknowledging the changes in our self when working with trauma survivors, we can

explore ways to ameliorate the effects of vicarious traumatization.

CHAPTER II

HISTORICAL ROOTS

In formulating their Constructivist Self Development Theory (CSDT), McCann et al. (1990, 1992, 1995) have extensively reviewed the evolution of contemporary theories of trauma and their historical roots. They discuss the work of Sigmund Freud and Joseph Breuer (1895) in the development of the first theory of trauma after observing that many of their female patients with conversion reactions reported histories of seduction by male parental figures. Freud and Breuer hypothesized that hysterical symptoms were symbolic representations of repressed memories of abuse. However, due to the social and cultural pressures in the late 1800's, Freud and Breuer focused on fantasy theory in which their patients' recollections of abuse were really fantasies that represented unacceptable oedipal longings. Their fantasy theory contributed to the denial of child sexual abuse and it became hidden for many years.

In 1920, Freud observed that many World War I veterans suffered nightmares and startle reactions. He hypothesized that these symptoms resulted from a breach in the "stimulus barrier" when the ego was overwhelmed by stimuli that it could not master. Freud acknowledged that a trauma of a certain

magnitude would affect almost all who were exposed to it (Freud, 1920).

Freud (1939) described the tendency to repeat or reexperience a trauma as an attempt to master it, thus integrating notions of the repetition compulsion into theories of trauma. He also described the use of denial as a defense against the painful affect that accompanies repetition.

Since post-traumatic stress disorder (PTSD) was included in the DSM-III (American Psychiatric Association, 1980), a number of theorists have attempted to explain how trauma results in the oscillation among reexperiencing symptoms (e.g., nightmares and flashbacks), denial or avoidance (psychic numbing and repression of traumatic memories), and hyperarousal (startle responses and overreactivity) (McCann & Pearlman, 1990).

The cognitive portion of CSDT is built upon a constructivist foundation. McCann and Pearlman (1994) cite two authors, Epstein (1989) and Mahoney (1981), who propose that human beings construct their own personal realities through the development of complex cognitive structures which are used to interpret events. These cognitive structures evolve and become increasingly complex over the life span as individuals

interact with their meaningful environment (McCann & Pearlman, 1990).

Pearlman et al. have also utilized Epstein's (1989) description of how trauma disrupts a person's schemas, or beliefs and assumptions about the self, other people, and the world. Epstein suggests that the disruptions of these schemas or conceptual systems can disrupt the entire personality, producing a state of disequilibrium and symptoms of post-traumatic stress disorder (McCann & Pearlman, 1990).

In his cognitive development theory, Piaget (1971) described these cognitive structures as schemas. Piaget proposes that as individuals develop, their cognitive structures become increasingly complex and differentiated through the processes of assimilation and accommodation (Mc Cann & Pearlman, 1990). These schemas include beliefs, assumptions, and expectations about self and world that enable individuals to make sense of their experience. Cognitive schemas are modified if the environment presents information that cannot be assimilated into existing schemas.

McCann et al. have studied the work of M.J. Horowitz in the area of stress response syndromes, emphasizing the impact of trauma on cognitive schemas and the role of defenses in regulating the processing of information. Until the

traumatic event is integrated into existing cognitive schemas, the psychological representations of the event are stored in active memory, which allows for repeated representations of the traumatic events (McCann & Pearlman, 1990). The survivor of the traumatic event may reexperience intrusive thoughts and images about the trauma, accompanied by intense and painful emotional states. Frequently, avoidance or denial will follow these experiences as a defense against becoming emotionally overwhelmed.

Williams (1994) quotes Epstein's (1991) four fundamental beliefs likely to be challenged through traumatization :

1. The world is benign, rewarding, and pleasurable.
2. The world is meaningful, controllable, just, safe, and predictable.
3. The self is lovable, competent, and is not to blame.
4. People are trustworthy and worthy of relating to. (p.177)

Theorists were unable to determine the degree to which personal factors, such as the individual's preexisting personality (or psychopathology), and situational factors, such as the magnitude or nature of the external stressor, determine the post-traumatic response (McCann & Pearlman, 1990). There appears to be a great degree of variability in response among people who have experienced the same traumatic life event.

Lisa McCann, David Sakheim, and Daniel Abrahamson (1988) presented the first formulations of Constructivist Self

Development Theory (CSDT) which focused on cognitive schemas disrupted by trauma. Lisa McCann and Laurie Pearlman (1990) expanded the cognitive portion of this work to include the concept of the self, the social and cultural context, and a fuller elaboration of the imagery and verbal systems of memory. They have developed CSDT in an interactive process of their research and clinical work at the Traumatic Stress Institute in Connecticut.

TRAUMA

"To study psychological trauma is to come face to face both with human vulnerability in the natural world and with the capacity for evil in human nature" (Herman, 1992; p.8). Witnesses as well as victims are subject to the dialectic of trauma (Herman, 1992). As trauma helpers we "witness" our client's trauma material on a regular basis. Herman (1992) suggests that "survivors challenge us to reconnect fragments, to reconstruct history, to make meaning of their present symptoms in the light of past events" (p.3).

In order to better understand vicarious traumatization, it is important to define what "trauma" means to both the trauma helper and the trauma survivor. Everstine and Everstine (1993) suggest that psychological trauma occurs in the wake of an unexpected event that a person has experienced intimately

and forcefully. They define trauma as "a response, a reaction, the answer to a question".

McCann and Pearlman (1990) define psychololgical trauma as "an event that overwhelms the individual's perceived ability to cope". Wilson (1994) defines a traumatic event as "one in which the person has experienced an external stressor event that is injurious to the normal state (stasis) and results in a condition that reflects this injury to the pretraumatic state of being".

As Herman (1992) notes, "traumatic events are extraordinary, not because they occur rarely, but rather because they overwhelm the ordinary human adaptations to life" (p.33). The DSMII-R (APA, 1987) defines traumatic events as events that are "out of the range of ordinary experience".

Williams and Sommer (1994) quote Janoff-Bulman (1992) who notes that to be classified as traumatic, "an event must be perceived and processed as serious enough to challenge basic assumptions of safety, predictability, justness, and fairness" (p. xiii).

Williams and Sommer (1994) also cite Horowitz (1986) who suggests that these events, during processing, become encoded in the brain as active memory and often return in the form of

intrusions such as images, dreams, reactions to triggers, and flashbacks. If the mind is unable or unwilling to process these intrusions, it tends to shut down and avoid them, until they become so intense that they are unavoidable and demand attention.

Wilson (1995) notes that persons affected by traumatic life events are "biological organisms who possess unique personality attributes that are shaped by their families of origin and the cultures in which they grew up". Thus, a traumatic event does not occur in a vacuum. We all experience trauma in our own unique way, depending on our personal coping skills and social supports. In order to treat trauma survivors, a holistic approach can be utilized to explore the environment and culture in which the traumatic event occurred.

Injury caused by a traumatic event may differ in length of time and degrees of distress depending on the nature of the survivor, the nature of the traumatic event, and the personal and social resources available to the survivor.

Lindy (1988) describes the level of social, economic, and personal support present as the "trauma membrane". He proposes that there is a tendency for significant others to form a protective membrane of support around the survivor to insulate him or her from further stress or harm. Lindy

hypothesizes that the stress recovery process will be more positive with a greater level of supportive mechanisms and opportunites after a traumatic event.

Pearlman and Saakvitne (1995) define trauma within a Constructivist Self Development Theory. Trauma is the

> "unique individual experience, associated with an event or enduring conditions in which the individual's ability to integrate affective experience is overwhelmed or the individual experiences a threat to life or bodily integrity " (p.60).

Pearlman and Saakvitne propose that trauma causes pathognomonic responses in the individual's frame of reference (usual way of understanding self and world, including spirituality), their capacity to modulate affect and maintain benevolent inner connection with self and others, their ability to meet their psychological needs in mature ways, their central psychological needs (which are reflected in disrupted cognitive schemas), and their memory system (including sensory experience).

THE EMPATHY CONNECTION

Empathy is defined as "the psychobiological capacity to experience another person's state of being and phenomenological perspective at a given moment in time" (Wilson & Lindy, 1994). The trauma helper's empathy is

essential to the creation of a therapeutic relationship and thus to the recovery of the trauma survivor (Wilson & Lindy, 1994). Wilson and Lindy (1994) believe that the capacity for sustained empathy is pivotal for the recovery process.

Empathy can be considered both the trauma helper's asset and liability (Pearlman & Saakvitne, 1995). The trauma survivor's material may not only stir empathy, but also memory and personal pain in the trauma helper (Pearlman & McCann, 1995). Pearlman et al. describe vicarious traumatization as "the consequence of empathy". During the therapeutic process, empathic engagement with the client may cause a transformation in the trauma helper resulting in vicarious traumatization (McCann & Pearlman, 1990).

