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Vicarious Trauma Coping and Self-Care Practices Among Trauma Therapists.

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Abstract

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Proposal Submitted in Partial Fulfillment

of the Requirements for the

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Abstract

Therapists who specialize in trauma therapy are indirectly exposed traumatic events presented by clients within the therapeutic relationship. The potential consequences for trauma therapists may be the risk of vicarious trauma. Effective coping and self-care are essential in the practice of trauma work. The research question for this study is: Do coping skills and self-care practices in trauma therapists moderate the disruptive effect of vicarious trauma on the fulfillment of their psychological needs (trust/dependence and control)? The purpose of this research study was to examine quantitatively, the role of trauma therapists' beliefs in the effectiveness of coping skills and time spent devoted to self-care practices as moderators of the disruptive effect of vicarious trauma on their fulfillment of psychological needs of trust/dependence and control. Based on the constructive self-development theory, this study explored 2 psychological needs areas including trust/dependence and control. A sample of therapists with 10 years or more experience in the field and who primarily treated traumatized populations were recruited. A survey design methodology via a customized internet-based system was used to administer the trauma and attachment belief scale and the coping inventory scale. A hierarchical multiple regression analysis was completed to address the research question and hypotheses. The results of regression analysis supported the research question. Contributions to positive social change include increased awareness of the risk of vicarious trauma and potential coping strategies necessary to address this phenomenon. Therapists may then enhance their therapeutic effectiveness and organizational service delivery to traumatized client populations.

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Chapter 1: Introduction to the Study

Introduction

Therapists who specialize in trauma typically work with survivors of significant loss including violence, sexual molestation, rape, life-altering medical conditions, and natural disasters. Psychotherapy can be demanding due to the responsibility held by therapists for being the dependent object for people in crisis (Neumann & Gamble, 1995). The prominent features of trauma therapy may include extensive and consecutive exposure to traumatic life events, empathic engagement with clients' traumatic experiences, and the facilitation of effective psychotherapeutic interventions that encourage progression and healing.

The cumulative effect of trauma work, according to the innovative research of Pearlman and Saakvitne (1995), may have a pervasive, transforming, and deleterious impact on therapists, resulting in vicarious traumatization. Influenced by the recognition that working with survivors of catastrophic or life-changing events may potentially impose an emotional cost for therapists, later researchers have attempted to further define vicarious trauma along with exploring a variety of strategies to reduce the pervasive symptoms of vicarious trauma. According to Bober and Regehr (2006), therapists who were exposed to victims of trauma tended to report higher levels of traumatic stress symptoms and higher level of intrusion symptoms typical of vicarious trauma; however, effective means of reducing distress among trauma therapists has not been evaluated. Adams and Riggs (2008) argued that education and training regarding the intensity of

trauma work and the psychological impact of vicarious trauma is essential for therapists entering the field along with exploring self-care strategies to manage the impact of working with survivors of trauma. Vicarious trauma is a relatively new phenomenon that focuses on the emotional and cognitive disruptions faced by therapists as they empathically engage in the therapeutic relationship, including the provision of psychotherapeutic interventions (Pearlman & Saakvitne, 1995). The following vignette illustrates the potential development of the deleterious impact of vicarious trauma experienced during a fictional day in the life of a typical therapist.

This chapter will provide with an introduction to vicarious trauma and its potential impact among therapists who treat trauma survivors. The development of this concept will be reviewed. Discussion of the innovative work established by earlier researchers who identified and explored the effect of trauma therapy is presented. The purpose of this study and its importance to the clinical work, service delivery, professional ethics, and the well-being of trauma therapists is discussed. The research question and hypotheses will be further defined and outlined. The theoretical framework for the current study focused on the constructivist self-development theory (CSDT) as instituted by Pearlman and Saakvitne (1995). This framework offered further insight in how trauma therapists relate to client survivors and their own experience of indirect exposure to trauma material. Later research that expanded upon the possible effects of vicarious trauma and the potential benefits of self-care will also be presented. This chapter concludes with definitions, assumptions, scope, and limitations. This allowed me to explore how coping skills potentially moderate the effect of vicarious trauma on the

fulfillment of psychological needs of therapists who treat trauma survivors. The social change implications of this study include an increased awareness of the risk of vicarious trauma and the potential individual and structural strategies necessary to address self-care management. In this study I further explore potential coping skills including self-care practices that may minimize the symptoms associated with vicarious trauma. Therapists may then enhance their therapeutic effectiveness and organizational service delivery to traumatized client populations.

Background

Survivors of trauma typically witness terrifying or life-threatening events that result in disruptive emotional and somatic reactions. The consequences of a traumatic experience may be severe and long lasting. A treating therapist may also experience a mirrored reaction to a client's disclosure of their traumatic story. The burden associated with treating traumatized populations may then contribute to disturbing and enduring alterations in a therapist's frame of reference, which in turn, may contribute to a therapist's transformation in identity, worldview, and spirituality (Pearlman & Saakvitne, 1995). Therefore, as posited by McCann and Pearlman (1990), vicarious trauma may be considered a normal reaction to trauma work. Catanese (2010) further argued that the innate responsibilities of the professional working in the realm of trauma could contribute to vicarious stress reactions. The difficult nature of providing services to survivor clients should be acknowledged and validated as there may be both personal and professional negative reactions for the therapist (VanDeusen & Way, 2006). Vicarious trauma, as noted by the current research, may result in emotional, cognitive, and physical symptoms

that can potentially disrupt a therapist's personal and professional self (Adams, Boscarino, & Figley, 2006; Boscarino, Adams, & Figley, 2010; Catanese, 2010; Kjellenberg, Nilsson, Daukantaite, & Cardena, 2013; Newell & McNeil, 2010; Williams, Helms, & Clemens, 2012). Therapists who work with traumatized populations are routinely and indirectly exposed to crisis situations and critical events as experienced and reported by their clients. Engaging in the therapeutic process can be particularly stressful for therapists who are charged with providing supportive interventions and tangible resources for their clients as well as fostering a healthy emotional adjustment to the considerable losses often associated with a life changing event. The act of sustained and empathic listening while absorbing the graphic details of a traumatic event, as suggested by McCann and Pearlman, can have adverse emotional consequences for therapists, thus furthering the risk of vicarious traumatization

The concept of vicarious trauma was developed through the pioneering work of McCann and Pearlman (1990) and Pearlman and Saakvitne (1995) who examined the emotional experience of therapists as they directly engaged with traumatized clients. McCann and Pearlman identified vicarious trauma as an interactive, cumulative, and inevitable process distinct from burnout or countertransference, which has a transforming effect upon therapists and is attributed to empathic engagement with traumatized clients. Although the concepts of burnout and countertransference offered a framework to explore the impact of vicarious trauma, the defining feature of these constructs both overlap and varies. Countertransference results from the interactive process within therapy with the focus on the therapist's own unresolved emotions that surface in the

treatment process (Hayes, Gelso, & Hummel, 2011). Emotional exhaustion stemming from the ongoing burden of working within a stressful helping profession and service environment basically defines the effect of burnout (Rubino, Luksyte, Jansen-Perry, & Valpone, 2009). The emotional and physical effect of vicarious trauma has been illustrated throughout the literature, suggesting that trauma therapists who specialize in working with trauma survivors may be especially vulnerable.

According to McCann and Pearlman (1990), second-hand exposure to traumatic material presented by clients results in pervasive and enduring changes in cognitive schema and personality that impact therapists' feelings, relationships, and lives, thus resulting in vicarious trauma. Indeed, symptoms of vicarious trauma include intrusive imagery and disturbing thoughts, avoidance and emotional numbing, hyper arousal, and somatization including headaches, nausea, and sleeplessness (Neumann & Gamble, 1995; Palm, Polusny, & Follette, 2004; Pearlman & Saakvitne, 1995). Dunkley and Whelan (2006) argued that a natural by-product of vicarious trauma is re-experiencing a client's suffering, potentially leading to feelings of anger, sadness, and anxiety. The emotional connection made between therapists and client survivors can potentially result in emotional turmoil including prolonged feelings of grief, anxiety, or sadness as well as manifestations of irritability, cynicism, and mood swings when work day experiences are especially strong (Catanese, 2010). Changes in self-identify, world view, spirituality, and disruption in one's belief system, including safety, personal vulnerability, interpersonal relationships, benevolence of the world, and feelings of powerlessness have also been identified as indicators of vicarious trauma (Figley, 1995; McMann & Pearlman, 1990).

Kjellenberg et al. (2013) posited that the result of trauma work may likely contribute to a change in helpers' attitudes, including greater fear of and resignation toward human evil, suggesting that feeling powerless increases psychological distress among trauma workers.

Palm et al. (2004) likened vicarious trauma to posttraumatic stress reactions as experienced by those indirectly exposed to traumatic events. The repeated exposure to a client's trauma material revealed in the therapeutic relationship can disrupt the therapist's cognitive and emotional processing and relationships to varying degrees in reaction to graphic narratives of violence and loss (Pearlman & Mac Ian, 1995) The CSDT developed by McCann and Pearlman (1990) further defines the concept of vicarious trauma, combining contemporary psychoanalytic theories (specifically self-psychology and object relations theory) with social cognition theories, thus providing a developmental framework for appreciating the traumatic life experiences of survivors. According to Pearlman (1998), CSDT is a developmental, interpersonal theory describing the impact of trauma on an individual's psychological development, adaptation, and identity marked by profound changes in the core aspects of a therapist's self or psychological foundation. The CSDT offers a comprehensive means of measuring personal traits while examining developmental structures that influence how one finds meaning in a traumatic event as well as how amenable they are to intervention, thereby, predicting the long-term impact of trauma. CSDT emphasizes the various aspects of personality such as defense styles, psychological needs, and coping resources that are affected by the ability to adapt to a traumatic event in the context of relational, social, and cultural variables that shape psychological responses (Pearlman & Mac Ian, 1995)

