Vicarious Trauma Among Therapists Working with Sexual Violence, Cancer, and General Practice

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ABSTRACT

Vicarious trauma, traumatic stress, and burnout were investigated among three separate groups of mental health professionals working primarily with three different client populations (sexual violence, cancer, and general practice). Participants (N = 221) completed the Traumatic Stress Institute Belief Scale Revision M (TSI), the Maslach Burnout Inventory (MBI), and the Impact of Events Scale (IES). Contrary to hypotheses, no significant differences were found between groups. The TSI and MBI were found to be highly correlated, suggesting psychometric overlap. It was concluded within this sample there was little evidence to support vicarious trauma as an occupational hazard unique to therapists working with trauma survivors.

RÉSUMÉ

Le traumatisme indirect, le stress traumatique et l'épuisement professionnel ont été étudiés chez trois groupes distincts de professionnels de la santé mentale travaillant principalement auprès de trois clientèles différentes (violence sexuelle, cancer, pratique générale). Les participants (N = 221) ont rempli le Traumatic Stress Institute Belief Scale Revision M (TSI), le Maslach Burnout Inventory (MBI), et l'Impact of Events Scale (IES). Contrairement aux hypothèses, aucune différence significative n'a été trouvée entre les groupes. Le TSI et le MBI se sont avérés hautement corrélés, suggérant un chevauchement psychométrique. On a conclu à partir de cet eechantillon qu'il y avait peu de preuves pour soutenir que le traumatisme indirect constituait un risque professionnel unique aux psychothérapeutes travaillant auprès de personnes victimes de traumatisme.

Providing psychological services can be rewarding and yet enormously challenging for helping professionals (Farber & Heifetz, 1981, 1982; Maslach, 1982; Savicki & Cooley, 1987). Professionals working with trauma survivors, however, have been identified as being particularly at risk for being negatively affected by their work (Figley, 1995; Haley, 1974; Herman, 1992; Kassam-Adams, 1995; McCann & Pearlman, 1990; Neumann & Gamble,1995; Schauben & Frazier, 1995). Common consensus on a descriptor that accurately conveys the uniqueness and range of responses to providing trauma therapy, in addition to an explanation that accounts for how and why these professionals may be affected by their work, has not yet been reached. Counter-transference (McCann & Pearlman; Wilson & Lindy, 1994), burnout (Freudenberger, 1974; Maslach), and compassion fatigue (Figley; Joinson, 1992) all offer ways to understand how professionals respond to providing counselling. The phenomenon of vicarious

trauma is related to each of these constructs, yet is thought to be distinct (McCann & Pearlman).

The term *vicarious trauma* describes profound and permanent changes in how therapists think, feel, and behave in relation to others and themselves as a result of their exposure to and empathic bonding with their clients' traumatic material (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995). Three conditions specific to clinical work with trauma survivors have been thought to facilitate this empathic bonding and produce the experience of vicarious trauma. These include: (a) empathic engagement and exposure of the therapist to graphic and traumatic material, (b) empathic engagement and exposure of the therapist to the reality of human cruelty, and (c) the therapists' participation in traumatic re-enactments where client responses re-enact elements of their trauma within the therapy process (McCann & Pearlman; Pearlman & Saakvitne). Vicarious trauma is thought to produce changes in the therapist's experience of spirituality, worldview, and self-identity as well as disruptions in cognitive schemas associated with trust, intimacy, safety, power, and control (McCann & Pearlman; Pearlman & Saakvitne). Intrusive and avoidant subclinical symptoms of posttraumatic stress disorder (PTSD) also hallmark the experience of vicarious trauma among professionals involved in trauma work (McCann & Pearlman; Pearlman & Saakvitne).

The concept of vicarious trauma clearly appears to resonate with professionals in the field of traumatology. Increasingly, it is being generalized to apply to groups of professionals working outside the context of trauma therapy (Clark & Gioro, 1998; Goldenberg, 2002; Lowe, 2002; Pearlman & Saakvitne, 1995; Robinson, Clements, & Land, 2003; Wasco & Campbell, 2002). Although the intuitive appeal of the construct has prompted several attempts to assess and understand the experience of vicarious trauma, research in this area to date has been hindered by the lack of baseline data, disparate results, and methodological limitations (Kadambi & Ennis, in press; Sabin-Farrell & Turpin, 2003).