Pearlman and Saakvitne (1995), describe two types of empathic connection in order to understand the relation between vicarious traumatization and empathy. Cognitive empathy focuses on the cognitive understanding of what happened, what the survivor says she experienced, how it came about, what it meant to her, and her narrative account of the abuse and its aftermath. Affective empathy occurs when the trauma helper feels some of the survivor's pain, fear, rage, grief, and the range of intense emotions connected with her experience. Pearlman and Saakvitne (1995) believe that the loss of empathy

with clients poses a "profound danger to any therapy and can result in retraumatization of survivor clients" (p.289).

PERSONAL TRAUMA HISTORY

Trauma helpers bring their own personality characteristics and idiosyncracies to the treatment situation (Wilson & Lindy, 1994). It is not uncommon for trauma survivors to pursue a healing mission, such as helping other survivors, as part of their own recovery (Pearlman & Saakvitne, 1995).

In their review of survivor research, Pearlman and Saakvitne (1995) found that the percentage of therapists who are themselves survivors of childhood sexual abuse is higher than the percentage of survivors in the general population (Follette, Polusny, & Milbeck, 1994; Schauben & Frazier, 1995). Survivor therapists may carry both a higher tolerance for painful feelings and a greater capacity for empathy (Pearlman & Saakvitne, 1995). However, these characteristics may increase the trauma helper's vulnerability to vicarious traumatization.

Trauma helpers with a personal trauma history may have their own trauma experience consciously or unconsciously reenacted while attending to the trauma experience of their clients. Trauma helpers with a personal trauma history are especially

vulnerable to empathic enmeshment in which they become overinvolved and overidentified with the trauma survivor (Wilson & Lindy, 1994). The trauma helper may unconsciously attempt to rescue trauma survivors as an indirect way of dealing with their own unintegrated personal conflicts. While identifying with a trauma survivor may facilitate empathy, it may also lead to the trauma helper's assumption that he or she knows or understands more of the trauma survivor's experience than the trauma helper really does (Pearlman & Saakvitne, 1995).

It is important that the trauma helper's own personal trauma history be evaluated and processed. If the trauma helper has not finished processing his or her own trauma history, it may be appropriate to refer the client to another trauma helper. As Dutton (1994) notes, a personal victimization history can dramatically influence the quality of the trauma helper's work. Wilson and Lindy (1994) believe that a personal trauma history is reflected in the defensive style and general level of stress of the trauma helper.

Pearlman et al. hypothesize that the trauma survivor's material may reawaken the trauma helper's own memories and consequent strong feelings. If the trauma helper's own history has not been addressed, he or she may use defense strategies when working with the trauma survivor. Trauma

helpers with a personal trauma history may also be more sensitive than non-survivors to the inner torment of survivor clients. Finally, the trauma helper's personal spirituality, including hope, connection and meaning, may become eroded when working with trauma survivors (Pearlman & Saakvitne, 1995). Pearlman and Saakvitne believe that this erosion of "hard won hope and optimism" contributes to increased vicarious traumatization in the trauma helper.

EFFECTS OF VICARIOUS TRAUMATIZATION

Vicarious traumatization is a result of the cumulative impact of all the trauma work engaged in by trauma helpers (Pearlman et al., 1993). Pearlman and her colleagues at the Traumatic Stress Institute believe that vicarious traumatization permeates the trauma helper's entire existence.

Vicarious traumatization is a process that resembles those experienced by trauma survivors (Neumann & Gamble, 1995). In their research, Neumann and Gamble (1995) found that many trauma helpers reported experiencing somatic symptoms of headaches, nausea, and sleeplessness, intrusive imagery, increased feelings of personal vulnerability, difficulty trusting others, emotional numbing and flooding, and sexual difficulties. They hypothesize that these symptoms represent

a trauma helper's "expectable" reaction to trauma work, vicarious traumatization.

Vicarious traumatization can be considered an occupational hazard for those who work with trauma survivors (Monroe, 1991), but may not reflect pathology in the trauma helper or intentionality on the part of the survivor client (Pearlman & MacIan, 1995).

According to Pearlman et al. (1994), a trauma helper's frame of reference is affected by vicarious traumatization. Frame of reference has two aspects- world view and identity.

World view is the beliefs about how and why things happen in the world and includes causality, justice, and predictability. Trauma helpers must listen to survivors' trauma material on a regular basis repeatedly challenging their world views as they hear in detail about exploitation, sadism, abandonment, and betrayal. Over time, trauma helpers may begin to view the world through a trauma lens, and become painfully attuned to human suffering, not only at work, but also during off-work hours (Neumann & Gamble, 1995).

Identity is the trauma helpers's inner experience of self and self in the world and refers to how we view ourselves as trauma helpers, human beings, men and women, etc. in relation

to others. Vicarious traumatization may cause disconnection from the trauma helpers' usual experience of themselves (Pearlman & Saakvitne, 1995). Trauma helpers may feel a sense of unrealness, affective numbness, and distance from others. Pearlman and Saakvitne (1995) suggest that this alienation from oneself may lead to rethinking one's basic beliefs about identity and self worth.

Vicarious traumatization may also affect our psychological needs. These are the same areas that are impacted in trauma survivors. Within a Constructivist Self Development Theory, Pearlman and her associates believe that these psychological needs motivate behaviour. These needs are manifested cognitively as schemas, or beliefs about self and others. They include safety of self and others, trust of self and others, control of self and others, esteem of self and others, and intimacy of self and others. For each trauma helper, some of these needs are more salient than others (Pearlman, 1993). Pearlman suggests that the trauma helper will experience changes in his or her beliefs about self and others in his or her most important psychological need areas.

Pearlman and Saakvitne (1995) suggest that vicarious traumatization may also affect trauma helpers' imagery sense of memory (i.e. the visual images of the event in the individual's mind). Trauma helpers may find themselves

"flashing" on graphic images that have been conveyed to them by their survivor clients. This intrusive imagery comes unbidden and is frequently very distressing (Neumann & Gamble, 1995).

"The pathognomonic sign of vicarious traumatization is the disruption to the therapist's spirituality" (Pearlman & Saakvitne, 1995; p.287). Pearlman and Saakvitne (1995) use the term spirituality to encompasses "hope, faith, joy, love, wonder, acceptance, forgiveness, gratitude, and creativity". Neumann and Pearlman (1994) understand sprituality as "an inherent human capacity for awareness of an elusive aspect of experience" (p.287). Over time, the trauma helper may begin to feel despair, isolation, loneliness, and lose their sense of hope and optimism through exposure to their clients' trauma. This "erosion of hope, connection, and meaning" may result in "spiritual damage" and lead to vicarious traumatization (Pearlman & Saakvitne, 1995).

Self capacities and ego resources are the aspects of the trauma helper's personality that may set the stage for, or contribute to vicarious traumatization (Pearlman et al., 1993). Self capacities and ego resources maintain an inner sense of positive self-esteem in the trauma helper.

Self capacities enable the trauma helper to maintain a core sense of self that is consistent and coherent across time and situation. Pearlman et al. identify self capacities as the ability to maintain a positive sense of self, manage and tolerate affect, and maintain an inner sense of connection with others. Impairments in self capacities imply difficulty in self-soothing (Pearlman & Saakvitne, 1995). When trauma helpers become vicariously traumatized, they may find it difficult to calm and comfort themselves. In their research, Pearlman and her associates have noted that some trauma helpers may turn to external sources of comfort, relief, or numbing (eg. alcohol consumption, overeating, overspending, overwork, etc.) if they become vicariously traumatized.

Pearlman and Saakvitne (1995) identify the ability to make self-protective judgments, the ability to be introspective, the ability to establish and maintain boundaries, the ability to take perspective (including empathy and sense of humour), the ability to strive for personal growth, and an awareness of one's psychological needs as the particular ego resources that are most sensitive to the effects of vicarious traumatization. They believe that trauma helpers are at risk to take on more trauma material or more trauma clients than they can handle without realizing that it would be a problem, if their ego resources are impaired. This may place trauma helpers at even greater risk for vicarious traumatization.

The TSI (Traumatic Stress Institute) Belief Scale (Revision L) provides a formal assessment of schemas. This is an 80-item, 6-point Likert-scale measure of disruptive cognitive schemas. The scale is based on Constructivist Self Development Theory and assesses disruptions in the five psychological needs areas of safety, trust, esteem, intimacy, and control that are hypothesized to be sensitive to traumatic experiences and to vicarious traumatization (Pearlman & MacIan, 1995). Within each area, the scale contains items intended to assess disruptions related to self and to other.

The TSI Belief Scale (Revision L) contains the following 10 subscales:

1. Self-safety: the need to feel one is reasonably invulnerable to harm inflicted by self or others.
2. Other-safety: the need to feel that valued others are reasonably protected from harm inflicted by oneself or others.
3. Self-trust: the belief that one can trust one's judgment.
4. Other-trust: the belief that one can rely upon others.
5. Self-esteem: the belief that one is valuable and worthy of respect.
6. Other-esteem: the belief that others are valuable and worthy of respect.