Several researchers have suggested that vicarious trauma is a natural cognitive, physical, behavioral, and emotional consequence of engaging in the helping process resulting from re-experiencing clients' trauma. These events can include emotional exhaustion, desire to avoid clients and reminders of the expressed event, increased anxiety, suspiciousness, vulnerability, and persistent arousal due to the intimate knowledge about a traumatic event; all of which may compromise the effective provision of service (Culver, McKinney, & Paradise, 2011; Harrison & Westwood, 2009; Figley, 1995, 2002; Pearlman, 1998; Pearlman & Mac Ian, 1995; Pearlman & Saakvitne, 1995; Sheehley-Carmel & Friendlander, 2009). Vicarious traumatization may consequently impose a deleterious effect on therapists both personally and professionally, ultimately becoming an occupational hazard of clinical work (Adams et al., 2006; Adams, Matto, & Harrington, 2001; Adams & Riggs, 2008; Bride, 2004; Harrison & Westwood, 2009; Figley, 1995, 2002; Pearlman, 1998; Pearlman & Mac Ian, 1995; Pearlman & Saakvitne, 1995; Sheehley-Carmel & Friendlander, 2009). A growing number of researchers have argued that therapists with a past trauma history, who experience organizational and work stress, have a lack of effective supervision, lack social support, and are new to the field are reported to have higher levels of vicarious trauma (Adams & Riggs, 2008; Devilly, Wright, & Varker, 2009; Jordan, 2010; VanDeusen, & Way, 2006; Voss Horrell, Holohan, Didion, & Vance, 2011). In contrast, professional and personal growth, spiritual well-being, (Laidig Brady, Guy, Poelstra, & Brokaw, 1999; Pearlman & Saakvitne, 1995) and compassion satisfaction (Alkema, Linton, & Davies, 2008) may also be associated with working with difficult populations. Radey and Figley (2007) argued that compassion

satisfaction can be further enhanced by (a) witnessing the progress made by clients, (b) maintaining a positive attitude toward clients (c) recognizing and increasing resources to manage work related stress and (d) increasing self-care that seeks inspiration and happiness in life. Current researchers have suggested that trauma work can have both negative and positive effects; however, there has been an increased concern for the well-being and health of those devoted to helping survivor clients cope with their personal tragedies (Bober & Regehr, 2006; Bober, Regehr, & Zhou, 2006; Kjellenberg et al., 2013). Bride, Radey, and Figley (2007) contended that some therapists experience positive aspects of trauma work that sustains and nourishes them. However, when faced with increased negative exposure to difficult populations, their satisfaction with clinical work may be reduced. Vicarious trauma can also result in emotional and financial costs to the client, therapist, and the organization charged with providing treatment services. Incidence of physical illness and poor mental health among employees leads to absenteeism and a high turnover rate as suggested by Klainin (2009). Workplace demands and the lack of resources in a number of organizations lead to burnout, emotional exhaustion, depersonalization, and reduced personal accomplishment (Maslach & Jackson, 1984). The struggle to manage a challenging caseload within a stressful work environment may further exacerbate the strain placed upon therapists providing trauma work.

It is also ethically necessary for therapists treating traumatized populations to become aware of their risk of experiencing vicarious trauma. The professional practice of psychology defines the principle to do no harm, thus guiding therapists to uphold the

ethical ideals of the profession (APA, 2002). When a therapist's ability to competently engage in the therapeutic process is compromised by vicarious traumatization, it can lead to boundary violations and adversely affect job performance including treatment planning and service delivery (McCann & Pearlman, 1990). The essence of the therapeutic relationship may be compromised when a therapist is faced with working with the effects of vicarious trauma. When a therapist is emotionally suffering, the decrease in quality of work and the ineffectiveness of the organization persists (Dunkley & Whelan, 2006; Sexton, 1999). An effective therapist according to Simon (2009), is passionately present to the diverse client systems they serve regardless of their own fundamental world-view and is especially attentive and responsive to the idiosyncratic characteristics of their clients while remaining creative and flexible when providing interventions. Maintaining such therapeutic effectiveness to ensure a positive outcome for the client while coping with individual anguish should be thoroughly examined by a treating therapist. Wise, Hersh, and Gibson (2012) suggested that therapists should create a sustainable balance between caring for clients and caring for self to further enhance professional functioning as well as avoid ineffective services or cause harm to those with whom we serve.

Another ethical consideration is the psychological implications of vicarious trauma experienced by therapists. Therapists may be confronted with cognitive alterations including cynicism and inefficacy with negative perceptions about job responsibilities and feelings of detachment as well as a belief in one's professional incompetence and lack of productivity (McCann & Pearlman, 1990; Maslach & Jackson, 1984**;** Pearlman & Saakvitne, 1995; Rubino et al., 2009). The provision of services when

working with the damaging effects of vicarious stress can result in disservice to both the client and the therapist as well as undermine the health of the community served (Harrison & Westwood, 2009).

The inability to manage the challenges of trauma work and sustain a sense of personal and professional balance may compromise therapeutic practices and impact treatment outcomes. Ignoring the symptoms associated with vicarious trauma may; therefore, jeopardize service to survivor clients who present in crisis. Harrison and Westwood (2009) argued that it is an ethical imperative to address the issue of vicarious trauma as both therapists and researchers are charged with providing appropriate and effective care for client survivors as well as those who serve them. According to APA Ethics Code 2.06a, a psychologist must refrain from initiating an activity when they are aware or should be aware that there is a substantial likelihood that their personal problems will interfere with their ability to competently engage in work related activities (APA, 2002). Therefore, if the cognitive and emotional distress experienced by a therapist interferes with their responsibilities in the act of treating a client, they must refrain from engaging in their job duties as their professional judgment may be impaired. The APA Ethics Code 2.06b directs a psychologist to take appropriate measures such as securing professional consultation or assistance, and determine if they should limit, suspend, or terminate work related duties if they find their personal problems are interfering with their job performance (APA, 2002).

Researchers have offered possible arguments about the negative impact of trauma work as well as the potential need for developing coping skills and self-care practices on

part of the therapist in order to manage vicarious trauma. There are few studies that empirically measure how coping skills moderate the potential disruptive effects of vicarious trauma on the fulfillment of psychological needs among trauma therapists. Researchers have further established that the practice of trauma therapy is often laden with challenges and stressors which may result in neglect of personal self-care needs. The absence of consistently managing a personal wellness inventory may then lead to emotional exhaustion and diminished capacity to effectively treat clients. Dedication to providing and improving treatment for trauma clients is critical to achieving effective treatment outcomes. In doing so, therapists may lose sight of their own needs to compose and recover through self-care. Acknowledging susceptibility of vicarious stress and recognizing individual limitations as well as engaging in self-care practices are essential for therapists who treat trauma populations. Therefore, increased awareness of vicarious trauma contributes to positive social change as effective treatment and organizational service delivery for clients who experienced trauma depends upon the professional responsibility of therapists to engage in self-care.

Problem Statement

Based on the research discussed, the question to explore is: Do coping skills and self-care practices in trauma therapists moderate the disruptive effect of vicarious trauma on the fulfillment of their psychological needs (trust/dependence and control)? Pearlman and Saakvitne (1995) argued that the recognition of vicarious trauma is the essential first step to self-protection therefore; normalizing vicarious trauma may minimize its negative effects. Integrating professional and personal self-care and creating coping skills and

strategies may be an effective means of addressing vicarious trauma as well as enhancing the provision of services to clients.

Recent researchers have identified the need for integrating useful self-care practices that offer therapists supportive resources for personal and professional growth. Several researchers have recommended self-care practices to manage the stress vicariously experienced by therapists working with traumatized populations, including maintenance of physical health, balanced diet, adequate sleep, regular exercise, or engaging in recreational activities (Harrison & Westwood, 2009). Developing graduate education about the effects of vicarious trauma and specific training in managing associated stress through self-care may be essential for learning and longevity in therapeutic practices (Shannon, Simmelink-McCleary, Im, Becher, & Crook-Lyon, 2014).

Professional peer support, supervision, and social support as well as participating in personal therapy, creative self-expression, and maintaining a spiritual connection are also recommended (Harrison & Westwood, 2009; Newell & MacNeil, 2010; Neumann & Gamble, 1995). Bober and Regehr (2006) suggested that further research into work conditions and individual strategies to address the potential distress of trauma work is urgently needed. Although a variety of coping strategies have been suggested by researchers, there has been a limited focus on evaluating the effectiveness of self-care and coping strategies as it relates to trauma work and working conditions for therapists (Bober & Regehr, 2006).

There have been relatively few studies that empirically examined the relationship between individual coping styles and self-care practices among therapists who treat traumatized populations to address the effect of vicarious trauma on the fulfillment of psychological needs. The importance of exploring the effect of trauma work and the potential benefit of coping strategies is timely in that the quality of the therapeutic relationship is paramount to the healing process for client survivors. Exposure to a considerable number of societal tragedies is recognized as a common occurrence prompting the need for client survivors to seek treatment (Cook, Dinnen, Rehman, Bufka, & Courtois, 2011). Belsher, Ruzek, Bongar, and Cordova (2012) argued that adjustment following a client survivor's exposure to a trauma experience is facilitated through supportive interpersonal processing in order to re-establish feelings of safety and self-worth.

Remaining empathic is a benefit in treating client survivors; however, it can also be a potential hindrance to the therapeutic process if a therapist does not have an effective self-care plan. In this study I explored how coping skills and self-care practices moderated the potentially disruptive effect of vicarious trauma on the fulfillment of psychological needs of therapists, thereby enhancing the well-being of the individual therapist and the effectiveness of their professional work.

Purpose of the Study

The purpose of the current study was to quantitatively examine if trauma therapists' coping skills and self-care practices moderated the disruptive effect of vicarious trauma on their fulfillment of psychological needs of trust/dependence and

control. To further define fulfillment of psychological needs, we contend that the ability to develop, achieve, and sustain psychological needs is essential to self-development and self-identity. The independent variable in this study is vicarious trauma. Vicarious trauma was measured by educational level, license to practice, years of experience in the field, and percentage of caseload that includes trauma survivors. The dependent variable in this study is psychological needs. Two types of moderating variables were measured: beliefs that coping skills lower the level of vicarious trauma and the time involved in self-care practices.

Based on the CSDT, this study explored two psychological needs areas of trauma therapists including trust/dependence and control. It was hypothesized that vicarious trauma contributes to disruption in these specific psychological needs areas based on the number of years of professional trauma experience and the percentage of trauma clients treated. This study further examined if there was a significant relationship between the use of coping skills and self-care and the disruptive experience of vicarious trauma as it related to trauma therapists' fulfillment of psychological needs of trust/dependence and control.