Studies investigating vicarious trauma among professionals have focused almost exclusively on professionals working with populations who have experienced a traumatic stressor associated with interpersonal violence (Brady, Guy, Poelstra, & Fletcher Brokaw, 1999; Genest, Levine, Ramsden, & Swanson, 1990; Kassam-Adams, 1995; McCann & Pearlman, 1990; Munroe, 1991; Pearlman & MacIan, 1995; Pearlman & Saakvitne, 1995; Schauben & Frazier 1995). It remains unclear whether the construct applies to professionals working with traumatic stressors unrelated to interpersonal violence, in situations unlikely to result in the three therapeutic conditions theorized to produce vicarious trauma. Moreover, it has yet to be conclusively demonstrated that trauma therapists exhibit significantly greater levels of vicarious trauma and traumatic stress than appropriately comparable counterparts working primarily outside the area of trauma.

The Traumatic Stress Institute Belief Scale (TSI) Revision M (Pearlman, 1996) was developed to assess cognitive disruptions in psychological need areas indicative of vicarious traumatization. Although the measure represents an important step

in operationalizing the phenomenon, the construct and divergent validity of the TSI are questionable (Betts Adams, Matto, & Harrington, 2001; Kadambi & Ennis, in press). Normative data for mental health professionals on the TSI reported by Pearlman were collected from professionals attending trauma-training workshops. It is unclear how the impacts of trauma histories (whether personal or professional) and trauma exposure were controlled, resulting in the possibility of inflated TSI scores for this group. As the measure has not been administered to professionals working across a variety of practice settings, the measure appears to have no solid normative data to which subsequent scores can be compared. Moreover, the TSI has not clearly or consistently differentiated vicarious trauma (Betts et al.; Kadambi & Truscott, 2003) from the symptoms of emotional exhaustion, depersonalization, and reduced personal accomplishment that define burnout (Maslach, 1982).

Rationale for Study

The purpose of this investigation was to investigate vicarious trauma and traumatic stress symptoms among professional groups working with client populations that, based on the presence or absence of the three aforementioned necessary conditions within trauma therapy, theoretically posed different levels of risk in producing vicarious trauma. Three groups of participants providing counselling services to different populations were surveyed to assess their levels of vicarious trauma, traumatic stress, and burnout. Two of these participant groups worked primarily with client populations that had experienced traumatic stressors (sexual violence, cancer diagnoses) thought to produce vicarious trauma. A third group of professionals providing counselling to a range of clients and issues were included as a comparison group.

It was hypothesized that if vicarious trauma was indeed present, significant differences would be found between groups on measures of trauma-related distress when confounding variables were controlled (e.g., personal trauma history). Specifically, it was predicted that, due to the presence of vicarious trauma, participants working with trauma clients would exhibit significantly higher levels of traumatic stress compared to participants working with a variety of client issues. These differences were also predicted to hold true if the effects of burnout were held constant across groups via covariate analyses. Consequently, the distinctiveness of the constructs and the divergent validity of the TSI Belief Scale would also be assessed.

METHOD

Participants

Three groups of mental health professionals providing counselling to different client populations (sexual violence, cancer, and general practice) were mailed survey packages and asked to participate in this study. Due to the sensitive nature

of the questions on survey measures and to ensure confidentiality, participants completed and returned the survey anonymously. Two of these participant groups worked primarily with client populations who experienced a "traumatic stressor." A traumatic stressor was defined as a situation in which the person "experienced, witnessed or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others" (DSM-IV; American Psychiatric Association, 1994, p. 427). A final participant group of professionals, who provided services primarily to a range of clients/issues and who were not working primarily with clients who experienced traumatic stressors, served as a comparison group. Across groups, participants were screened out of the final sample if they did not provide direct counselling services or if they indicated that they worked with two or more of the primary client populations either currently or in the past year. Surveys with incomplete data were also excluded from the study.