7. Self-intimacy: the belief that time spent alone is enjoyable.
8. Other-intimacy: the belief that one is close and connected to others.
9. Self-control: the need to be in charge of one's own feelings and behaviours.
10. Other-control: the need to manage interpersonal situations.

DEALING WITH VICARIOUS TRAUMATIZATION

Vicarious traumatization is unique to trauma work and is hypothesized to be cumulative (Pearlman & Saakvitne, 1995). Vicarious traumatization may result from working directly with trauma survivors or perpetrators of violence, or indirectly through exposure to graphic descriptions of violence or victimization in supervision, sessions, readings, journal articles, or professional presentations (Pearlman, 1993).

Pearlman and her associates believe that from a theoretical perspective, the effects of vicarious traumatization may be permanent, but modifiable if addressed. However, this statement could have ethical implications. Employers may "write off" employees who are identified as vicariously traumatized believing that they are permanently damaged.

Employees who believe that they are suffering the effects of vicarious traumatization may feel a sense of hopelessness and despair. Perhaps placing the focus on ameliorating the effects of vicarious traumatization might be more constructive than focusing on the damage caused by it.

From their clinical experience, Wilson and Lindy (1994) have found that trauma helpers who worked in isolation were most vulnerable to vicarious traumatization. Conversely, trauma helpers who shared their concerns and reactions with peers, who do not allow themselves to be alone with the traumatic material, and who engage in the "gallow humour" common among those in the healing profession, tend to be less vicariously traumatized (Wilson & Lindy, 1994). Wilson and Lindy also found self-care, personal therapy, and supervision to be mitigating factors.

Pearlman et al. suggest that trauma helpers make a personal committment to address their own needs. They suggest that we actively fight cynicism, question ourselves and others when we hear hopelessness, despair, or overgeneralized negative expressions. They also suggest that we avoid exposure to unnecessary further traumatic material (e.g. violent movies, articles, news, etc.) By utilizing the TSI Belief Scale (Revision L), we can identify the disruptions in our cognitive schemas and actively work to counter them.

Neumann and Gamble (1995) believe that the importance of the trauma helper's self-care can never be emphasized enough. They believe that self-care is an ethical responsibility, and that if trauma helpers do not care for themselves, they are at much greater risk for hurting their clients. To counter the invasion of vicarious traumatization into all areas of the trauma helper's life, they recommend that the trauma helper establish firm boundaries around home and work lives. Trauma helpers should develop and maintain solid, non-work related interpersonal relationships in which the trauma helper's needs for esteem, intimacy, safety, and trust can be nourished (Neumann & Gamble, 1995). If necessary, the trauma helper should be encouraged to seek personal treatment for their own traumatization.

As trauma work inevitably raises questions of good and evil, the trauma helper should become involved in activities that restore a sense of meaning, connection, and hope (Neumann & Gamble, 1995). Pearlman suggests that we connect with something outside ourself, beyond ourself, and greater than ourself.

Salston (1994) suggests that trauma helpers must continuously self-assess and evaluate their personal responses to trauma as a means to protect and lessen retraumatization in the trauma

survivor and in the trauma helper. She believes that by understanding our own responses to trauma, we can recognize countertransference, personal reactions, or inappropriate involvement with the trauma survivor.

ORGANIZATIONAL AND GENDER ISSUES

Trauma amplifies the common gender sterotypes (Herman, 1992). " Men with histories of childhood abuse are more likely to take out their aggressions on others, while women are more likely to be victimized by others or to injure themselves" (Herman, 1992; p.113).

When an organization has a traditional structure of male administrators and female front line staff, Pearlman and Saakvitne (1995) suggest that the situation is ripe for the reenactment of abuse dynamics and cultural patriarchy within the power structure of the organization. They believe that organizations have a responsibility to create a climate that supports the pursuit of learning through consultation and supervision.

Neumann & Gamble (1995) believe that organizations who train trauma helpers have an ethical responsibility to provide and environment in which:

1) the inevitable mistakes inherent in the learning process are responded to in a non-shaming manner,
2) therapists are encouraged to struggle with and tolerate the condition of "not knowing";
3) professional development is supported by providing flexible leave and funding for work-related professional conferences,
4) personal psychotherapy is encouraged,
5) there is overt recognition and valuing of trainee's hard work, and
6) attention is given to the organizational dynamics which may interfere with trainee's development (e.g., the existence of secrets within the organization; issues of exclusion and inclusion; power struggles). (p.345)

EDUCATION AND TRAINING

Neumann and Gamble (1995) suggest that when new trauma helpers are being trained to work with trauma survivors, support for the trauma helpers must include oganizational acknowledgment and validation of the impact of vicarious traumatization. When institutions fail to create an environment in which the trauma helper feels that he or she is part of a cooperative team with shared values and commitment to aid trauma survivors, the impact on the trauma helper is likely to be a negative one (Wilson & Lindy, 1995).

In a 1995 study by Bober, trauma helpers reported that their college training did not appear to be helpful in dealing with traumatic material. However, trauma specific training at the individual and team level was ranked highly.

CHAPTER III

REVIEW OF VICARIOUS TRAUMATIZATION RESEARCH

Pearlman and MacIan (1995) examined vicarious traumatization in 188 self-identified trauma therapists. The results of this study revealed that trauma therapists with a personal trauma history showed more negative effects from the work than those without a personal trauma history as measured by the TSI Belief Scale (Pearlman, 1995) and Symptom Checklist-90-Revised (Derogatis, 1977). Disruptions were significantly greater in schemas related to safety, self-trust, other-trust, self-esteem, and other-intimacy .

Pearlman and MacIan (1995) found that therapists who had been doing the work for the shortest period of time and who were not being supervised had the highest TSI Belief Scale scores. The newest therapists in the trauma history group experienced the most difficulties while the more experienced survivor therapists showed significantly less general distress.

Battley (1995), studied the effects of vicarious traumatization on 88 female Master's level social workers who had a minimum of two years of experience as psychotherapists. This study found no significant differences in how therapists viewed themselves and/or the world based on whether their

caseload included trauma victims. Higher levels of posttraumatic stress-related symptomatology were reported in therapists working with trauma victims than therapists without victim clients. Symptomatology was negatively correlated with the therapist's age, and positively correlated with weekly victim clientele caseload. Therapists with a personal history of victimization were less positive in their views of themselves and the world, and scored significantly higher on a PTSD measure.

In a 1995 study of 281 therapists throughout Ontario, Bober found that over 70% of the sample had experienced a traumatic event in their own childhood, adulthood, or both. Over one third of the sample had received therapy to assist them regarding the traumatic event. The traumatic events included sexual or physical abuse and assault as children and/or adults, work place accidents, violent crimes, and unexplained or sudden death related to accidents or illness.

Bober (1995) found significant positive correlations between the number of hours of trauma work and the total IES (Impact of Events Scale- Horowitz, Wilner, & Alvarez, 1979). Trauma hours were also significantly correlated with disruptions in cognitive schemas, particularly in the areas of safety, self-esteem, and intimacy. Therapists reported that their college training did not appear to be helpful in dealing with

traumatic material. Contact with one's professional association and with management staff within the organization was generally rated as one of the least helpful activities in coping with the impact of trauma related work. Trauma specific training at the individual and team level was ranked highly.

Follette, Polusny, and Milbeck (1994) studied secondary (or vicarious) traumatization among 215 mental health professionals and 46 law enforcement officers who were providing services to childhood sexual abuse survivors. Both mental health and law enforcement professionals reporting a history of childhood sexual or physical abuse had significantly higher levels of trauma-specific symptoms (identified by the Trauma Symptom Checklist-40; Briere & Runtz, 1989) than did those without these forms of childhood trauma.

In a multiple regression analysis, Follette, Polusny, and Milbeck (1994) found post-trauma symptoms in mental health professionals were predicted by "negative coping", level of personal stress, and negative clinical response to sexual abuse cases. Neither the individual's personal childhood abuse history nor the percentage of caseload reporting a sexual abuse history contributed significantly to the prediction of trauma symptoms.

Galloucis (1995) studied the psychological effects on 253 certified paramedics of the repeated indirect exposure to traumatic events associated with emergency medical work. The majority of the paramedics in this sample did not experience significant disruption of their schemas about themselves, others, and the world. A relatively small but clinically significant percentage of the sample did report negative changes in schemas that were similar to that obtained by patient groups.

Twenty-six percent of Galloucis' (1995) sample had significant concerns with the vulnerability of significant others and perceived the world as less meaningful. Perceived social support and personality hardiness (the ability to survive hardships) exerted mostly direct effects on many of the schemas measured by the Traumatic Stress Institute Belief Scale. Perceived social support buffered the negative effects of secondary trauma exposure on beliefs about self-safety. Hardiness buffered the negative effects of negative life event stress on beliefs regarding the ability to nurture, comfort and soothe oneself.