Research Question

Do coping skills and self-care practices in trauma therapists moderate the disruptive effect of vicarious trauma on the fulfillment of their psychological needs (trust/dependence and control)?

H_1: The use of coping skills by trauma therapists will moderate the relationship between the disruptive effects of vicarious trauma on the fulfillment of their psychological need for trust/dependence.

H_0: The use of coping skills by trauma therapists is unrelated to the disruptive effect of vicarious trauma on their fulfillment of psychological need for trust/ dependence.

H_2: The use of coping skills by trauma therapists will moderate the disruptive effects of vicarious trauma on the fulfillment of their psychological need for control.

H_0: The use of coping skills by trauma therapists is unrelated to the disruptive effect of vicarious trauma on their fulfillment of psychological need for control.

H_3: The use of self-care practices by trauma therapists will moderate the disruptive effects of vicarious trauma on the fulfillment of their psychological need for trust/dependence.

H_0: The use of self-care practices by trauma therapists is unrelated to the disruptive effects of vicarious trauma on the fulfillment of their psychological need for trust/dependence.

H_4: The use of self-care practices by trauma therapists will moderate the disruptive effects of vicarious trauma on the fulfillment of their psychological need for control.

H_0: The use of self-care practices by trauma therapists is unrelated to the disruptive effects of vicarious trauma on the fulfillment of their psychological need for control.

Theoretical Framework

To further explain and define vicarious trauma as potentially experienced by trauma therapists, we have identified the CSDT as a useful framework. As a comprehensive theory on how traumatic stressors affect individuals, the CSDT provides a construct that defines the impact of traumatic life experiences either directly or indirectly on psychological needs within relational and sociocultural contexts (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995). For this study, we were specifically interested in examining the potential effects of vicarious trauma that may alter psychological needs of trauma therapists as well as coping and self-care practices that may moderate its potential effects. Therefore, the components of individual self-development most vulnerable to the effects of a trauma and those that encourage adaptation to a traumatic experience and its aftermath are rooted in the context of individual personality, history, society, environment, and culture. According to McCann and Pearlman (1990), trauma experiences may significantly disrupt psychological needs, however; the CSDT suggest that the perception of what people find traumatic and the symptoms manifested by exposure to trauma are individualized as each person constructs their own reality, beliefs, and perceptions, thereby defining trauma from their previous or early life experiences. Psychological needs, as defined by McCann and Pearlman (1990), are internal forces that motivate behavior and shape one's interactions with others. Within the CSDT, there are five psychological needs identified that may be susceptible to the disruption associated with a traumatic event including safety, trust/dependence, esteem, intimacy, and control. For the purpose of this study, we examined two

psychological needs area of trust/independence and control using the framework of the CSDT to measure the disruptive effects of traumatic stress. We also explored coping skills and self-care among trauma therapists with a specific focus on individual beliefs about which coping strategies lower the level of traumatic stress and the time spent engaged in self-care practices. In chapter two we expanded upon the definitions of keys concepts and theoretical framework. We also reviewed research detailing the effect of vicarious trauma and the significance of coping strategies and self-care practices to address the potential impact of vicarious trauma among trauma therapists.

Nature of the Study

A variety of studies have cited the effects of trauma work on therapists. There has been a number of qualitative research that offered suggestions for trauma therapists in managing the negative effects of vicarious trauma. According to Bober et al. (2006), quantitative research that measures forms of self-care as a protective tool against the development of vicarious trauma is limited. In this study we will be using the Trauma and Attachment Belief Scale (TABS) (Pearlman, 2003) to measure the effects of traumatic stress on trauma therapists in the fulfillment of two psychological needs area of trust/independence and control. We will also be using the Coping Skills Inventory (CSI) (Bober et al., 2006; Regehr, 2006) to measure trauma therapists' beliefs about the effectiveness of coping skills and the amount of time spent on self-care.

The Trauma and Attachment Belief Scale (TABS) (Pearlman, 2003) was developed within the theoretical framework of the CSDT operationalizing the universal constructs of psychological needs. To address the need for an empirical measure that

would evaluate coping skills and self-care as a means of diminishing the effect of trauma work, Bober et al. (2006) developed the Coping Skills Inventory (CSI) which measures beliefs about which coping strategies will lower the level of vicarious trauma and time spent participating in coping strategies. These two elements were derived from frequently offered recommendations and solutions for reducing the impact of vicarious trauma identified in qualitative studies (Bober et al., 2006). This study will use the CSI to explore how coping skills moderate the disruptive effect of vicarious trauma on psychological needs of trust/independence and control. The independent variable in this study is vicarious trauma and the dependent variable is psychological needs with coping skills as the moderator variable.

The population of interest for this study is therapists who treat trauma victims. Data will be collected through a cross-sectional survey design methodology via a secure password protected customized internet-based system. Demographic data will be collected via questionnaire online. These variables include age, gender, and education, license to practice, discipline, and percentage of caseload that includes trauma clients. The TABS (Pearlman, 2003) and CSI (Bober et al., 2006; Regehr, 2006) have been identified as the most appropriate self-administered surveys as they reflect the conceptual framework of the CSDT. We will use multiple regression analysis to determine if coping skills moderate the disruptive effect of vicarious trauma specific to psychological needs of trust/dependence and control among trauma therapists.

The independent variable in this study is vicarious trauma which will be assessed by measuring disruptive variations on the fulfillment of psychological needs of therapists

treating client survivors. Additional variables that form our main independent variable vicarious trauma include (a) years of experience in the therapeutic profession, and (b) percentage of current caseload that includes trauma survivors. The dependent variable is psychological needs including trust/independence and control. Vicarious trauma will be measured on the potential disruption of two psychological needs defined as trust/dependence and control. The moderating variable is coping skills including two types of skills defined as beliefs that coping skills diminish the effects of vicarious trauma and time spent participating in self-care practices.

Definitions

Vicarious trauma: McCann and Pearlman (1990) defined vicarious trauma as a negative transformation in the self of a therapist as they empathically engage and are indirectly exposed to trauma material within the therapeutic relationship.

Psychological needs: Internal forces that motivate behaviors and are developed and shaped through individual early life experiences and traumatic life events that can transpire during the course of one's lifetime (Pearlman, 2003).

Empathy: Primary resource that allows the therapist to assess areas of concern, develop an appropriate treatment plan that includes supportive interventions, and recognize and appreciate the traumatic event as experienced by the client (Kahill, 1988).

Countertransference: Therapist's reactions to their client within the therapeutic setting in which their unresolved conflicts are implicated (Hayes et al., 2011).

Emotional Exhaustion: Basic stress reaction of feeling emotionally overextended. However, the multidimensional model of professional burnout includes emotional

exhaustion as well as cynicism, and a sense of inefficacy in relationship to the individual, the organization, and the client level (Maslach, 2003; Maslach & Jackson, 1985).

Coping skills and *self-care*: Reduction in the disruptive effect of vicarious trauma among trauma therapists including the belief in the use of coping skills and the time spent engaged in self-care practices (Bober et al., 2006).

Assumptions, Scope, and Limitations

It was assumed that trauma therapists are vulnerable to the disruptive effects of vicarious trauma through their work with client survivors. It is also assumed that the cumulative effect of secondary exposure to trauma through sustained empathic engagement is disruptive to the fulfillment of psychological needs of therapists, thus affecting their personal and professional self. It was assumed that the use of coping skills and participation in self-care are potentially useful in managing vicarious trauma as well as the belief in the efficacy of coping skills and the time devoted toward self-care. However, empirical research that offers effective means for coping with and managing vicarious trauma is limited (Bober el al., 2006). It was further assumed that the participants in this study will represent the population of therapists who treat trauma survivors and will respond truthfully to survey questions based on their personal and professional experiences.

The scope of this study is the examination of how trauma therapists respond to the potentially disruptive effects of vicarious trauma and what coping skills are useful in managing the risk of vicarious trauma. Within the framework of the CSDT I specifically explored the potential relationship between the experience of vicarious trauma and on the

fulfillment of psychological needs of trust/independence and control among trauma therapists. I further assessed how the use of coping skills and self-care may potentially moderate the experience of vicarious trauma for therapists based on their age, gender, and education, license to practice, discipline, and percentage of caseload that includes trauma clients.

This study utilized self-reporting measures as this method is most useful for the purpose in securing data. Limitations of this study therefore included reliance on the honesty and forthrightness of participants who were asked to introspectively assess their beliefs, coping behaviors, and self-care practices as accurately as possible. Consideration of participants' varied interpretation of presented abstract concepts such as personality, psychological needs, and behaviors as well as differences in use and understanding of self-reporting scales further limited the accuracy of reporting.

An additional limitation in this study was the use of a correlational design. A correlational design allowed an examination of the strength of the relationship between vicarious trauma and the potentially disruptive effects of psychological needs among the population of trauma therapists. However, the implication that there was a potential causation cannot be assumed or inferred.

The method of non-random sampling was used in the selection of potential participants for this study. Potential participants were invited through the use of email listings from professional associations and organizations of practicing therapists and social workers. Potential participants were able to make the decision to participate. The limitation of self-selection bias was a consideration. Inclusion criteria included licensed

clinical therapists holding a masters or doctoral degree with 10 plus years of experience in the field. Participants' caseload must include at least 50 % or more of trauma survivors. Exclusion criteria included individuals who are not licensed to practice, hold less than a master degree, and less than 10 years of experience in the field. Although I was reasonably certain that the convenience sample would be representative of the population of trauma therapists, I could not depend upon random selection or the rationale of probability theory thus, the degree of generalization is be debatable. However, threats to external validity may be diminished through this sampling method again, allowing me to be reasonably sure that the sample was representative of the population of trauma therapists.

The capacity in which the scale accurately represented the experience of vicarious trauma among therapists who treat client survivors presented additional limitations. To date, there is no tool that measures vicarious trauma. In this study, the use of the TABS (Pearlman, 2003) offered the best assessment to measure vicarious trauma. Several researchers have used the TABS (Pearlman, 2003) as a measurement of vicarious trauma (Cunningham, 2003; McCann & Pearlman, 1990; Pearlman & Mac Ian, 1995; Van Deusen & Way, 2006; Vrklevski & Franklin, 2008). I therefore, assumed that the TABS (Pearlman, 2003) are the most reliable and valid measurement of disruptions in psychological needs associated with the experience of traumatic life event whether directly or indirectly.