Group 1: Sexual violence. Participants within Group 1 consisted of professionals providing counselling primarily to individuals who experienced the trauma of sexual violence. This professional group has been consistently identified by previous researchers as exhibiting signs of vicarious trauma, and meet the three hypothesized criteria for the therapeutic conditions within which vicarious trauma can occur (Herman, 1992; Munroe, 1991; Neumann & Gamble, 1995; Pearlman & MacIan, 1995; Pearlman & Saakvitne, 1995; Schauben & Frazier, 1995). A total of 260 professionals providing counselling within 44 Canadian sexual assault centres were surveyed. One hundred and two surveys were completed and returned, for a response rate of 39%. Sixteen surveys that were returned by this group were excluded on the basis of screening criteria and/or incomplete data. The final sample size for this group was 86 participants.

Group 2: Psycho-oncology. Participants composing Group 2 were professionals providing counselling primarily to individuals affected by cancer. This professional group was selected because, although their primary client population had experienced a traumatic stressor, they were unlikely to encounter the therapeutic conditions proposed to produce vicarious trauma (e.g., exposure to stories of intentional human cruelty) in the context of providing therapy.

A total of 183 professionals providing counselling to cancer patients and their families were surveyed. Participants were identified through their affiliation with Canadian hospitals and cancer centres across eight provinces that offered distinct support services to cancer patients. Sixty-seven surveys were returned, resulting in a response rate of 37%. Eight surveys were excluded on the basis of screening criteria and/or missing data. For planned analyses, a minimum of 60 participants were required for each group. Excluded surveys resulted in a shortage of participants in this group. As the number of identified professionals engaging in this work in Canada was small and all who were identified were surveyed, five additional surveys were obtained from professionals at two cancer facilities with psychosocial support departments in the United States. Ultimately, the final sample size for this group was 64 participants.

Group 3: General practice. Participants in Group 3 were chosen to represent a comparison group of professionals providing counselling to clients with a wide range of issues, reflective of "typical" mental health professionals working outside the area of trauma. Researchers have reported that university counselling centres see and treat a wide range of client problems (Benton, Robertson, Tseng, Newton, & Benton, 2003; Heppner et al., 1994; Pledge, Lapan, Heppner, Kivlighan, & Roehlke, 1998). A total of 182 participants from 23 Canadian university counselling centres within 8 provinces were surveyed. Eighty-two surveys were returned, resulting in a response rate of 45%. After excluding participants that did not meet screening criteria and/or surveys with missing survey data, 71 surveys were included in the study.

Final sample. Overall, 625 participants were surveyed across three groups. Completed surveys totaled 251, resulting in a response rate of 40%. Thirty surveys did not meet screening criteria and were excluded from the sample.

A final sample size of 221 participants was reached with 86 participants in Group 1, 64 in Group 2, and 71 in Group 3. This resulted in an overall response rate of 35%. The majority of participants (68.2%) reported spending between 75% and 100% of their clinical time with their primary client population. The remaining participants reported spending between 50% and 75% of their clinical time with their identified primary population. Groups were similar to the participant groups from which they were sampled in terms of gender and education level. The majority of participants held a graduate degree, although the proportion of participants with and without an advanced degree varied between groups. Within Group 1, 52.3% of participants possessed graduate-level training in comparison to 65.6% in Group 2 and 83.1% in Group 3.

Measures

The Participant Questionnaire is a 23-item questionnaire developed by the researchers to collect demographic information and to assess aspects of work specific to primary client populations. The Participant Questionnaire collected information similar to that collected by other researchers investigating vicarious trauma (Brady et al., 1999; Pearlman & MacIan, 1995; Schauben & Frazier, 1995). These variables included: age, gender, length of time in the field and in trauma work, supervision, level of exposure to traumatic material, and personal trauma history. Supplemental information regarding participants' work and work setting was gathered to determine predictive or mitigating influences on dependent measures.

The TSI Revision M (Pearlman, 1996) is a 77-item questionnaire that measures cognitive disruptions in five psychological need areas (relative to self and others) hypothesized to be sensitive to trauma (safety, trust, intimacy, esteem, and power), producing 10 subscale scores. The overall reported reliability (Cronbach's alpha) of the TSI is .98 (Pearlman). Subscale reliabilities range from .77 (Other Safety, Self Control) to .91 (Self-Esteem) (Pearlman). The TSI also yields a total score, with higher scores representing greater levels of cognitive disturbance. The TSI

was used to determine the overall level of cognitive disruption suggestive of vicarious traumatization for participants in each of the three groups.