Gamble, Pearlman, Lucca, and Allen (1995) studied 120 licenced Connecticut psychologists to identify specific aspects of psychotherapy with trauma survivors which differ from psychotherapy with non-traumatized clients. Their sample of

psychologists reported that their trauma survivor clients tended to engage in distressing behaviours more frequently than did their nonsurvivor clients. These stressful client behaviours included flashbacks and dissociation, episodes of self-destructive behaviour (with the exception of suicide attempts), and hostile acting-out.

Therapists in Gamble et al.'s study also experienced a number of events to be significantly more distressing when they occurred in work with trauma clients versus nontrauma clients. The therapists reported significantly more stress in working with trauma clients compared with nontrauma clients, even when the frequency of distressing behaviours was held constant.

This sample of psychologists experienced their work with trauma clients as distinctly different and more distressing than their work with nontraumatized clients. Self-destructive behaviour, including suicide attempts, self-injury, psychiatric hospitalization, and client being currently in danger, were all significantly more stressful for psychologists when these occurred with trauma clients as compared to nontrauma clients. Very few of the psychologists in this sample reported a personal trauma history.

Kassam-Adams (1994) studied the risks of treating sexual trauma on 100 psychotherapists in central Virginia and central Maryland. Results of her study show that the therapist's level of PTSD symptoms (measured by the Impact of Event Scale; Horowitz, Wilner, & Alvarez, 1979) were significantly associated with both the current and the cumulative level of exposure to sexually traumatized clients. PTSD symptoms were not related to exposure to any of the other client problems.

Work environment factors were not found to be related to the level of PTSD symptoms reported by the therapists in Kassam-Adams' study. Emotional and technical support available in the workplace was inversely related to more general symptoms of work stress. Gender and personal trauma history were significant predictors of the therapists' level of PTSD symptoms. The combined effects of gender, personal trauma history, and exposure to sexually traumatized clients were significant in predicting the level of PTSD symptoms reported by the therapists.

Kassam-Adams found the effects of exposure to sexual trauma issues on therapists in this sample appeared most evident when these effects were accumulated over time and over a number of clients, and when they were measured in relation to a therapist's whole body of work rather than in a single therapy relationship.

In a 1991 study of 138 therapists in Veterans Administration facilities, Monroe found that current and cumulative exposure to combat-related trauma clients correlated significantly with intrusive symptoms. These results suggest that exposure to combat PTSD clients is related to parallel PTSD-like symptoms in therapists. Monroe suggests that these effects are distinct from burnout, but may be compounded by burnout. Age, experience, and social support did not provide any buffering effects.

Schauben and Frazier (1995) assessed vicarious traumatization, disrupted schemas, posttraumatic stress disorder (PTSD) symptoms, burnout, and coping in 118 female psychologists and 30 female rape crisis counsellors. Results showed that counsellors who had a higher percentage of sexual violence survivors as clients reported more disruptions in their basic schemas about themselves and others, more symptoms of PTSD, and more self-reported vicarious trauma. Counsellors with a history of victimization were not more distressed by seeing survivors than were counsellors without a history of victimization.

CHAPTER IV

RESEARCH METHODOLOGY

RESEARCH DESIGN

As the intent of this study is to develop generalizations that may contribute to vicarious traumatization research and identify variables which may predict, explain, or help understand vicarious traumatization, a quantitative paradigm has been chosen.

RESEARCH QUESTION

Within this quantitative paradigm, an exploratory research design was chosen to address the research question, "is there a relationship between a personal trauma history and level of vicarious traumatization?".

The research question was answered by testing the following hypotheses:

i) Null hypothesis:

There is no relationship between a personal trauma history and level of vicarious traumatization.

Ho: a personal trauma history is not related to level of VT.

ii) Research hypothesis:

I am assuming that there is a positive relationship between a personal trauma history and level of vicarious traumatization.

Hi: a personal trauma history is positively related to level of VT.

A number of minor research questions emerge from the research hypothesis. What effect, if any, do variables such as gender, age, years as a trauma helper, highest level of education attained, clinical and administrative supervision, and size and type of caseload have on vicarious traumatization levels?

PROCEDURE

The ethical guidelines as outlined by the NASW ethical code were considered in constructing and implementing this study. Approval was obtained from the University of Manitoba Ethics Committee on February 22, 1996 (for Kenora-Patricia Child and Family Services participants) and March 6, 1996 (to include the Child Development Centre participants) (Appendix I).

1. PARTICIPANTS

A questionnaire packet was distributed to 81 front-line trauma helpers employed by Kenora-Patricia Child and Family Service in Northwestern Ontario on March 14, 1996. These trauma helpers are the total number of front-line workers employed at the Kenora and Branch Offices (Sioux Lookout, Dryden, and Red Lake) of Kenora-Patricia Child and Family Services. Permission was obtained from this agency for this research.

A questionnaire packet was also distributed to 15 trauma helpers employed by the Child Development Centre in Kenora, Ontario. These trauma helpers are the total number of front-line workers employed at the Child Development Centre. Permission was obtained from this agency for this research.

2. QUESTIONNAIRE PACKET

The questionnaire packet contained a covering letter outlining the purpose of the study, and ensuring informed consent and confidentiality (Appendix II). A self-addressed, stamped envelope was provided. All packets were mailed to an independent researcher in Winnipeg, Manitoba to further ensure confidentiality. The participants were not required to identify themselves.

The participants were asked for the following demographic information: gender, age, number of years as a trauma helper, highest level of education attained, whether they felt that they receive adequate clinical and administrative supervision, size and type of caseload, and whether they are a survivor of physical, sexual or emotional abuse (i.e. have a personal trauma history) (Appendix III). In keeping with the Constructivist Self Development Theory, the participant rather than the researcher, defined what is traumatic.

The participants were then asked to complete the TSI (Traumatic Stress Institute) Belief Scale (Revision L).

3. INSTRUMENT

The TSI (Traumatic Stress Institute) Belief Scale (Revision L) is an 80-item, 6-point Likert-scale measure of disruptive cognitive schemas. The scale is based on Constructivist Self Development Theory and assesses disruptions in five psychological needs areas (i.e. safety, trust, esteem, intimacy, and control) that are hypothesized to be sensitive to traumatic experiences and to vicarious traumatization (Pearlman & MacIan, 1995). Within each area, the scale contains items intended to assess disruptions related to self and to other.

4. VALIDITY AND RELIABILITY

CRITERION BASED VALIDITY

In their 1995 study of 188 self-identified trauma therapists, Pearlman and MacIan utilized the Impact of Event Scale (IES; Horowitz, Wilner, & Alvarez, 1980) and the Symptom Checklist-90- Revised (SCL-90-R; Derogatis, 1977) with the TSI Belief Scale as their dependent measures. The TSI Belief Scale has criterion based validity with the intrusion ($r=.25$; $p<.0001$) and the avoidance ($r=.29$; $p<.0001$) subscales of the IES, and the SCL-90-R ($r=.61$; $p<.0001$).

Response style bias was determined with the Marlowe-Crowne Social Desirability Scale (Marlowe-Crowne; Crowne & Marlowe, 1964). The correlations between the Marlowe-Crowne and all dependent measures in their study were less than .2 indicating that the participants' responses were not shaped by a desire for approval of powerful others.

INTERNAL RELIABILITY (Cronbach's Alpha)

The subscales and their internal consistencies (Cronbach's alpha) are as follows:

1. Self-safety: the need to feel one is reasonably invulnerable to harm inflicted by self or others. (Cronbach's alpha = .89)
2. Other-safety: the need to feel that valued others are reasonably protected from harm inflicted by oneself or others. (Cronbach's alpha = .82)
3. Self-trust: the belief that one can trust one's judgment (Cronbach's alphas = .78 - .91)
4. Other-trust: the belief that one can rely upon others. (Cronbach's alphas = .79 - .88)
5. Self-esteem: the belief that one is valuable and worthy of respect. (Cronbach's alphas - .81 -.91)
6. Other-esteem: the belief that others are valuable and worthy of respect. (Cronbach's alpha = .80)
7. Self-intimacy: the belief that time spent alone is enjoyable. (Cronbah's alphas = .70 -.84)
8. Other-intimacy: the belief that one is close and connected to others. (Cronbach's alpha = .88)
9. Self-control: the need to be in charge of one's own feelings and behaviours. (Cronbach's alpha = .86)
10. Other-control: the need to manage interpersonal situations. (Cronbach's alpha =.77)

In the event that the questionnaire packets evoked any painful memories, the Director of Community Counselling in Kenora and a mental health therapist at the Kenora Sexual Assault Centre

were informed of the contents of this study and offered to provide confidential counselling if required. The participants were informed of the availability of the therapists in the covering letters (Appendix II).