This study used the TABS (Pearlman, 2003) and the CSI (Bober et al., 2006; Regehr, 2006). As survey instruments, the TABS (Pearlman, 2003) and the CSI (Bober et

al., 2006; Regehr, 2006), may limit participants to the response categories presented as well as affect potential time constraints in completing the surveys. The inability for participants to ask for clarification may also affect the responses to the surveys contributing to further limitations.

Significance

The cumulative and transforming effects of working with survivor clients may lead to cognitive shifts with pervasive effect on therapists' cognitive schemas including identity, world view, beliefs, and psychological needs (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995), thus, contributing to vicarious trauma. Enhancement of the professional self through the deployment of self-care practices may decrease the risk of vicarious trauma which in turn, improves the therapeutic relationship and treatment outcomes. The examination of therapists' responses to treating survivor clients is however, relatively new with ongoing efforts to address the deleterious effects of vicarious trauma and the value of integrating self-care practices.

The literature has established that vicarious trauma can potentially have a disruptive and devastating impact on the psychological needs of therapists as they engage in the therapeutic relationship; therefore finding avenues to thoroughly examine and empirically validate vicarious trauma can be useful to the profession of psychology in general, and specifically, therapists who work with traumatized populations. Positive social change includes an increased awareness of the risk of vicarious trauma and the development of potential coping strategies necessary to address this phenomenon.

Therapists may then enhance their therapeutic effectiveness and organizational service delivery to traumatized client populations.

Summary

In this chapter we discussed the disruptive effect of trauma work and the effect of secondary trauma among therapists who treat client survivors, thus contributing to vicarious traumatization. The development and establishment of this concept through the pioneering research of Pearlman and Saakvitne (1995) was reviewed. The theoretical framework of the CSDT which further defined vicarious trauma and its effects on the fulfillment of psychological needs of trauma therapists was presented. Later research that explored the impact of vicarious trauma and the use of coping strategies and self-care practices to diminish the risk of vicarious trauma was discussed. Through a literature search, we determined that quantitative examination about the relationship between vicarious trauma and the use of coping skills to lower the risk of indirectly experiencing trauma material was limited. The purpose of this study and its significance to social change and the practice of clinical care for trauma survivors as well as to professional trauma therapists were discussed. Identification of the research question, assumptions and limitations of this study was also explored.

In Chapter 2 we provide a comprehensive analysis of the CSDT and its usefulness as a framework in exploring vicarious trauma. Focus is placed on trauma therapists' response to the therapeutic process and potential disruptions in building a therapeutic alliance when strategies for coping and self-care diminish as the result of vicarious trauma. Further expansion and clarification of the conceptual frameworks of

countertransference, professional burnout, compassion fatigue, secondary traumatic stress, and vicarious trauma as well as the concept of post traumatic stress disorder as the basis for defining vicarious trauma is presented. The research on stress and coping with a focus on self-care practices is reviewed. The chapter concludes with the relevancy of this study to the profession of trauma psychology and its contribution to social change.

Chapter 2 - Literature Review

Extraordinarily stressful life events may result in psychological, cognitive, and physical trauma that potentially have lasting effects for survivors. According to Cook et al. (2011), national and international events including the September 11th attacks, school shootings, natural disasters, and the Iraq and Afghanistan wars as well as increased awareness of community and domestic violence, and child abuse have prompted greater public attention to the devastating consequences of trauma. Traumatic events have therefore encouraged survivors to seek out behavioral health services (Cook et al. 2011). Considering the prevalence of traumatic life events and the need for psychotherapeutic interventions to address hardships faced by survivor clients, it is essential for therapists to recognize their own vulnerability and emotional risks while providing helping services. Awareness of the psychological consequences of trauma work and taking appropriate actions to ensure healthy self-care practices is fundamental to the practice of therapy.

The therapeutic relationship often assists survivor clients in processing their traumatic experience through vivid reenactments, thereby becoming an effective intervention which fosters progression, coping, and closure with traumatic stresses (Bride, 2004). However, the hazards of indirect exposure to survivor client material may result in therapists' experience of both compassion satisfaction as well as vicarious traumatization. According to Craig and Sprang (2010), stress is an anticipated by-product for those in the behavioral health professions that influence various responses such as burnout, compassion fatigue, and compassion satisfaction. In their study about the secondary traumatic effects on social workers who treated survivors of the September 11

attacks, Boscarino, Figley, and Adams (2004) posited that secondary trauma was positively associated with the World Trade Center recovery involvement; however, it was negatively associated with having a supportive work environment. In addition, Culver et al. (2011) concluded, in their study of incidents of vicarious trauma among mental health professionals in the aftermath of Hurricane Katrina, that repeated exposure to client's trauma material may have adverse effects including increased anxiety, suspiciousness, and vulnerability; thus, affecting their ability to provide effective services for clients. Voss Horrell et al. (2011) suggested that clinicians who treat veterans of the Iraq war and service members of the Afghanistan war must develop an awareness of their personal responses to their clients and the potential problematic symptoms similar to PTSD that lead to vicarious trauma and burnout. Ben-Porat and Itzhaky (2009) reported both positive and negative changes in therapists specializing in the field of family violence including disruptions in their beliefs and schemata regarding spousal relations, the world, and humanity as well as increased awareness of spousal and parenting needs. It is therefore evident that trauma therapists are indirectly exposed to a variety of trauma experiences as relayed by clients.

The potential challenge for trauma therapists is empathically engaging in the therapeutic process, thereby encouraging the course of healing for a client while minimizing the impact of vicarious trauma. Examining the effect of vicarious trauma on the psychological needs of therapists who treat traumatized populations as well as exploring potential coping skills and self-care practices that address the risk of secondary traumatization is an issue to consider. Optimal service delivery to effectively treat,

advocate, and coach can be further enhanced through professional and personal awareness of the risk of vicarious trauma inherent in trauma work thus, contributing to positive social change.

The purpose of the current study was to quantitatively examine if coping skills moderate the disruptive effect of vicarious trauma on the fulfillment of psychological needs of trauma therapists. Within the framework of the CSDT, I examined two psychological needs of trauma therapists: (a) trust/independence and (b) control. I also examined if there was a significant relationship between the use of coping skills and the experience of vicarious trauma as it relates to the fulfillment of the psychological needs of trust/dependence and control among trauma therapists.

In this chapter a broader understanding of the CSDT is presented. Likewise, the usefulness of this framework when examining individual responses to stress and trauma as well as defining psychological needs that may be affected by trauma are also addressed. This chapter will expand upon the use of the therapeutic process as a means of healing and recovery for a client following a traumatic event. Discussion of the goals of the therapeutic relationship and the role of the therapist in developing an empathic connection and a collaborative relationship with a client in order to rebuild the disruption allied with a trauma experience is explored. Therapists' potential response to trauma material disclosed within the therapeutic relationship is examined. In addition, further clarification and delineation between the conceptual frameworks of countertransference, professional burnout, and vicarious trauma will be reviewed. The concept of post-

traumatic stress disorder which contributed to the recognition of indirectly experiencing the disruptive effects of trauma is presented. The conception of vicarious trauma, secondary traumatic stress, and compassion fatigue as it relates to the trauma therapists' experience in treating clients who survived a traumatic event is discussed. This chapter will conclude with a review of the research on stress and coping as well as examination of self-care practices to address the impact of vicarious trauma.

Literature Search Strategy

A focused literature search to locate key articles, books and resources was completed. The initial search was broad to include principal topics of vicarious trauma, compassion fatigue, secondary stress disorder, countertransference, professional burnout, and PTSD. Additional key concepts of trauma therapy and theories of stress and coping were also targeted. Our literature search was narrowed to include relevant citations specific to the effect of vicarious trauma in the practice of trauma therapy. Research specific to coping strategies and self-care practices to address the risk of compromised professional practices associated with vicarious traumatization was done.

Specific data based search was accessed through Walden University Library PsycINFO, PsycARTICLES, PsycBOOKS, and PsycTESTS. Sources secured and reviewed included historical peer reviewed articles from dates 1932 to current 2013. Diagnostic and Statistical Manual of Mental Health Disorders (DSM -5), Diagnostic and Statistical Manual of Mental Health Disorders (DSM -4), Diagnostic and Statistical Manual of Mental Health Disorders (DSM-3) were secured from PsychiatryOnline.

Google Books and ebrary search was also conducted. (a. 32 URR) Approximately 750 searches were completed to secure the most relevant material for inclusion in this study.

Theoretical Foundation: Constructivist Self Development Theory (CSDT)

The CSDT offers a theory that explains the impact of a trauma experience on self-development including both the negative changes following a traumatic event and the positive changes toward adaptation and efforts to seek out the meaning of a trauma experience (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995; Saakvitne, Tennen & Affleck, 1998). As a trauma theory the CSDT integrates the theoretical contributions of psychoanalysis, social learning, object relations, developmental and relational models, and social cognition theories of trauma. Saakvitne, et al. (1998) argued that CSDT combines constructs from psychoanalytic and social learning theories to explain personality development specifically as "the interaction between core self-capacities (related to early relationships, secure attachments, and ego resources) and constructed beliefs and schemas (related to cumulative experiences and the attribution of meaning to those experiences) that shape perception and experience" (p. 282).

CSDT, as noted by Pearlman and Mac Ian (1995) considers that psychological responses to trauma are influenced by the interaction between personality style namely, defensive styles, emotional needs, and methods of coping and the prominent characteristics of the traumatic experience within the context of social and cultural variables. The experience of a traumatic event is individualized in that one's personal perception and interpretation of a trauma is influenced by early relationships, social

learning, and personality development as fostered within familial systems, cultural norms, and living environments.

CSDT focuses on the associations experienced early in life with self and with others emphasizing the significant impact of these alliances on individual coping behaviors as it relates to one's environment. Coping behaviors and adaptation to a traumatic event can be attributed to these various factors. Therefore, the CSDT defines the elements of self-development that are most vulnerable to the effects of a trauma experience which encourages adaptation to a traumatic event and its aftermath within the context of individuals' personality, history, social, environmental, and cultural.