The Impact of Event Scale (IES; Horowitz, Wilner, & Alvarez, 1980) is a 15-item self report measure that has been used to assess reactions to stressful events with diverse populations. Containing two subscales—Intrusion and Avoidance—the IES assesses the central features of PTSD. Reliability data indicate good internal consistency, with coefficients of .86 for the Intrusion subscale and .90 for the Avoidance subscale (Fischer & Corcoran, 1994). Participants in this study were directed to indicate how frequently (on a four-point scale) each of the 15 statements was true for them concerning their work with their primary client population. The IES was used to identify trauma-related distress among participants.

The Maslach Burnout Inventory-Human Services Survey (MBI; Maslach, Jackson, & Leiter, 1996) is a 22-item questionnaire designed to assess the three central aspects of burnout: emotional exhaustion, depersonalization, and decreased sense of personal accomplishment. The MBI has been used extensively with mental health professionals with reported reliability coefficients (Cronbach's alpha) of .90 for the Emotional Exhaustion subscale, .79 for Depersonalization, and .71 for Personal Accomplishment (Maslach et al.). The measure produces three scores for each of the three aspects of burnout that are not combined, but can be categorized into high, moderate, or low levels, relative to normative sample data (Maslach et al.). High scores on Emotional Exhaustion and Depersonalization in conjunction with a low score on the Personal Accomplishment (subscale is reverse scored) are thought to represent a hallmark pattern of professional burnout (Maslach et al.).

RESULTS

Participant Demographics

The final sample consisted of 186 women and 35 men. The mean age of participants was 42 years, ranging from 21 to 63 years of age. Participants spent an average of 11.49 years (SD = 7.90) engaged in the practice of counselling, ranging from 1 to 38 years in the field. The amount of time participants had been working with their primary population ranged from 1 to 31 years, averaging 8.26 years (SD=6.72). A large proportion of participants, 58.2%, indicated that they had personally experienced a traumatic stressor as defined by the DSM-IV (American Psychiatric Association, 1994). Although this percentage may seem high, research conducted with similar participant populations have found similar proportions (60%) of participants with a personal trauma history (Pearlman & MacIan, 1995). Demographic information for participants across groups is presented in Table 1.

Performance on Dependent Measures

To examine how participants in this sample compared to those in previous research and normative data on various measures, descriptive statistics for each

dependent variable were calculated. Mean and subscale scores for the three groups on each dependent measure are presented in Table 2. Participants' mean scores and standard deviations were comparable to previous researchers' findings for groups of mental health professionals for the TSI (Pearlman, 1996), MBI (Maslach et al., 1996), and reported normative data for the IES (Fischer & Corcoran, 1994).

Table 1
*Demographic Information for Participants (*N = *221)*

Gender	
Male	15.8%
Female	84.2%
Highest degree obtained	
Diploma/certificate	6.8%
Bachelors degree	24.9%
Graduate degree	68.3.%
Professional designation	
Therapist/counsellor	35.0%
Social worker	41.5%
Nurse	2.8%
Psychologist	12.4%
Psychiatrist	1.8%
Pastoral counsellor	1.4%
Other	5.1%
Average time in field	11.49 yrs
Average time primary population	8.26 yrs
Received specialized training	
Yes	89.6%
No	10.4%
Training adequate to work with primary population	
Not applicable	10.0%
Not at all	0%
Minimally	4.5%
Moderately	57.5%
Profoundly	28.1%
Training adequate to prepare for personal impact of the work	
Not applicable	10.0%
Not at all	1.8%
Minimally	27.1%
Moderately	46.6%
Profoundly	19.5%
Exposure to traumatic material	
None at all	2.3%
Minimal amounts	28.1%
Moderate amounts	45.2%
Profound amounts	24.4%
Exposure to human cruelty	
None at all	9.5%
Minimal amounts	37.6%
Moderate amounts	29.4%
Profound amounts	23.5%
Currently supervised	
Yes	51.8%
No	48.2%
Addressed impact in personal therapy	
Yes	52.5%
No	47.5%
Venue to address impact of work	
Yes	89.5%
No	10.5%
Experienced a traumatic stressor	
Yes	58.2%
No	41.8%
Traumatic stressor type	
Not applicable	42.0%
Sexual violence	13.2%
Domestic violence	4.1%
War veteran	0%
Other	20.1%
Combination of above	20.5%
Work considered traumatizing	
Yes	58.9%
No	41.1%