5. DATA ANALYSIS

A significance level of .05 was used to accept or reject the null hypothesis as this study is exploratory in nature and will be used to help establish normative data.

SPSS, the Statistical Package for the Social Sciences (Norusis, 1992), was used to summarize the data, create tables and graphs, examine relationships among the variables, and perform tests of statistical significance on the hypothesis.

6. VARIABLES

In this study, the major dependent variable is the level of vicarious traumatization as measured by the TSI Belief Scale (Revision L). Independent variables include a personal trauma history, gender, age, clinical and administrative supervision, type and size of caseload, highest level of education attained, and number of years as a trauma helper.

CHAPTER V

RESEARCH FINDINGS

PARTICIPANTS

In total, 53 trauma helpers completed the TSI Belief Scale and study questionnaire. Trauma helpers from Kenora-Patricia Child and Family Services were 45 of the participants and 8 were from the Child Development Centre. This was an overall response rate of 64%. Women comprised 72% (n=38) and men 28% (n=15) of the sample.

The age category was bimodal with 13 participants in the 26-30 years and 13 participants in the 31-35 years age groups. These two categories comprised almost half (49%) of this sample. The participants had a mean of 8 years of trauma work experience (SD= 5.65).

When asked if they received adequate supervision, 87% (n=46) felt that they received adequate "administrative supervision" while 59% (n=31) felt that they received adequate "clinical supervision".

The level of education attained ranged from high school to Master's level (Table I).

TABLE 1- EDUCATION LEVEL

Highest level attained	N	%
High School	7	13.2
Community College	14	26.4
Undergraduate	28	52.8
MSW	1	1.9
Other *	3	5.7

* 1-MA in Clinical Psychology, 1 teaching certificate, 1 BA in theology.

The size of caseload ranged from 0 to 68 clients , with a mean caseload of 14 (SD=13).

Participants reported the percentage of clients on their caseloads who are survivors of abuse. Means were:
47% (SD=37) for sexual abuse survivors;
56% (SD=34) for physical abuse survivors;
62% (SD=35) for emotional abuse survivors.
It is interesting to note that approximately 20% of the trauma helpers reported that they carried a caseload in which 100% of

their clients had been sexually, physically, and emotionally abused.

Regarding their own personal trauma history, 25% (n=13) of the trauma workers self-identified as survivors of physical abuse, 19% (n=10) as survivors of sexual abuse, and almost half, 47% (n=25) as survivors of emotional abuse. When distinguished by gender, 31% (n=4) of the survivors of physical abuse were male and 69% (n=9) were female. All of the survivors of sexual abuse were female (n=10). Survivors of emotional abuse were 20% (n=5) male and 80% (n=20) female.

DEPENDENT MEASURE: TSI BELIEF SCALE (REVISION L)

Vicarious traumatization was measured by the Traumatic Stress Institute Belief Scale: Revision L (TSI). The total scores ranged from 95 to 276 with a mean score of 174.80 (SD=33.24) The mean total TSI score for males was 182.53 (SD=45.21) and 171.79 (SD=27.31) for females. These differences were not statistically significant (t=1.06; p=n.s.).

Table 2 shows the mean scores from this sample (KP-CDC in Table 2) compared with the normative data (TSI in Table 2) reported by the Traumatic Stress Institute.

TABLE 2- COMPARISON OF THE SCORES FROM TSI NORMS AND KP- CDC

	N	X	SD
KP-CDC	53	174.8	33.24
TSI	188	184	37.21

The two samples were not significantly different (t=-1.81; p=n.s.)

T-tests were conducted comparing means of the subscales from this study (KP-CDC) and the subscale means from the TSI normative data (Table 3).

TABLE 3-COMPARING TSI AND KP-CDC SUBSCALE SCORES

SUBSCALES	KP-CDC X	TSI X	t-VALUE	p-VALUE
self-safety	1.87 (SD=.45)	2.16 (SD=.81)	-1.94	n.s.
other-safety	2.25 (SD=.50)	2.16 (SD=.81)	.57	n.s.
self-trust	2.26 (SD=.61)	1.76 (SD=.68)	3.49	<.001
other-trust	2.18 (SD=.61)	1.79 (SD=.63)	3.81	<.001

self-esteem	1.84 (SD=.48)	1.37 (SD=.54)	4.66	<.001
other-esteem	2.26 (SD=.49)	2.63 (SD=.60)	-2.72	<.01
self-intimacy	2.20 (SD=.59)	1.62 (SD=.57)	4.58	<.001
other-intimacy	2.23 (SD=.68)	1.73 (SD=.82)	3.55	<.001
self-control	2.49 (SD=.70)	*	*	*
other-control	2.30 (SD=.61)	*	*	*

*Note: TSI normative data was not available for the self-control and other-control subscales.

The self-trust, other-trust, self-esteem, other-esteem, self-intimacy, and other-intimacy subscales in this sample were significantly different from the TSI normative data.

Table 4 shows the correlations for the total TSI score and its ten subscales.

TABLE 4 CORRELATIONS AMONG DEPENDENT MEASURE

	correlations ** p<.001
self safety	.76 **
other safety	.73 **
self trust	.64 **
other trust	.72 **
self esteem	.84 **
other esteem	.64 **
self intimacy	.69 **
other intimacy	.75 **
self control	.80 **
other control	.81 **

These scores reflect a strong positive correlation between the total TSI score and its 10 subscales.

RELATIONS AMONG INDEPENDENT MEASURES

Table 5 shows the significant correlations between the independent variables used in this study.

TABLE 5

SIGNIFICANT CORRELATIONS AMONG INDEPENDENT VARIABLES

	EXP	SIZE	TXHXPHY	TXHXSEX
GENDER	-.47 **			
AGE	.54 ***			
ADSUP		.53 ***		
CLSUP	.36 *		-.33 *	
TXHXEMOT			.47 ***	.32 *
CLSEX		-.48 **		
CLPHY		-.48 **		
CLEMOT		-.46 **		

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

Note: exp= number of years of experience
adsup= adequate administrative supervision (yes or no)
clsup= adequate clinical supervision (yes or no)
size= number of clients on caseload
txhxphy= personal physical trauma history
txhxsex= personal sexual trauma history
txhxemot= personal emotional trauma history
clsex= percentage of clients who are survivors of sexual abuse
clphy= percentage of clients who are survivors of physical abuse
clemot= percentage of clients who are survivors of emotional abuse

Significant correlations were found between gender and number of years of experience (r=-.47; p=<.0.5). This moderate

relationship indicates that the women in this sample had more years of experience than their male colleagues.

None of the male participants in this study were survivors of sexual abuse.

The more experienced trauma helpers tended to be older than the less experienced trauma helpers ($r=.54$; $p=<.001$). There was also a moderate relationship between perceived adequate clinical supervision and the more experienced workers ($r=.36$; $p=<.05$).

Trauma helpers who carried a larger caseload tended to perceive that the administrative supervision they received was adequate ($r=.53$; $p=<.001$).

Larger caseloads tended to be comprised of a smaller percentage of clients who were survivors of sexual abuse ($r=-.48$; $p<.01$), physical abuse ($r=-.48$; $p<.01$) and emotional abuse ($r=-.46$; $p<.01$).

A significant relationship of moderate magnitude was found between those trauma helpers with a personal physical trauma history and perceived adequacy of clinical supervision ($r=-.33$; $p<.05$). These workers were likely to feel that the clinical supervision that they recevied was not adequate.

The trauma helpers who were survivors of physical abuse were also likely to have survived a personal emotional trauma history (r=.47; p<.001). Trauma helpers who were survivors of sexual trauma also tended to be survivors of emotional trauma (r=.32; p<.05).

RELATIONSHIP BETWEEN DEPENDENT AND INDEPENDENT VARIABLES

T-tests were conducted to test the difference between perceived adequacy of administrative and clinical supervision with the total TSI score. There were no significant differences found between the total TSI score and perceived adequacy of administrative supervision (ADSUP in Table 6), and the total TSI score and perceived adequacy of clinical supervision (CLSUP in Table 6).

TABLE 6 COMPARISON OF SUPERVISION AND TOTAL TSI SCORE

	X	SD	t-VALUE
ADSUP	yes- 175.43 no - 172.60	34.12 34.89	.18 (p=n.s.)
CLSUP	yes- 168.32 no - 183.18	30.08 38.09	-1.49 (p=n.s.)

Analysis of variance was conducted to test the difference between total TSI score and the age category of the trauma

helper. There was no significant difference found ($F(6,52)=.94$; p=n.s.).

There was no significant correlation found between total TSI score and size of caseload ($r=.05$; p=n.s.)

T-tests were conducted to test the difference between a personal trauma history and total TSI score. As personal trauma history was divided into physical, sexual and emotional categories, three separate t-tests were conducted (trauma yes=1; trauma no=2). These findings are outlined in Table 7.