Pearlman and Mac Ian (1995) argued that CSDT also applies to the experiences of therapists who treat survivor clients specifically, the vulnerability to vicarious trauma and its symptomatic expressions that emerge from the interaction of the therapist's personality styles with aspects of their working environment over time. CSDT focuses on the individual nature of a trauma experience including the construction and the meaning of the event. It also identifies various areas of personality that are affected by a traumatic event. For instance, the aspects of personality that may be impacted include frame of reference, self-capacities, ego resources, central psychological needs, related cognitive schemas, and perceptual and memory systems (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995). Specifically, the CSDT contends that the individual response to trauma will be determined by one's psychological needs of safety, trust, dependency, esteem, and control (McCann & Pearlman, 1990).

Psychological needs encompasses an individual's belief and capacity for safety; trust in self, the world, and dependency on others; self-esteem as in a strong sense of self and feeling appreciated; intimacy in personal connection to self and others; and control of self-thoughts and behaviors as well as those of others. These psychological needs form an individual's sense of self, construction of a personal world view, and encourage the ability to maintain a healthy level of inner stability (McCann & Pearlman, 1990). The introduction of a traumatic event as posited by Pearlman and Saakvitne (1995) contributes to changes in one's frame of reference or the way they commonly view their life experiences thereby, disrupting their capacity to modulate and maintain benevolent inner connection to self and the fulfillment of psychological needs. The cumulative exposure of working with survivor clients may therefore, challenge a therapist understanding and interpretation of themselves and their world view. The ability for a therapist to meet and sustain one or more psychological needs may also be compromised, ultimately resulting in vicarious traumatization and ineffective means of coping.

The utilization of the CSDT in the recent literature has demonstrated the effectiveness of this framework when examining individual responses to stress and trauma (Dunkley & Whelan, 2006; Giller, Vermilea, & Steele, 2006; Miller, Flores, & Pitcher, 2010; Williams, Helm, & Clemens, 2012). In their study about judges' reactions to violence experienced in courthouses, Miller et al. (2010) concluded that participants experienced distortions in at least one of the psychological needs identified by the CSDT. Williams et al. (2012) suggested that CSDT as a model reflected personal wellness and childhood trauma as significant variables in examining the impact of vicarious trauma on

mental health workers. Dunkley and Whelan (2006) further contended that CSDT offers a viable theoretical basis for identifying and recognizing vicarious traumatization among counselors who work with trauma populations; whereas, Giller et al. (2006) built upon the framework of the CSDT to develop mental health training curriculum that fosters effective responses to the complex needs of survivor clients and promotes the well-being of clients and therapists; thus, enhancing collaborative therapeutic relationships. Based on the identified studies, we suggest that CSDT is a useful construct in defining the experience of vicarious trauma and potential opportunities to develop healthy coping strategies and self-care practices.

Literature Review Related to Key Concepts

The nature of trauma work often includes the survivor client's disclosure of strong emotions intermingled with the recollection of critical events. The provision of effective trauma treatment encourages survivor clients to work through and bring closure to their crisis event, which in turn repeatedly exposes therapists to trauma events through vivid imagery (Bride et al., 2007). According to Figley (1995), the therapeutic relationship is centered on the relief of emotional suffering encountered by survivor clients however, in their professional role; the therapist absorbs information that is all about suffering. Throughout the assessment phase, goal setting, and the determination of the most effective interventions, the therapist engages in the arduous task of verbally and emotionally exploring a survivor client's trauma event and related circumstances. The trauma must be assessed to evaluate specific symptoms presented by the survivor client as well as determine the dysfunction that disrupts the recovery process before a suitable

intervention to best treat the survivor client's needs is determined (Briere & Scott, 2006).

Interventions such as distress reduction and acute regulation training, cognitive and emotional processing, re-experiencing the trauma, client narratives and insight all offer detailed reconstruction of a traumatic event. Briere and Scott (2006) suggested that the repeated description of a trauma within the context of therapy guides a survivor client through their assumptions, beliefs, and perceptions by actively remembering the trauma and re-experiencing the thoughts and feelings at that point in time. Remaining client-focused during the detailed descriptions of trauma may produce emotional responses on the part of the therapist that may disrupt the clinical experience and the treatment process.

Although therapists are committed to clients' right to self-determination, it is important to recognize that personal experiences, perceptions, ideals, beliefs, reactions, and defenses may be challenged when faced with the cumulative effect of vicarious trauma thereby impacting psychological need fulfillment. The objectivity of the helping professional engaged in trauma work may perhaps compromise the emotional distance necessary in the therapeutic relationship and result in boundary violations, avoidance, and cynicism. Sheely, Carmel and Freidlander (2009) argued that the characteristics of therapists are likely to influence survivor clients' experiences of the therapeutic relationship; however, they are not inclined to be directly related to treatment success. It is nonetheless, necessary for therapists to be aware of their reactions toward their clients' trauma material considering the lack of emotional reciprocity within the therapeutic relationship. As most aptly noted by Pearlman and Saakvitne (1995), "When we do not recognize our limitations and the lenses through which we see and hear our clients'

material, we all run the risk of disconnection, failure, and harm to our clients" (p. 49). In an effort to encourage an effective therapeutic alliance with clients and minimize the effects of vicarious trauma, therapists must be attuned to their own self-care needs that foster their sense of well-being.

The healing process, according to Pearlman and Saakvitne (1995), occurs overtime within the context of the therapeutic relationship through clinical interactions and the way the therapist and client relate to one another. Adame and Leitner (2009) suggested that therapists engage clients in their personal struggles by providing a safe forum to explore their injuries which in turn, encourages healing within the therapeutic relationship. The therapeutic relationship offers an adaptive healing process by providing a safe and secure attachment enabling the client to experience the blocking associated with trauma and the ability to release deep-level feelings (Woody, 2007). Recognizing the client's need for safety, connection, and meaning, the therapist strives to reconstruct and repair the chaos associated with trauma.

Openness to exploration and discussion of presented events within the structure of the therapeutic relationship is necessary as the relationship exists to address the client's needs (Pearlman & Saakvitne, 1995). Briere and Scott (2006) noted that establishing a positive therapeutic rapport enhances the likelihood that the survivor client will become psychologically available to the therapeutic process, thereby encouraging confrontation of painful memories and integrating them into the fabric of one's life. The commitment to remaining open to survivor clients' trauma material exposes therapists to harsh realities of traumatic experiences on a daily basis and overtime may progress to vicarious

traumatization. The disruption in therapists' self-protective beliefs, control, predictability, and attachment resulting from vicarious trauma may, therefore be a consequence of trauma therapy (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995).

Psychological Needs

The professional and personal self are especially affected as exposure to the intensity of an event may challenge one's frame of reference as well as existing beliefs of self and others. According to Saakvitne, Tennen and Affleck (1998) five areas of self may be affected by exposure to a direct or indirect trauma including frame of reference, self-capacities, ego resources, psychological needs and perceptual and memory systems. Therapists' response to trauma material presented in the therapeutic relationship will be influenced by individual psychological needs for safety, trust, dependency, esteem, and control.

For the purpose of this study, I focused on the psychological needs for trust and control as these specific aspects of self may be most affected by engaging in trauma work. In order to develop and sustain a mutually collaborative relationship and openness, the therapist should examine their own subjectivity and psychological needs. The relational space of the treatment is shaped by the therapist's history, defenses, unconscious processes, conscious processes, and behaviors. In their study of the therapeutic working alliance with perpetrators of sexual abuse, Sheehy, Carmel and Friedlander (2009) concluded that therapists' personal characteristics and perceptions of their relationship with clients play a role in the working alliance and are important predictors of treatment success as well as contribute to therapists' emotional adjustment.

These processes build the therapeutic alliance and are the primary means of therapeutic intervention with trauma survivors.

Helping professions, including trauma therapists, will be treating clients who have experienced one or more traumatic life events. Therefore, the need for specialized treatment that focuses on the needs of survivor clients has influenced the scope of the therapeutic process. This suggests that therapists become knowledgeable in theory-based psychotherapy and in the competent delivery of mental and behavioral health services to traumatized populations as well as become aware of the emotional risks to their professional and personal self. Sommer (2008) posited that incidents of vicarious trauma among trauma workers is an important discussion for the counseling profession with an emphasis on mitigating its effects along with appreciating the ethical responsibility to provide specific training and preparation practices to prevent harm to clients and to therapists.

Empathy

Historically, the focus of the therapeutic relationship rests with the needs of the client through the process of assessment, establishment of treatment goals and appropriate interventions, and treatment outcomes. The role of the therapist is to provide a high standard of care with an obligation to remain unbiased, including the recognition that the client is the focal point of the therapeutic process. Pearlman and Saakvitne (1995) proposed that the therapeutic relationship is "founded on basic respect for the personhood of the client" (p. 17). The practice of building rapport and establishing an empathic and

collaborative effort with the client contributes to the development and understanding of mutually agreed upon and goal-directed treatment.

The principal idea of the therapeutic relationship is the premise that a client can disclose any information to the therapist, and events discussed within the context of the relationship are open to observation and discussion (Pearlman & Saakvitne, 1995). The mutual collaboration between the therapist and the client emphasized during the psychotherapeutic process enhances successful treatment outcomes; therefore, the therapeutic alliance is essential in the client's healing process. The recuperative process for the client occurs within the framework of the therapeutic relationship. Successful interventions are to a large extent dependent upon the therapeutic support and connection to the client which in turn encourages the processing of painful life events, feelings of despair, and vulnerability (Briere & Scott, 2006).

The provision of trauma therapy fosters additional challenges to the therapeutic relationship. The complexity of a traumatic experience can further compound the survivor client's presented difficulties and potentially disrupt the recovery process (Briere & Scott, 2006; Bride et al., 2007). Additionally, the complication of developmental and comorbid conditions may increase with the introduction of trauma, thus becoming a critical issue in the development of treatment strategies (Briere & Scott, 2006; Courtois, 2002; Courtois & Gold, 2009; Cook et al., 2011). A survivor of a traumatic event will often present long-term emotional distress with profound feelings of anxiety disrupting the ability to engage in life. The human response to trauma can be catastrophic as survivor clients typically perceive that they no longer have control of their lives which

may have been severely destroyed or damaged by their experience making effective trauma-focused therapy essential to the healing process (Briere & Scott, 2006; Lazarus, 2007).