Scores above 26 on the IES are considered to be indicative of moderate to severe levels of traumatic stress (Horowitz et al., 1980). Of the entire sample, 20.8% scored at or above this score. On the MBI, participants' mean scores in this sample fell within the moderate range for Emotional Exhaustion and the low range for both Depersonalization and Personal Accomplishment. High scores on both the Emotional Exhaustion and Depersonalization scales are considered to be the hallmarks of professional burnout (Maslach et al., 1996). Only 2.3% of the entire sample obtained high scores on both of these subscales.

Reliability and Validity of the TSI

Reliability was calculated for the TSI. Internal consistency was found to be high, at .92. To investigate the divergent and convergent validity of the TSI Revision M, correlational analyses were conducted. It was predicted that the TSI Revision M would have high positive correlations with the IES total score and the two subscales, as both measures purport to assess aspects of traumatic stress responses. As the TSI has been designed to assess aspects of vicarious trauma, correlations with the three subscales of the MBI were hypothesized to be positive,

Table 2
Mean Scores and Standard Deviations for Participants on Dependent Measures

	Group One Sexual Violence	Group Two Psycho-oncology	Group Three General Practice	Total Sample (N = 221)
Traumatic Stress Institute Belief Scale	146.65 (27.24)	138.10 (25.96)	140.71 (28.28)	141.27 (26.27)
Impact of Events Scale total	16.47 (14.44)	16.07 (11.12)	13.14 (12.91)	15.22 (13.08)
Intrusion	8.29 (7.10)	8.10 (6.10)	6.54 (6.17)	7.65 (6.54)
Avoidance	8.28 (8.21)	7.82 (6.51)	6.61 (7.39)	7.59 (7.48)
Emotional exhaustion	21.41 (13.61)	18.94 (9.46)	18.54 (8.36)	19.27 (9.48)
Depersonalization	4.96 (3.88)	3.19 (4.02)	4.42 (4.07)	4.27 (4.03)
Personal accomplishment	40.90 (4.38)	41.71 (4.47)	41.79 (4.20)	41.38 (4.30)

but weaker than the correlations with the IES. Contrary to expectations, the TSI Revision M showed stronger correlations with each of the three subscales of the MBI in comparison to the IES total and subscale scores. The strongest correlation was a positive relationship between the TSI total score and the Emotional Exhaustion subscale, followed by the Depersonalization subscale and a negative correlation with the Personal Accomplishment subscale. Correlational analyses are presented in Table 3.

Table 3
Pearson Product – Moment Intercorrelations Among Dependent Variables for Participants with High TSI Scores

Variable	1	2	3	4	5	6	7
1. TSI total	1	.189**	.182**	.159*	.386**	.351**	-.322
2. IES total		1	.923**	.944**	.425**	.194**	-.035
3. Intrusion			1	.744**	.409**	.172*	-.42
4. Avoidance				1	.372**	.183**	-.037
5. Emotional exhaustion					1	.509**	-.183**
6. Depersonalization						1	-.178**
7. Personal accomplishment							1

*$p < .05$ **$p < .01$ $N = 221$

Examining Differences Between Groups

A Multiple Analysis of Covariance (MANCOVA) was used to test the hypothesis that there would be significant differences between groups on the TSI and IES. Unexpectedly, correlational analyses revealed that personal trauma history was not significantly related to scores on dependent measures and was therefore not included as a covariate. Groups differed significantly on three demographic variables: gender composition ($\chi^2 = 12.926$, $df = 2$, $p > .05$), education level ($\chi^2 = 30.144$, $df = 4$, $p > .05$), and length of time in the field ($F(2, 218) = 8.924$, $p > .05$). Only one variable, length of time in the field, was related to scores on dependent measures and was therefore included as a covariate in the analyses.