TABLE 7- COMPARISON BETWEEN PERSONAL TRAUMA HISTORY AND TOTAL TSI SCORES

	X	SD	t-VALUE	p-VALUE
TXHXPHY	yes-179.46 no-172.33	47.48 27.38	.67	n.s.
TXHXSEX	yes-169.50 no-175.21	28.10 34.45	-.49	n.s.
TXHXEMOT	yes-171.96 no-177.39	35.26 31.75	-.59	n.s.

Significant differences were not found between a personal physical trauma history, a personal sexual trauma history, or

a personal emotional trauma history and level of vicarious traumatization (as measured by total TSI score). These results suggest that although many of the trauma helpers were survivors of abuse, this experience has not put them more at risk for vicarious traumatization than trauma helpers who do not have a personal trauma history.

Table 8 shows the relationship of type of caseload with total TSI score.

TABLE 8-RELATIONSHIP OF TYPE OF CASELOAD WITH TOTAL TSI SCORE

	r	P
CLSEX	-.08	n.s.
CLEMOT	-.03	n.s.
CLPHY	-.04	n.s

Note: CLSEX= survivor of sexual abuse
CLEMOT= survivor of emotional abuse
CLPHY= survivor of physical abuse

There were no significant correlations found between the type of caseload and total TSI score.

As approximately 20% of the trauma helpers identified that 100% of their caseload was comprised of sexual, emotional, and physical abuse survivors, t-tests were conducted to test if

there was a difference between these trauma helpers and the remainder of the participants. Significant differences were not found for the trauma helpers carrying 100% sexual abuse survivors (t=1.51; p=n.s.), 100% physical abuse survivors (t=1.51; p=n.s.) and 100% emotional abuse survivors (t=1.51; p=n.s.).

A one way analysis of variance was conducted to test the differences between the various levels of education attained and total TSI scores. Table 9 shows the TSI score means and standard deviations for the education levels.

TABLE 9- TSI SCORE MEANS AND SD FOR EDUCATION LEVELS

	N	X	SD
HIGH SCHOOL	7	209.71	35.60
COM. COLL.	14	165.43	33.89
UNDERGRAD.	28	173.21	29.59

There was a significant difference between the total TSI scores and level of education (F (2,48)=4.85; p<.01). The Scheffe multiple comparison test was conducted to identify which of the three education levels were significantly different. There were significant differences between the high school graduates and both the community college and

undergraduate trauma helpers at the 0.05 significance level. These results indicate that the high school graduates had significantly higher levels of vicarious traumatization (as measured by total TSI score) than their colleagues who held either an undergraduate degree or community college diploma.

Crosstabs with the three personal trauma history categories (physical, sexual, and emotional) by gender were conducted to test the relationship between gender and a personal trauma history. The Phi values for a personal physical trauma history and gender (Phi=.05) and a personal emotional history and gender (Phi=-.17) were not significant at the .05 level. As previously noted, all of the participants with a personal sexual trauma history were female.

When the three trauma history groups were collapsed into one "trauma subgroup", moderate significant correlations were found between the total TSI scores and gender (r=-.45; n=24; p=<.05). These results indicate that within the trauma history group, the female trauma helpers were more likely to have a higher level of vicarious traumatization than their male colleagues.

T-tests between the total TSI scores and personal physical trauma history (t=1.10; p=n.s.), TSI score and personal sexual trauma history (t=-.18; p=n.s.), and TSI score and personal

emotional trauma history (t=-.30; p=n.s.) were not significant within this "trauma subgroup".

DISCUSSION

The level of vicarious traumatization as measured by the TSI Belief Scale (Revision L) of the trauma helpers in this study is not significantly different from the level of vicarious traumatization found in Dr. Pearlman's study of 188 trauma therapists. However, the results of this study do not support the results of studies suggesting that vicarious traumatization is more of an issue for trauma helpers who are themselves survivors of trauma (Pearlman & MacIan, 1994; Battley, 1994; & Kassam-Adams,1995).

The results of this study replicate findings from other studies which indicate that trauma helpers with a personal trauma history do not show greater levels of vicarious traumatization than those without a personal trauma history (Follette, Polusny,& Milbeck, 1994; Schauber & Frazier,1995; and Lucca & Allen, 1995).

These findings suggest that the trauma helpers in this study are functioning well psychologically despite the high percentage of trauma helpers with a personal trauma history in the sample. Other studies have found that trauma helpers who

were survivors were convinced that they were better able to understand and help survivors because of their shared experience (Danieli, 1994). Trauma helpers with a personal trauma history may have had lower levels of vicarious traumatization as they were able to find meaning in their own trauma by working with trauma survivors. Pearlman & MacIan (1995) have found that trauma helpers who enter this field to work on their own recovery, may actually accomplish this through their own work.

While the majority of the participants felt that they received adequate "administrative supervision", only 57% felt that they received adequate "clinical supervision". There was a significant positive correlation between the years of experience of the trauma helper and clinical supervision. These results suggest that the less experienced trauma workers did not perceive that they received adequate supervision.

Trauma helpers who were not being adequately clinically supervised had the highest TSI Belief Scale scores in the Pearlman & MacIan (1995) study. In this study, there was a significant correlation between the participants with a personal physical abuse trauma history and perceived adequacy of clinical supervision. These results indicate the importance of adequate supervision and the negative impact on trauma helpers who are not adequately supervised. Dutton

(1994) suggests that a supervisor's modelling recognition of the "inevitability and normalcy" of the effects of trauma work and responsible handling of them is an effective teaching tool.

The trauma helpers in this study also dealt with a high percentage of trauma survivors on their caseloads. The size of caseload was significantly negatively correlated with the percentage of clients who were survivors of sexual, physical, and emotional abuse. Although the workers with larger caseloads tended to have a smaller percentage of clients who were survivors of abuse, approximately 20% of the workers carried caseloads comprised of 100% sexual, physical, and emotional abuse survivors. These results reflect the challenging population served by approximately one fifth of trauma helpers in the study.

A significant relationship was found between the different levels of education attained and level of vicarious traumatization. Those participants who identified high school as their highest level of education attained, had the highest levels of vicarious traumatization as measured by the total TSI scores. Their scores were significantly higher than both the community college and undergraduate groups. Perhaps these individuals lacked a theoretical framework from which to

view trauma and abuse and may have internalized their client's trauma.

The community college and undergraduate participants were not significantly different from each other in their level of vicarious traumatization suggesting a common theoretical framework and training for their work as trauma helpers.

In 1986, both of the agencies participating in this study were instrumental in bringing the Honours Bachelor of Social Work Program from Lakehead University off-campus to Kenora, Ontario. These agencies provided financial support and encouraged their social workers to finish their undergraduate degrees through this program. The results of this study suggest that their support of the H.B.S.W program may have been worthwhile and perhaps decreased vulnerability to vicarious traumatization in the trauma helpers who participated in this program.

Within the "trauma subgoup", there was a significant correlation between the female participants with a personal trauma history and their level of vicarious traumatization. These results suggest the importance of exploring and acknowledging the effects of abuse on women.

CHAPTER VI

CONCLUSIONS

PERSONAL TRAUMA HISTORY AND LEVEL OF VICARIOUS TRAUMATIZATION

Trauma helpers in this study with a personal trauma history were not more vulnerable to vicarious traumatization than those participants without a personal trauma history. A personal trauma history in this sample was not a significant variable for levels of vicarious traumatization (as measured by the TSI Belief Scale- Revision L). The mean TSI Belief Scale Scores for the trauma survivor and non-survivor groups were not significantly different. Trauma workers with a personal trauma history may actually be able to empathize and assist their clients because they share a trauma history. This shared experience may help the trauma helpers to work on their own recovery and perhaps give meaning to their own survivor experience.

Other researchers have found that survivor trauma helpers may contribute to their own healing as they share in their clients' growth and change (Pearlman & MacIan, 1995). By working with trauma clients, trauma helpers with a personal trauma history continue to engage in a process of personal

development and healing which may over time decrease the effects of vicarious traumatization.

EDUCATION AND LEVEL OF VICARIOUS TRAUMATIZATION

The participants in this study who had attained high school as their highest level of education appeared to be more vulnerable to the effects of vicarious traumatization than did their colleagues with community college diplomas or undergraduate degrees. While this result is significant, we do not know exactly what aspects of education buffer vicarious traumatization.

Studies by Monroe (1991) and Pearlman and MacIan (1995) have found trauma-specific training to be a factor in ameliorating the effects of vicarious traumatization. The two agencies who participated in this study might consider increased clinical supervision and trauma-specific training to assist and support the trauma helpers in dealing with their difficult to serve caseloads.

Training could provide a solid theoretical foundation that includes an understanding of the effect of psychological trauma and addresses countertransference and vicarious traumatization. Although Bober (1995) found that trauma

helpers did not find that their college training was helpful in dealing with traumatic material, they did find trauma specific training at the individual and team level very helpful.