Empathic engagement with clients is a critical feature in the restorative process of trauma work. Lambert and Barley (2001) suggested that effective treatment outcomes can be attributed to therapists' empathic understanding, affirmation of the client, the ability to engage the client, and communicating personal comprehension of the client's experience with non-evaluative caring and respect. The ability of a therapist to relate to a survivor client is vitally important to the treatment process of reducing client suffering as well as promoting a client's growth (Bruce, Manber, Shapiro, & Constantino, 2010). As an essential feature of the psychotherapeutic process, empathy is a fundamental asset that fosters the survivor client's healing throughout the therapeutic relationship. Clark (2010) found that within an empathic context, counseling interventions such as confrontation, cognitive restructuring, reframing, and the potential to influence new client perspectives contributes to the quality of the therapeutic process. Empathy has also been noted to be a prominent feature in prompting positive treatment outcomes (Clark, 2010). As a major resource for the therapeutic process, Figley (1995) further noted that empathy enables therapists to recognize and understand the experience of their traumatized clients; thus, fostering problem identification and the formulation of useful treatment approaches. The act of being fully present through empathic involvement with survivor clients may perhaps lead to an over-identification and adverse emotional consequences for therapists.

Sexton (1999) posited that the therapeutic relationship includes empathic engagement with a client as a means of providing effective psychotherapeutic interventions; however, this process places a therapist at risk for the detrimental effects of vicarious trauma including compromised empathic abilities, difficulty in maintaining a therapeutic stance, and disrupted establishment of boundaries. In some instances, therapists' personal trauma history, meaning of traumatic events, interpersonal style, and current stressors and support can contribute to a negative clinical response; thus, placing the client and themselves in jeopardy (Palm et al., 2004; Pearlman & Mac Ian, 1995). Admittedly, the development of a strong therapeutic alliance, including therapists' self-awareness and empathic responsiveness, is essential to affect successful treatment outcomes; however, it becomes challenging when working with difficult populations. Figley (1995) argued that therapists' efforts to empathize encourage an understanding of clients' trauma experience yet, in the process of therapeutic intervention therapists may be traumatized as well.

Countertransference

The likelihood of countertransference also plays a role in therapists' emotional responses to specific trauma experiences introduced by clients in the therapeutic relationship. Countertransference as an unconscious displacement of therapists' emotional reactions toward their clients is typically triggered by a present clinical interaction within the therapeutic relationship. Although countertransference was originally thought to compromise the therapeutic process, the recent literature considers it to be potentially useful in that therapists' self-awareness of their internal reactions

encourages increased self-understanding, empathy toward clients, greater working alliance and trust, and attention to psychological health (Hayes et al., 2011; Nutt Williams & Fauth, 2005; Yeh & Hayes, 2011). Pearlman and Saakvine (1995) argued that therapists' powerful feelings and internal processes elicited through countertransference are critical components of the treatment.

Although countertransference and vicarious traumatization generate feelings and experiences on the part of the therapist, they each offer distinct interpretations of the therapist's experiences. According to McCann and Pearlman (1990), the phenomenon of vicarious trauma cannot be easily explained by the hindrance of countertransference or simply job demands leading to burnout. Hayes et al. (2011) posited that countertransference can be described as therapists' reactions to unresolved conflicts triggered by a client and manifested during a therapeutic session while occupational stress leading to burnout has been found to be organizationally related (Meadors, Lamson, Swanson, White, & Sira, 2010). Countertransference identifies the therapist reaction to the client during the treatment process whereas; vicarious trauma is the result of a therapist ongoing trauma work with a variety of clients. Therefore, vicarious trauma is considered to be the cumulative effect of working with trauma populations and its pervasive impact on the self of the therapist (Pearlman & Saakvitne, 1995) and not a short term response within the context of a therapy session (Harrison & Westwood, 2009), or specific to one particular client or therapeutic relationship as indicated with countertransference.

Professional Burnout

The psychological demands and workplace expectations placed on therapists may result in acute emotional disturbances and emotional exhaustion leading to a state of professional burnout. Prolonged exposure to the stress coupled with clinical work and challenging client populations can be exhausting both emotionally and physically. Instances of sleeplessness, irritability, general anxiety, depression, guilt, and a sense of hopelessness can be attributed to emotional exhaustion (Kahill, 1988). The inability to cope with the challenges of job and organizational responsibilities while engaging in the practice of service delivery can potentially lead to feelings of discouragement and ineffectiveness.

Professional burnout within therapeutic practices has been widely examined in the literature. Burnout has been defined as a psychological syndrome complicated from extended response to stressors within the workplace; thus, resulting from the chronic strain associated from an incongruence between the worker and the organization (Maslach, 2003; Maslach, Schaufeli, & Leiter, 2001; Newell & MacNell, 2010). The interplay between a therapist's response to stress within the context of their work responsibilities and the organizational culture of their employment may compromise their ability to effectively engage in their work with clients. According to Maslach (2003) the interpersonal framework of burnout focuses on worker's emotions including distancing oneself from aspects of the job which in turn may lead to a high level of cynicism and dysfunctional or negative consequences for clients and/or colleagues. The gradual

evolution of negative feelings associated with burnout includes feelings of hopelessness, challenges in coping with work or completing a job effectively (Stamm, 2005).

Although parallels can be also be drawn between vicarious trauma and burnout, the essential feature of burnout is the emotional exhaustion resulting from the stress of interpersonal contact and organizational demands experienced by professionals in the human services industry (Maslach, 2003; Maslach et al., 2001; Newell & MacNell, 2010). The progression of burnout can be attributed to a number of factors that ultimately lead to a diminished ability to cope with work related stressors. The interrelationship between the individual, the population served, and the organization can contribute to the cumulative effect of burnout resulting in emotional exhaustion, depersonalization, and a lowered sense of personal accomplishment. (Maslach, 2003; Maslach & Jackson, 1985). Professional burnout therefore, develops over time and can be the result of difficult working conditions. The difference between vicarious trauma and burnout is evident as incidents of burnout are attributed to the circumstances encountered within the working environment; whereas, vicarious trauma results in cognitive shifts and reactions of trauma therapists (Laidig Brady et al., 1999; McCann & Pearlman, 1990). As with the occurrence of countertransference, therapists who experience symptoms of burnout may treat clients with a variety of clinical diagnostic categories while, vicarious traumatization is the direct result of trauma work. McCann and Pearlman (1990) posited that vicarious trauma sequele is specific to the ongoing exposure of disturbing images and suffering as described by traumatized clients.

Posttraumatic Stress Disorder (PTSD)

Instances of individual exposure to catastrophic life events or personal involvement in stressful life circumstances that is beyond normal human experience is an indisputable fact. Green, Wilson, and Lindy (1985) suggested that throughout history people have experienced wars, earthquakes, tornadoes, floods, and devastating accidents, along with other comparable critical life incidents which profoundly impact the lives of the average person. Interest in individual reactions to traumatic experiences and the short and long term emotional consequences following crisis events emerged in response to the increased societal awareness to the effects of war, hostage taking, domestic violence, natural disasters, accidents, and loss through death (Figley, 1995). The Korean and later the Vietnam Wars encouraged further attention of the American public and professionals to the problems presented by returning soldiers who appeared to be emotionally and behaviorally compromised (Figley, 1995; Trimble, 1985). Efforts to capture the emotional distress associated with individual traumatic life events and to designate specific behavioral features observed in survivors has produced a variety of constructs. Trimble (1985) identified concepts such as posttraumatic neurosis, compensation neurosis, hysteria, shell shock, survivor syndrome, and nervous shock to describe survivor responses to number of historical traumatic events.

The conceptualization of trauma as a diagnostic category of posttraumatic stress disorder (PTSD) was first introduced in the American Psychiatric Association DSM-III of 1980 defining the symptoms commonly experienced following exposure to an event that was catastrophic; thus, encouraging an accurate assessment and identification of a

psychiatric diagnosis of trauma survivors. According to Friedman (2007) the initial formulation of PTSD within the DSM-III characterized a traumatic event as a catastrophic stressor that was beyond the scope of usual human experience such as war, torture, rape, human made, and natural disasters. However, PTSD as documented in the DSM-III of 1980 was limited to direct exposure to a trauma without consideration to the secondary or indirect effects of trauma (Figley, 1995; Harrison & Westwood, 2009). To address this limitation the DSM –IV of 1994 expanded upon this initial description of PTSD to include traumatic events that were learned indirectly or secondarily. The DSM-IV-TR (2000) included diagnostic features and criterion for PTSD that includes indirect or secondary exposure to a traumatic event.

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

In 2013, the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) developed criteria that included repeated and extreme indirect exposure to aversive details of event(s) usually in the course of professional duties. The criterion for PTSD as indicated in the DSM-5 (2013) included the following conditions:

direct exposure; witnessing an event; indirectly learning about an event; repeated exposure via professional duties; avoidance; negative alterations in cognitions and mood; alterations in arousal and reactivity; duration; and functional significance. Since the introduction of PTSD as a psychiatric disorder, the presentation of symptoms associated with direct, indirect, and repeated and extreme indirect exposure in the course of professional responsibilities were validated; thereby, fostering the conceptual framework for vicarious trauma, secondary trauma, and compassion fatigue.