It was predicted that due to the presence of vicarious trauma, Group 1 (sexual violence) would exhibit significantly higher scores on the TSI and IES than Group 3 (general practice). If vicarious trauma was present within Group 2 (psycho-oncology), that group would similarly exhibit higher scores on the TSI and IES than Group 3. Differences between groups on the remaining dependent measures and the MBI were also explored to determine if the effect of burnout needed to be controlled between groups and to generate ideas for future research. An alpha level of .05 was used for all analyses. Groups were not found to differ significantly on any of the dependent measures ($F(12, 384) = .681$, $p > .05$).

Exploring the Impact of Trauma History

As the research investigating the importance of therapists' personal trauma history in traumatic stress responses resulting from clinical work has been so inconsistent, the differential impact of trauma history was explored. Differences on dependent measures between participants who indicated they had experienced a traumatic stressor (n = 124) and those who did not have a personal trauma history (n = 89) were investigated using a 2 × 6 (trauma history by dependent measure) Multiple Analysis of Variance (MANOVA). No significant differences were found (F (6, 193) = 1.789, $p > .05$).

Investigating Proportional Differences

Although no significant differences in traumatic stress, vicarious trauma, or burnout were found between the three groups, there were participants within each group reporting high levels of trauma-related distress as measured by the TSI and IES. Chi square post-hoc analyses were therefore conducted to explore the possibility that differences existed between groups in terms of the proportion of group members reporting high levels of trauma-related distress. It was expected that the proportion of participants reporting high levels of traumatic stress would be greater in Groups 1 and 2 (i.e., sexual violence and cancer) than the proportion of participants reporting the same in Group 3 (i.e., general practice).

Scores above 26 on the IES suggest moderate to severe traumatic stress (Horowitz et al., 1980). To determine if the three groups differed in the proportion of participants exhibiting traumatic stress symptoms, two categories based on IES total score were created: low = scores under 25, and high = scores at or above 26. A 3 × 2 (group by IES category) Pearson Chi Square analysis was conducted. There were no significant differences in the proportion of participants reporting low or high levels of traumatic stress symptoms across client populations (χ^2 = 1.031, df = 2, $p > .05$).

Participant scores on the TSI were also divided into three categories to explore proportional differences between participant groups. TSI scores that fell one standard deviation below the sample mean were classified as low (at or below 115). Scores falling one standard deviation above the mean were classified as high (at or above 168). Remaining scores were classified as average. Across groups, 19.6% fell within the low range, 64% were within the average range, and 16.4% obtained high TSI scores. A 3 × 3 (group by TSI score category) Pearson Chi Square analysis was conducted, which revealed no significant differences between proportions of participants in low, average, or high categories for TSI scores between groups (χ^2 = 1.532, df = 4, $p > .05$).

Although objective measures failed to indicate differences in trauma-related distress between groups, subjective data related to perceived impact of the work on the professional yielded interesting findings. A final chi square analysis was conducted to determine differences between groups on their perceptions of whether or not they perceived their clinical work to be potentially traumatizing.

Significant differences were found between groups (χ^2= 38.476, *df* = 2, p <.05). The majority of participants working with sexual violence (83%) felt their work was potentially traumatizing as compared to participants working with cancer (50%) and general practice (36%) who felt their work was potentially traumatizing.

Identifying Predictive Variables

A stepwise multiple regression analysis was used to test the predictive power of variables theorized to contribute to vicarious trauma. Six variables—supervision, level of exposure to human cruelty, venue to address concerns, number of years in the field, education level, and personal trauma history—were included in the regression analyses. Two variables, length of time in the field and personal trauma history, were found to contribute to TSI scores (F (1, 205) = 4.757, p < .05). Both history of personal trauma (β = -.160, p < .05) and length of time in the field (β = -.190, p < .05) were negatively related to TSI scores. Although the results were statistically significant, the total proportion of variance accounted for by both variables (R^2 = .056) was minimal.