Continuing education and specialized training opportunities might also be considered to increase the educational level of the trauma helpers in this study. In their 1995 study, Pearlman and MacIan found that trauma therapists rated attending workshops as the best means of addressing the stresses of trauma work. Attending workshops also offers the opportunity for trauma helpers to build supportive networks with others in this field.

Workshops could provide an opportunity to discuss the importance of self-care for trauma helpers. As Neumann and Gamble (1995) noted, self-care is an ethical responsibility and if trauma helpers do not care for themselves, they are at much greater risk for hurting clients. Training in self-care could focus on establishing firm boundaries around the trauma helper's home and work lives. By providing continuing education opportunities, trauma helpers can explore and discuss the rewards and impact of working with trauma survivors.

STUDY LIMITATIONS

A qualitative component could have been added to the research by interviewing a small number of voluntary participants in this study. Participants could have discussed the positive coping skills they employ when dealing with their difficult to serve client loads. However, due to the small size of the agencies involved, confidentiality was a concern. It would have been extremely difficult to have the participants remain anonymous.

Questions regarding the frequency and quality of clinical supervision might also have been useful. However, the participants who were directly supervised by this writer may have been reluctant to discuss their perception of the adequacy of clinical and administrative supervision.

Although the level of education attained was statistically significant with vicarious traumatization levels, it is not clear just what aspects of education might lessen the effects of vicarious traumatization. Other studies (Monroe, 1991) have also found education to be a buffer, but have not been able to identify how education is effective.

RECOMMENDATIONS FOR FUTURE STUDIES

The results of this study suggest that future studies might consider further examination into the role of gender and the trauma helper's personal trauma history. There was a significant correlation found between the female participants within the "trauma subgroup" and their level of vicarious traumatization.

As survivor trauma helpers did not show more negative effects from their work than those without a personal trauma history, future studies might explore the positive coping skills employed by survivor trauma helpers which may lessen their vulnerability to vicarious traumatization.

A more indepth exploration into the relationship between education level and vicarious traumatization might also be worthwhile. Education appears to buffer vicarious traumatization, but it is unclear exactly what aspects of education are effective. Future research could focus on what kind of education (e.g. formal training, workshops, graduate work) might lessen the effects of vicarious traumatization.

SUMMARY

As trauma helpers, we are exposed to trauma material that is shameful or unbelievable in society (Herman, 1992). Although this work is extremely difficult and may result in vicarious traumatization, it is valuable. Trauma helpers speak out for those who have been harmed and offer new hope and direction in their lives. As Pearlman and Saakvitne (1995) note, "this work is demanding and important, and satisfying because it makes a difference, both to the individual clients and to society " (p.405).

It may be useful to remember why we chose to work with trauma survivors. Vicarious traumatization need not be the only consequence of empathy. Empathy can allow the trauma helper to provide a safe and supportive environment in which the trauma survivor may begin to recover, heal, and integrate their traumatic life experience.

We can combat vicarious traumatization by ensuring that we <u>have</u> a personal life. Danieli (1994) suggests that "being kind to oneself and feeling free to have fun are not a frivolity in this field but a necessity without which one cannot fulfill one's professional obligations" (p.550).

BIBLIOGRAPHY

Babbie, E. (1989). The practice of social research (Fifth Edition). Belmont: Wadsworth Publishing Company.

Battley, S.L. (1995). Vicarious traumatization: The effects on psychotherapists of working with trauma victims. In S.J. Gamble & J. Monroe (Eds.) Trauma's impact on helpers: Research Handbook. Boston: International Society of Traumatic Stress Studies.

Bloom, M., Fischer, J., & Orme, J.G. (1995). Evaluating practice: Guidelines for the accountable profession (Second Edition). Boston: Allyn and Bacon.

Bloom, S.L. (1994). The sanctuary model: Developing generic inpatient programs for the treatment of psychological trauma. In M.B. Williams & J.F. Sommer, Jr. (Eds.) Handbook of post-traumatic therapy. Westport, CT.: Greenwood Press.

Bober, T.E. (1995). Vicarious trauma and a therapeutic work environment. In S.J Gamble & J. Monroe (Eds.) Trauma's impact on helpers: Research handbook. Boston: International Society of Traumatic Stress Studies.

Creswell, J.W. (1994). Research design: Qualitative & quantitative approaches. Thousand Oaks: Sage Publications.

Cronbach, L. (1951). Coefficient alpha and the internal structure of tests. In Psychometrika- Vol. 16, No.3. Sept. 1951. pp.297-334.

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

Dutton, M.A. (1994). Post-traumatic therapy with domestic violence survivors. In M.B. Williams & J.F. Sommer, Jr.(Eds.) Handbook of post-traumatic therapy. Westport, CT.: Greenwood Press.

Everstine, D.S. & Everstine, L. (1993). The trauma response:treatment for Emotional Injury. New York: W.W. Norton & Company.

Follette, V.M., Polusny, M, & Milbeck, K. (1994). Mental health and law enforcement professionals: Trauma history, psychological symptoms, and impact of providing services to child sexual abuse survivors. In S.J. Gamble & J. Monroe (Eds.) Trauma's impact on helpers: Research handbook.

Boston: International Society of Traumatic Stress Studies.

Galloucis, M. (1995). The psychological impact of repeated indirect exposure to trauma: An investigation of the role of perceived social support and hardiness as moderators of disruption in cognitive schemas among a sample paramedics. In S.J. Gamble & J. Monroe (Eds.) Trauma's impact on helpers: Research handbook. Boston: International Society of Traumatic Stress Studies.

Gamble, S.J., Pearlman, L.A., Lucca, A.M., & Allen, G.J. (1995). Differential therapist stressors in psychotherapy with trauma vs. non-trauma clients. In S.J. Gamble & J. Monroe (Eds.) Trauma's impact on helpers: Research handbook. Boston: International Society of Traumatic Stress Studies.

Golan, N. (1978). Treatment in crisis situations. New York: The Free Press.

Grinnell, R.M. & Stothers, M.(1988). Utilizing Research Designs. In R.M. Grinnell, Jr. (Ed.). Social work research and evaluation (3rd. ed., pp. 197-232). Itasca, Il.: Peacock.

Grinnell, R.M., Jr. & Williams, M.(1990). Research in social work: A primer. Itasca, Il.: Peacock.

Herman, J.L. (1992). Trauma and recovery: The aftermath of violence- from domestic abuse to political terror. New York: Basic Books.

Isaac, S. & Michael, W.B. (1984). Handbook in research and evaluation (Second Edition). San Diego: Edit Publishers.

James, B. (1994). Long-term treatment for children with severe trauma history. In M.B. Williams & J.F.Sommer, Jr. (Eds.) Handbook of post-traumatic therapy. Westport, CT.: Greenwood Press.

Kassam-Adams, N. (1994). The risks of treating sexual trauma. In S.J. Gamble & J. Monroe (Eds.) Trauma's impact on helpers: Research handbook. Boston: International Society of Traumatic Stress Studies.

Levin, J. & Fox, J.L. (1994). Elementary statistics in social research (Sixth Edition). New York: Harper Collins.

Locke, L.F., Spirduso, W.W., & Silverman, S.J. (1993). Proposals that work: A guide for planning dissertations and grant proposals. (Third Edition). Newbury Park: Sage Publications.

Mac Ian, P.S., & Pearlman, L.S. (1992). Development and use of the TSI Life Event Questionnaire. Treating abuse today: The international newsjournal of abuse, survivorship and Therapy, 2 (1) pp.9-11.

McCann, I.L., & Pearlman, L.A. (1992). Constructivist self development theory: A theoretical model of psychological adaptation to severe trauma. In K.K.Sakheim & 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. (1990). Vicarious traumatization: A framework for understanding the psychological effects of working with victims. Journal of traumatic stress 3 (1) pp.131-149.

McCann, I.L. & Pearlman, L.A. (1993). Vicarious traumatization: The emotional costs of working with survivors. Treating Abuse Today, 3 (5) pp.28-31.

McCann, I.L., & Pearlman, L.A. (1990). Vicarious traumatization: A framework for understanding the psychological effects of working with victims. Journal of Traumatic Stress 3 (1), pp.131-149.

McCann, I.L. & Pearlman, L.A. (1993). Vicarious traumatization: The emotional costs of working with survivors. Treating abuse today, 3 (5) pp.28-31.

McCann, I.L., Pearlman, L.A., Sakheim, D., & Abrahamson, D.J. (1988). Assessment and treatment of the adult survivor of childhood sexual abuse within a schema framework. In S.M. Sgroi (Ed.), Vulnerable populations: Evaluation and treatment of sexually abused children and adult survivors (vol.1), pp. 77-101.

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

Monroe, J. (1991). Therapist Traumatization from exposure to clients with combat related post traumatic stress disorder: Implications for administration and supervision. In S.J. Gamble & J. Monroe (Eds.) Trauma's impact on helpers: Research handbook. Boston: International Society of Traumatic Stress Studies.