Vicarious Trauma, Secondary Traumatic Stress, and Compassion Fatigue

Boscarino et al. (2010) suggested that the emergence of constructs to describe the impact of secondary exposure to client narratives within the practice of trauma work appeared when therapists discovered occupational hazards of experiencing the effects of their clients' trauma vicariously. Accordingly, attention to the residual impact of the therapeutic relationship on the helping professional began to surface through the early research of Figley, (1995); Figley,(2002); Joinson, (1992) ; Pearlman, (1998); Pearlman & Mac Ian, (1995); Pearlman & Saakvitne, (1995), Sexton (1999) which examined the adverse effects placed on the therapist as a consequence of empathic engagement with clients' trauma material. Trauma work, therefore, may result in cumulative, transformative, and deleterious effects as well as cognitive shifts and reactions (Pearlman & Saakvitne, 1995); states of tension and preoccupation with traumatized clients; persistent arousal associated with clients; and numbing and avoidance of clients (Figley, 1995; Figley, 2002). These researchers concluded that the potential for a therapeutic impasse as well as the detrimental risk of disconnection, failure, and harm to clients may

be a likely outcome of therapists' secondary stress. According to Adams et al. (2006), therapists often re-experience clients' traumatic event with subsequent effects of emotional exhaustion, desire to avoid clients and reminders of the expressed event, and persistent arousal due to the intimate knowledge about a traumatic experience. Therapists may also experience physical, emotional, and cognitive symptoms similar to their traumatized clients as contended by Harrison and Westwood (2009).

The establishment and cultivation of a framework to describe the effect of trauma work on therapists was introduced in the literature through the examination of countertransference and burnout (Maslach & Jackson, 1985). These concepts provided a basis to explore vicarious trauma and related constructs including compassion fatigue (Joinson, 1992; Figley, 1995) and secondary traumatic stress (Figley, 1995). These secondary trauma-related constructs significantly encouraged further attention and research surrounding therapists' emotional well-being in recent years, even though the concept of burnout offers more sophisticated and healthy empirical validation (Devilly et al., 2009).

The literature has noted similarities among these concepts as well as distinct features to describe the characteristics of each. Although there is an apparent overlap among the theoretical constructs of empathic stress, countertransference, secondary traumatic stress, compassion fatigue, burnout, and vicarious trauma, Sexton (1999) suggested that there are notable differences. Jenkins and Baird (2002) attempted to compare and differentiate secondary trauma stress and vicarious trauma reporting both constructs stem from work with trauma clients and include similar PTSD like symptoms;

however, differ in regard to observed symptomatology and observable reactions associated with secondary traumatic stress verses the theoretical underpinnings and covert changes in thinking as reflected in vicarious trauma.

Newell and MacNeil (2010) suggested that the defining features of vicarious trauma, secondary stress, and compassion fatigue are similar; nevertheless, the distinction between each include cognitive change processes as conceptualized by vicarious trauma verses the outward behavioral symptoms emphasized by secondary traumatic stress and the all-embracing experience of emotional and physical fatigue associated with compassion fatigue. However, distinguishing between each concept remains a challenge in the current research. Baird and Kracen (2006) concluded that a lack of clarity remains in the literature on vicarious trauma and secondary stress indicating that further research is necessary to provide clarification. Devilly et al. (2008) noted that the distinction between secondary traumatic stress and compassion fatigue is unclear although compassion fatigue has been more so considered a form of caregiver burnout. Boscarino et al. (2010) further argued that vicarious trauma, secondary traumatic stress, and compassion fatigue are all concepts variously used in the research resulting from the lack of conceptual clarity in defining the adverse consequences of treating traumatized clients.

Consequently, vicarious trauma, secondary traumatic stress, and compassion fatigue are all frameworks that have been utilized interchangeably to describe the impact on therapists who work specifically with traumatized populations. As noted by Craig and Sprang (2010) definitive data has not been established that proposes a conceptual distinction between these frameworks which suggests, the most suitable term to use in

any given situation would be premature. Although the literature has not clearly delineated between the constructs of secondary traumatic stress, compassion fatigue, and vicarious trauma, I will discuss the theoretical frame work for each.

Secondary Traumatic Stress

Secondary traumatic stress can be described as therapists' natural and consequential emotions and behaviors that emerge in response to knowing about a client's traumatic event as well as the stress associated with helping or wanting to help a traumatized person (Figley, 1995, Figley, 2002). Exposure to traumatic events either directly or indirectly can contribute to symptoms identical to PTSD including characteristic indicators such as intrusion, avoidance, and arousal; therefore, Figley (1990) proposed that secondary traumatic stress defined symptoms reflect this similarity though specific to individuals who care for traumatized clients.

Therapists who work with victims of rape may experience symptoms of physical and emotional arousal or detachment from clients and/or primary relationships whereas, those who work with survivors of natural disasters or military combat may endure intrusion of thought similar to the pain and emotional suffering discussed by their clients. Dutton and Rubinstein (1995) discussed categories of secondary traumatic stress reaction including symptoms of psychological distress or dysfunction, cognitive shifts, and relational disturbances to describe secondary exposure to clients' trauma material reflecting the features of PTSD. Secondary traumatic stress therefore, can be considered a symptom based diagnosis (Figley, 2002) unlike vicarious trauma which recognizes the role of meaning and adaptation (Pearlman & Saakvitne, 1995) more so than symptoms.

Secondary traumatic stress may be experienced by helping professionals who empathically respond to and engage with survivor clients. Therapists' indirect exposure to traumatized clients can potentially result in both physical and emotional stress reactions that parallel those of their clients. The distinguishing features of secondary traumatic stress include secondary exposure to other's traumatic event while performing a job with a rapid onset of symptoms associated with a particular event (Stamm, 2005). The act of empathic connection to a survivor client's emotional reaction to a shocking and horrifying event relayed within the therapeutic relationship can therefore result in the therapist experiencing symptoms analogous to post trauma stress expressed by their clients.

Bride (2007) argued that human service professionals who provide direct services are highly likely to be secondarily exposed to trauma material and are also likely to experience some symptoms of secondary trauma stress. Meadors et al. (2010) noted that professionals who treat traumatized populations will likely struggle with secondary traumatic stress at various times in their career. Within the professional work context, service provision to survivor clients can be especially challenging placing the therapist at risk on a variety of fronts. Secondary traumatic stress experienced by human service professionals may adversely affect their ability to effectively provide services, sustain positive personal and professional relationships (Meadors et al., 2010), and is considered to be one of the many viable reasons for leaving the field prematurely (Beaton & Murphy, 1995; Bride, 2007; Figley1995). Ignoring the signs of secondary traumatic stress can result in "short-term and long-term emotional and physical disorders, strains on

interpersonal relationships, substance abuse, burnout, and shortened careers" (Beaton & Murphy, 1995, p. 52).

Compassion Fatigue

Compassion fatigue was a model used by Joinson (1992) to describe the feelings of stress and fatigue as a contributing factor of burnout among individuals in the nursing profession. The practice of caring for patients with multiple medical issues, providing palliative care for individuals diagnosed with terminal conditions, or responding to those in medical emergencies may potentially result in a profound sense of exhaustion. Emotional manifestations of compassion fatigue may include anger, ineffectiveness, apathy, and depression which are unique among people in care giving professions with nurses being especially susceptible (Joinson, 1992). According to Rutledge, Stucky, Dollarhide, Shively, Jain, Wolfson, Weinger, and Dresselhaus (2009) nurses as well as physicians experience burnout, depression, job dissatisfaction, and workplace fatigue resulting from the long work days, high caseloads, time pressures, poor sleep habits, and high performance expectations.

Figley (1995) expanded upon the concept of compassion fatigue to include trauma therapists suggesting that providing therapy to clients who experienced a traumatic event within the context of formal care giving can be emotionally challenging. Compassion fatigue as noted by Figley (2004) is considered a more user friendly term for secondary traumatic stress disorder. Both Figley (1995, 2003) and Stramm (1995) considered compassion fatigue and secondary traumatic stress most similar in meaning and often used interchangeably. Vicarious trauma is also closely associated with compassion

fatigue with both identifying changes in cognitive and emotional well-being as well as sense of meaning, safety, spiritual needs, and feelings of trust (Naturale, 2007; Pearlman, 1998; Pearlman & Mac Ian, 1995; McCann& Pearlman, 1990).

Figley (1995) argued that compassion fatigue encompasses a number of stress reactions including cognitive, emotional, physical, and spiritual disturbances as a byproduct of therapeutic engagement with traumatized clients. Similar to vicarious trauma and secondary traumatic stress, a client's vivid and detailed presentation of traumatic event and the necessary confidentiality within the therapeutic relationship may leave a therapist feeling isolated, angry, and frustrated about how and why incidence of trauma and brutality occur; thus, contributing to compassion fatigue. The cumulative effect of compassion fatigue may result in therapists becoming emotionally hardened to clients' traumatic experiences lessening its effect on them and resulting in losing the ability to balance objectivity and empathy (Figley, 2002). Figley (2002) further suggested that the best therapists may become the most likely victims of compassion fatigue.

Vicarious Trauma

Vicarious trauma can be considered a disruption in a therapist's life experience associated with their role as a secondary witness to their clients' trauma narrative. Specifically, individual self-identity, ideals, and strongly held beliefs may be compromised when remaining empathically available to survivor clients over time; thus, changing one's perceptions of the world, personal relationships, as well as potentially disturbing a therapist's emotional and spiritual well-being. McCann and Pearlman (1990)

defined vicarious trauma as a negative transformation within a therapist's inner experience through the process of empathic engagement with a client's trauma material.

The process of vicarious traumatization and its impact is unique for each therapist contingent upon one's personality, defense style, and resources (Pearlman & Saavitne, 1995). Pearlman and Saakvitne (1995) noted that vicarious trauma "includes significant disruptions in one's sense of meaning, connection, identity, and world view, as well as in one's tolerance, psychological needs, beliefs about self and others, interpersonal relationships, and sensory memory, including imagery" (p. 151). Vicarious traumatization can; therefore, substantially harm the professional therapist and adversely influence delivery of care to clients. Pearlman and Saakvitne (1995) posited that the impact of vicarious traumatization on a helping professional resemble those of traumatic experiences; hence, enhancing an awareness of the potential harm in one's personal life and adversely affecting the therapeutic relationship if not addressed.

According McCann and Pearlman (1990), vicarious trauma emphasizes the changes in therapists' cognitive schema, belief systems, and personality as a consequence of their indirect exposure to a client's traumatic material with manifestations of disruptive symptoms including intrusive imagery and painful affect. Symptoms associated with vicarious trauma as contended by Bober et al. (2006) include "intrusive imagery, nightmares, fears for safety of oneself and loved ones, avoidance of violent stimuli in the media and emotional numbing" (p. 72). Empathically engaging with survivor clients' experiences can significantly transform therapists' perceptions of self, the world, psychological needs, beliefs, and memory systems that are pervasive, cumulative, and

permanent (McCann & Pearlman, 1990). For instance, feelings of personal vulnerability when walking alone at night, anxiety when driving on a busy highway, or parental hyper vigilance and perceived loss of safety within your home and community may be ongoing themes experienced by therapists who work with survivor clients.