The same six variables were used in a stepwise multiple regression to determine if they were predictive of traumatic stress as measured by the IES, given the validity concerns surrounding the TSI in measuring vicarious trauma. Results indicated that only one variable, length of time in the field, contributed to IES scores (F (1, 208) = 4.567, p < .05). The length of time participants worked in the field was negatively related to IES scores (β = -.141, p < .05). Again, the variance within IES scores accounted for was minimal (R^2 = .022).

DISCUSSION

The results of this study showed no differences in assessed levels of vicarious trauma, traumatic stress symptoms, and levels of burnout between professionals providing counselling to different client populations. Moreover, the majority of participants in this study did not appear to be experiencing either traumatic stress symptoms or burnout. Only 5% of participants in this study showed elevated levels of traumatic stress as measured by the TSI and IES. These findings appear to be consistent with several studies that have concluded that the majority of mental health professionals are not suffering significant emotional or psychological concerns, and in fact are coping well with the demands of their work (Coster & Schwebel, 1997; Elliot & Guy, 1993; Raquepaw & Miller, 1989; Thoreson, Miller, & Krauskopf, 1989).

Accounting for Lack of Significant Differences

Limitations of the research. Although many previous studies have utilized survey research to investigate vicarious trauma among professionals (Betts Adams et al., 2001; Kadambi & Truscott, 2003; Pearlman & MacIan, 1995; Schauben & Frazier, 1995), this may not be an ideal way to gather data. Response bias may

have affected results in that professionals doing well emotionally may have been more likely to respond to the survey. A self selection bias may also have impacted the results of this research. Therapists working with the client populations in this study self-select into these groups, and it is likely they would do so and remain so, partially on the basis of their ability to tolerate the emotional demands of clinical practice with their particular client population.

Sabin-Farrell and Turpin (2003) have noted discrepancies between quantitative and qualitative research regarding the prevalence, scope, and severity of vicarious trauma among professionals. Notable within this study was the finding that there were significant differences between groups in their perceptions of their work as traumatizing despite the lack of differences on their measured level of distress. It remains to be determined whether these differences are due to a lack of sensitivity among quantitative measures to detect true distress or concerns relating to the reliability and accuracy of self report in identifying work-related trauma (Steed & Downing, 1998). Until this issue is resolved, it may be important to include both quantitative assessment tools and qualitative data gathering to more accurately assess the experience among professionals.

Sensitivity of measures. Another possible explanation for the lack of significant results may be related to the sensitivity of the TSI in detecting differences between groups. While differences on the IES would also have been expected between groups, the IES assesses only intrusive and avoidant traumatic stress symptoms and not the changes in cognitive functioning that are central in the experience of vicarious trauma. The most recent version of the TSI (Revision M) failed to discriminate between samples of professionals who have been hypothesized to be highly likely to experience cognitive disruptions associated with vicarious trauma. These findings contribute to concerns relating to the psychometric limitations noted in previous research (Betts et al., 2001; Kadambi & Ennis, in press; Kadambi & Truscott, 2003). Moreover, this version of the TSI continues to show stronger correlations with established measures of burnout than with measures of traumatic stress, suggesting significant overlap. Accurate assessment of vicarious trauma may be a significant challenge to future researchers and may best be achieved by including measures that go beyond the cognitive and behavioural components of the phenomenon to assess the affective and physiological components of the experience.

Conceptual challenges. While the sensitivity of the measures used in detecting differences between participant groups in this study is in question, the notion that vicarious trauma is a cumulative and permanent phenomenon may also need to be revisited. Differences between groups may not have appeared as presenting symptoms, and cognitive disruptions associated with vicarious trauma may fluctuate over time. Vicarious trauma, as it is currently thought of, may be more of an acute state than a chronic condition among a variety of counselling professionals (Chrestman, 1995; Steed & Downing, 1998). Some researchers have found that professionals new to the practice of therapy with trauma clients

show significantly higher levels of cognitive disruptions and traumatic stress symptoms as compared to colleagues who have been in the field for an extended period of time (Gamble, Pearlman, Lucca, & Allen, 1994; Pearlman & MacIan, 1995; Schauben & Frazier, 1995). In this study, professionals had been working with their respective client populations for an average of 8.26 years. Researchers have yet to compare these new professionals' levels of traumatic stress to their peers working outside the area of interpersonal trauma to determine if the levels of traumatic stress are unique to those working in the area of trauma. Indeed, elevated levels of stress and traumatic stress may be a universal experience to new professionals adjusting to the emotional and professional challenges of providing counselling regardless of their client populations.