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 (2), pp. 341-347.

Norusis, M.J. (1992). SPSS/PC+ base system user's guide, version 5.0. Chicago: SPSS.

Ochberg, F.M. (1998). Post-traumatic therapy and victims of violence. New York: Brunner/Mazel Publishers.

Pearlman, L.A., & MacIan, P.S. (1995). Vicarious traumatization: An empirical study of the effects of trauma work on trauma therapists. In S.J. Gamble & J.Munroe (Eds.), Trauma's impact on helpers: Research handbook. Boston: The International Society of Traumatic Stress Studies.

Pearlman, L.A. & McCann, I.L. (1994). Integrating structured and unstructured approaches to taking a trauma history. In M.B. Williams & J.F. Sommer, Jr. (Eds.) Handbook of post-traumatic therapy. Westport, CT.: Greenwood Press.

Pearlman, L.A. & Saakvitne, K.W. (1995). Trauma and the therapist:countertransference and vicarious traumatization in psychotherapy with incest survivors. New York: W.W. Norton.

Pearlman, L.A. & Saakvitne, K.W. (in press). Treating traumatized therapists. in C.R.Figley (Ed.) Secondary traumatic stress disorder: Trauma and its wake. New York: Brunner/Mazel.

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

Publication manual of the American psychological association-Fourth Edition (1994). Washington: American Psychological Association.

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

Saakvitne, K.W. (in press). Therapist responses to dissociative clients: Countertransference and vicarious traumatization. In L. Cohen, M. Elin J. Bercoff, (Eds.) Multiple personality disorder: Critical issues and controversies. New York: Jason Aronson.

Salston, M.D. (1994). Clinical treatment of survivors of homocide victims. In M.B. Williams & J.F. Sommer, Jr. (Eds). Handbook of post-traumatic therapy. Westport, CT.: Greenwood Press.

Schauben, L.J. & Frazier, P.S. (1995). Vicarious trauma: The effects on female counselors of working with sexual violence survivors. In Psychology of women quarterly, 1995, Vol.19, pp.49-64.

Sellitz, C., Wrightsman, L.S., & Cook, S.W,.(1976). Research methods in social relations. (3rd. Ed.). New York: Holt, Rinehart and Winston.

Triopodi, T. (1983). Evaluative research for social workers. Englewood Cliffs, N.J.: Prentice-Hall, Inc.

Wilson, J.P. (1994). The need for an integrative theory of post-traumatic stress disorder. In M.B. Williams & J.F. Sommer(Eds.) Handbook of post-traumatic therapy. Westport, CT.: Greenwood Press.

Wilson, J.P. & Lindy, J.D. (1994). Countertransference in the treatment of PTSD. New York: The Guildford Press.

APPENDIX I

ETHIC APPROVAL CERTIFICATE

Faculty of Social Work
University of Manitoba
Winnipeg, Manitoba.

Research Ethics Committee

To: C. Green.

February 22, 1996.

YOUR PROJECT ENTITLED *A STUDY OF THE RELATIONSHIP BETWEEN PERSONAL TRAUMATIC HISTORY AND VICARIOUS TRAUMATIZATION* HAS BEEN APPROVED BY THE RESEARCH ETHICS COMMITTEE ON FEBRUARY 21, 1996.

CONDITIONS ATTACHED TO THE CERTIFICATE:

1. You may be asked at intervals for a progress report. Any significant changes of the protocol should be reported to the Chairperson of this Committee so that they can be reviewed prior to their implementation.

Yours truly,

Grant Reid
Chair
Research Ethics Committee.

( ) ( ).

RESEARCH ETHICS COMMITTEE APPROVAL CERTIFICATE

Faculty of Social Work
University of Manitoba
Winnipeg, Manitoba.

To: C. Green. March 6, 1996.

YOUR PROJECT ENTITLED *A Study of the Relationship Between A Personal Trauma History & Vicarious Traumatization* HAS BEEN APPROVED BY THE RESEARCH ETHICS COMMITTEE ON March 6, 1996.

CONDITIONS ATTACHED TO THE CERTIFICATE:

1. You may be asked at intervals for a progress report. Any significant changes of the protocol should be reported to the Chairperson of this Committee so that they can be reviewed prior to their implementation.

Yours truly,

Grant Reid
Chair
Research Ethics Committee.
( ) ( )

APPENDIX II

Cheryl Green

Dear Colleague:

As a component of my thesis for the M.S.W. Program at the University of Manitoba, I am conducting a study of the relationship between vicarious traumatization and a personal trauma history. I have received permission from Kenora-Patricia Child and Family Services to conduct this study on front-line workers at this agency.

Vicarious traumatization is defined as "a transformation in the helper's inner experience, resulting from empathic exposure to clients' trauma material" (McCann & Pearlman, 1990). From a constructivist perspective, the respondent, rather than the researcher, defines what is traumatic.

Your participation in this study is strictly voluntary. Your decision as to whether or not participate will not prejudice your relations with Kenora-Patricia Child and Family Services. You will not be required to identify yourself in this study. Data compiled from your responses will be soley used for my thesis. The return of the questionnaire will constitute informed consent.

In order to ensure confidentiality, all responses can be mailed in the self-addressed, stamped envelope provided. Linda Campbell, a research consultant in Manitoba, has agreed to code the questionnaires and forward them to me. This will ensure that I am not able to identify responses from the Branch Offices.

In the event that this questionnaire evokes any painful memories, the following therapists have reviewed the contents of this study and have offered to provide confidential counselling if required:
Garry Norris, M.S.W., Director of Community Counselling Services, 807-468-6099.
Jan Aylward, M.S., Abuse Counsellor, Kenora Sexual Assault Centre, 807-468-7958.

If you have any additional questions, please contact me at . I am taking an educational leave from February 5 to April 1, 1996.

If you decide to participate in this study, please return this as soon as possible. Thank you very much.

Sincerely,

Cheryl Green

Cheryl Green

Dear Colleague:

As a component of my thesis for the M.S.W. Program at the University of Manitoba, I am conducting a study of the relationship between vicarious traumatization and a personal trauma history. I have received permission from the Child Development Centre to conduct this study on front-line workers at this agency.

Vicarious traumatization is defined as "a transformation in the helper's inner experience, resulting from empathic exposure to clients' trauma material" (McCann & Pearlman, 1990). From a constructivist perspective, the respondent, rather than the researcher, defines what is traumatic.

Your participation in this study is strictly voluntary. Your decision as to whether or not participate will not prejudice your relations with your agency. You will not be required to identify yourself in this study. Data compiled from your responses will be soley used for my thesis. The return of the questionnaire will constitute informed consent.

In order to ensure confidentiality, all responses can be mailed in the self-addressed, stamped envelope provided. Linda Campbell, a research consultant in Manitoba, has agreed to code the questionnaires and forward them to me.

In the event that this questionnaire evokes any painful memories, the following therapists have reviewed the contents of this study and have offered to provide confidential counselling if required:
Garry Norris, M.S.W., Director of Community Counselling Services, 807-468-6099.
Jan Aylward, M.S., Abuse Counsellor, Kenora Sexual Assault Centre, 807-468-7958.

If you have any additional questions, please contact me at . When this study is completed, you will be invited to attend a presentation of the results at Cameron Bay Children's Centre.

If you decide to participate in this study, please return this as soon as possible. Thank you very much.

Sincerely,

Cheryl Green

APPENDIX III

DEMOGRAPHICS

1. Male_____
   Female_____

2. Age (in years):

under 20_____	36-40_____
21-25_____	41-45_____
26-30_____	46-50_____
31-35_____	over 50_____

3. For the purpose of this study, all front-line workers will be referred to as "trauma helpers". How many years have you worked as a trauma helper or as a social worker dealing with difficult to serve children?

_____years

4. Highest level of education attained:

high school _____
community college_____
BA or BSW _____
MSW _____

other (please specify)_____

5. Do you feel that you receive adequate supervision?

administrative supervision yes_____
no_____
clinical supervision yes_____
no_____

6. What is the approximate size of your current caseload?

_____clients

7. As a rough estimate, what percentage of your clients are:

survivors of sexual abuse _____%
survivors of physical abuse _____%
survivors of emotional abuse_____%

8. Personal trauma history: If you respond "yes" to any of the following questions, please circle a number from the scale below which you feel most closely matches your beliefs about the severity of your abuse.

1	2	3	4	5	6
very mild	mild	moderate	severe	very severe	extremely severe

Are you a survivor of physical abuse? yes- 1 2 3 4 5 6

no___

Are you a survivor of sexual abuse? yes- 1 2 3 4 5 6

no____

Are you a survivor of emotional abuse? yes- 1 2 3 4 5 6

no____

*PLEASE COMPLETE THE TSI BELIEF SCALE ON THE FOLLOWING PAGES.