Alternatively, there is a possibility that there was no vicarious trauma phenomenon distinct to the participant groups that were studied. The theoretical assumptions that underlie the development of vicarious trauma clearly suggest that professionals who are exposed to traumatic stressors via clients who have been violently victimized are at a particularly high risk of being traumatized themselves (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995). The absence of differences in the degree of measured distress between those who work with clients who have experienced different types of traumatic stressors and those not working primarily with trauma clients challenges the notion that there is something specific about trauma therapy that produces a unique constellation of objective symptoms and experiences for the clinician. What the results do suggest is that there may be a small minority of professionals providing counselling (regardless of client population) who may be experiencing traumatic stress symptoms and cognitive disruptions suggestive of trauma. Whether these disturbances are in response to clinical work or to other external life events, however, remains undetermined.

In light of the current findings, it would appear that a reconceptualization of the phenomenon of vicarious trauma may warrant consideration. Specifically, the validity of the assumption that the professionals' exposure to clients' traumatic material and tales of human cruelty may represent the "active ingredients" in the development of traumatic stress reactions should be examined further. Instead, factors related to the manner in which the therapist empathically connects or identifies with client material, and the subsequent processing of their own feelings around it, may be more important in the development of traumatic stress than the content or dynamics of the therapy being provided.

In considering the contributions and interactions between factors that influence whether mental health professionals will experience traumatic stress reactions, individual and interpersonal characteristics of the clinician may be the most important determinant of how he or she will be impacted by the provision of counselling. Perhaps it is because vicarious trauma has been viewed as "normal and inevitable" (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995) that comparatively little attention has been devoted to the examination of therapist

characteristics (with the exception of personal trauma history) that may predict the development of traumatic stress in response to clinical work. Parallel research investigating the experience of traumatic stress among individuals directly exposed to catastrophic events has demonstrated that the majority of people exposed to a traumatic stressor do not exhibit persistent, traumatic stress reactions that significantly interfere with functioning (Breslau, 2002). Furthermore, research investigating factors that contribute to the development of PTSD following a direct traumatic stressor supports the notion that pre-morbid functioning, personal characteristics, and peritraumatic psychological processes play more salient roles in determining clinical symptoms than the characteristics of the traumatic stressor itself (Katz, Pellegrino, Pandya, Ng, & DeLisi, 2002; Lauterbach & Scott, 2001; Ozer, Best, Lipsey, & Weiss, 2003). Correspondingly, it would seem counter-intuitive to expect to find differing trends among therapist populations who are exposed to second-hand accounts of traumatic experiences through their clients.

CONCLUSIONS

Although clear psychometric and conceptual questions surround the phenomenon of vicarious trauma, there does appear to be something that is intuitively resonant with many clinicians. For a minority of professionals, the idea of significant permanent change in internal and external functioning may be very relevant. Vicarious trauma offers a framework for understanding their experience in a way that serves to respect and normalize their response to their work. The emphasis the construct places on the interaction between the professional, their work, and their work setting in determining how the professional can be affected also accounts for the range of responses professionals may exhibit in response to clinical practice.

Before organizations and individuals begin adopting intervention strategies to help address this issue among therapists, further research needs to confirm the existence of a unique phenomenon and develop more sensitive assessment tools that accurately measure and clearly differentiate vicarious trauma from other work-related stress responses such as burnout. A crucial step toward clearly understanding and/or addressing the experience of traumatic stress among therapists is likely to involve longitudinal research that explores the importance of therapist characteristics and pre-morbid functioning in the development of traumatic stress responses across a variety of client populations.

A vital aspect in understanding the impact counselling has on treatment providers may be the resilience they possess to experiencing traumatic stress responses. Examining how professionals working with challenging populations such as traumatized clients find a sense of meaning and reward from their work may offer us a more complete understanding of how mental health professionals can not only survive clinical practice, but thrive in their profession.

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