Therapists who work with victims of sexual abuse is another example of one's potential vulnerability to vicarious trauma as exposure to graphic accounts of abuse within the therapeutic relationship fosters the realities of intentional cruelty and interpersonal violence (Pearlman & Saakvitne, 1995). Baird and Kracen (2006) suggested that vicarious trauma may be viewed as a normal reaction to continuous challenges to a therapist's values, convictions, and principles however; it can also result in harming the professional self by interfering with the motivation, efficacy, and empathy necessary in trauma work. Therapists often work in isolation which furthers their risk of vicarious traumatization (Pearlman & Saakvitne, 1995). Disregarding the impact of vicarious trauma may result in significant disruptions in beliefs of self and others, and distressing psychological and physical symptoms (Pearlman & Mac Ian, 1995), emotional and physical depletion, sense of hopelessness, shift in world view including suspicion and cynicism (Bober et al., 2006), as well as a therapist leaving their professional work (Pearlman & Saavitne, 1995).

In an effort to better appreciate the impact of traumatic life events on the survivor client and its secondary vicarious affect on the treating therapist, McCann and Pearlman (1990) and Pearlman and Saakvitne (1995) developed the CSDT. CSDT integrates personality theory and the clinical psychological complexity of psycho analysis theory

with the clarity and contextual emphasis of social learning, developmental, and cognitive theories (Pearlman & Saakvitne, 1995). The combination of stated theories fostered the idea that people individually interpret their trauma experience and all related circumstances associated with an event. As such, further understanding of the survivor client within their own developmental, social, and cultural context is established offering a psychological, interpersonal and transpersonal examination of traumatic life events on the adult survivor (Pearlman & Saakvitne, 1995).

The clinical implication of the constructivist model as presented by Pearlman and Saakvitne (1995) is that the survivor client constructs and interprets their individual trauma; thereby, defining the meaning of their experience. The secondary impact of a survivor client's narrative on the therapist is also a consideration. Pearlman and Saakvitne (1995) proposed that the CSDT also provides a useful framework for understanding the impact of vicarious trauma on the therapists. Therapists' individual responses to trauma disclosures offered within treatment can be as disruptive to therapists' cognitive schemas including personal beliefs, expectations, and assumptions as it is for client survivors. According to McCann and Pearlman (1990) disruptions in therapists' schema about self and their world may produce changes that are subtle or shocking depending upon the level of differences between client's trauma experiences and the therapist's existing schemas.

Coping and Self-care Practices

Saakvitne and Pearlman (1996) argued that vicarious trauma may also encourage opportunities for personal and spiritual growth, lowering the deleterious effects of

working with survivor clients and enhancing therapist's psychological needs. Integrating adaptive coping strategies and self-care practices may positively transform the negative feelings associated with vicarious trauma creating balance, healthy life style choices, appropriate boundaries, and meaningful connection to self and others. Recognizing the cumulative effect of vicarious trauma may potentially challenge therapists' who work with survivor clients disrupting their efforts to incorporate healthy practices. Examining the balance of psychological needs and means to maintain a sense of well-being may further the personal and professional growth of therapists.

It is evident that the literature has explored the adverse effects of working with traumatized populations; thus, defining and establishing constructs such as vicarious trauma, compassion fatigue, and secondary stress (Bride, 2004; Joinson, 1992; Figley, 1995; Figley, 2002; Pearlman & Mac Ian, 1995; Pearlman & Saakvitne, 1995; Sommer, 2008; VanDeusen & Way, 2006). It is; however, essential to appreciate therapists' ability to develop effective coping styles and self-care practices that allow them to withstand the burdens often associated with their work. Harrison and Westwood (2009) argued that the challenge to effectively cope with the stress of work and to sufficiently balance professional and personal aspects of life may lead to therapists abandoning their field of practice; thereby, resulting in an immense loss of resources and potential. Briere and Scott (2007) further contended that therapists are often exposed to the pain and suffering revealed in the therapeutic process as they observe the worst humans can do to each other; thus, making their work vicariously traumatic.

Sommer (2008) suggested that educators in counseling have an ethical obligation to inform counselors and supervisors of the effects of vicarious trauma as a means of detecting and preparing them for the potential negative effects on service delivery and their well-being. Research to explore and identify practices that foster work satisfaction and encourage the professional and personal well-being of established and new therapists, as well as students is beginning to emerge (Harrison & Westwood, 2009; Myers, Sweeney, Popick, Wesley, Bordfeld, & Fingerhut, 2012; Patsiopoulos & Buchanan, 2011; Webb, 2011). Myers et al. (2012) concluded that self-care practices were significantly related to perceived stress among a national sample of psychology graduate students with specific practices such as sleep, hygiene and social support contributing to the variance in perceived stress. The integration of self-compassion as a means of self-care within the practice of psychotherapy as suggested by Patsiopoulos and Buchanan (2011) fostered skillful management of the effects of occupational stress and challenges as well as encourages individual well-being and an increased ability to identify and approach signs of depletion and ethical dilemmas. The process of effectively managing work related stressors leading to vicarious stress reflects one's ability to individually cope and to integrate and manage self-care practices. Therefore, it is necessary to fundamentally understand the effects of stress and the ability to recognize and cope with the potential strain and disruption of stress.

Stress and Coping

Examination into the effect of stress on the human condition was initially introduced through the work of Cannon (1932) who defined the concept of homeostasis,

suggesting that internal physiological and emotional processes work in a coordinated effort to maintain a balanced state when subjected to high degrees of stress. Therefore, emotional and physiological responses synchronously react to stress. Based on Cannon's early research, theorists furthered the concept of stress capturing the zeitgeist of post-World War I and II.

Medical research, specifically the harmful impact of excessive stress on physical functioning (Selye, 1953) encouraged further study into the adverse effects of extremely traumatic events concluding that trauma may be a leading cause of emotional distress. Emerging interest in the psychological study of stress and the means by which people cope with its impact responded to the political and social climate of the world conflicts in the 20th century. Lazarus (1999) and Lazarus (2007) argued that the question of stress and its impact on the well-being and performance of soldiers during and following the world wars; technological advances in warfare that terrorized civilian populations making everyone a potential victim to war; as well as an acute awareness that stress was evident both in war and peace time are the most likely impetus for the exploration and growth of stress as of major importance to scholars and professional workers.

According to Cooper and Dewe (2007) the concept of stress was legitimized and established within the discipline of psychology by the end of the 1950s and the early 1960s. The analysis of stress specifically, the physiological, cognitive, and behavioral impact as well as the manner in which individuals engage in coping and adaptation became a growing interest in the field of psychology and health care to address stress related conditions. The human response to acute and chronic stress and its influence upon

physical and emotional adaptations and the potential to be a compromising factor on health care also contributed to the ongoing examination of stress within the mental and medical health models.

Miller, Cohen, and Ritchey (2002) argued that psychological stress has been linked with a considerable number of adverse health conditions. However, acute stress within a limited time frame may be beneficial as a natural physiological response to environmental conditions that enhance survival and adaptation to inherent risks such as a potential injury. On the other hand, chronic stress as a pervasive force in a person's life can result in significant instability especially if the individual is unable to determine if and when a stressor will decrease or cease to exist. Segerstrom and Miller (2004) posited that a feature of chronic stress is the uncertainty of knowing whether or when a life challenge will end or ever end. Although acute stress within a narrow time frame may be beneficial, stressors in our modern world are considerably different resulting in chronic stress.

Theories of stress and coping originated and presented by Selye and Lazarus attempted to conceptualize and define the impact of stress on the human condition. Selye (1953) approach examined the biological reaction to stress as described in the general adaptation syndrome including the alarm response and the stages of resistance and exhaustion. This stimulus response point of view defined external stressors as the catalyst that produces a physiological reaction therefore; the biological response to an environmental stressor is the critical factor in the interpretation of stress (Selye, 1953) and not a reciprocal relationship between perception and reaction. This particular theory

did not however; include the psychosocial and cognitive aspects of stress. Lazarus (2007) proposed that coping is essential to the emotional process and emotional life as it is a significant feature of stress and individual emotional reactions. The stress and coping theory established by Lazarus suggested that stress compromises three processes including cognitive appraisals (primary and secondary) identified as critical mediators by which an individual evaluates their interaction with their environment as being relevant to their well–being and coping (Folkman, Lazarus, Dunkel-Schetter, DeLongis, & Gruen, 1986; Folkman, Lazarus, Gruen, & DeLongis, 1986).

In primary appraisal an assessment of whether there is a potential risk of harm or benefit and relevance to one's self esteem is entertained in their interactions with the environment and secondary appraisal is concerned with one's ability to overcome or address potential risks or action taken as to enhance outcomes (Folkman, Lazarus, Dunkel-Schetter et al. 1986; Folkman, Lazarus, Gruen et al., 1986). The interaction between persons and their environments are appraised with each encounter allowing the demands to be managed both cognitively and behaviorally through the coping process. According to Folkman, Lazarus et al. (1986) individual ability to manage the demands of a stressful encounter whether or not successful constitutes the defining feature of coping. Carver, Sheier, and Weintraub (1989) contended that coping is the process of executing a response to the primary appraisal of perceived threat as it converges with the secondary appraisal of evaluating potential harm, risks, or benefits of a presented stress.

The major functions of coping include problem-focused coping and emotion-focused coping (Folkman et al., 1986). Problem-focused coping utilizes self-directive

action and deliberate efforts to problem solve as a means to change a given situation whereas; emotion-focused coping in terms of problem resolution includes distancing, self-control, identifying social support and responsibility, and avoidance (Folkman, et al., 1986; Heppner, Cook, Wright, & Johnson, 1995). Folkman et al. (1986) further defined coping as cognitive and behavioral efforts to manage the internal and external demands that may be taxing or burdensome beyond individual capacity within the person-environment transaction. According to Lazarus (1991) cognitive activity acts as a guide enabling individuals to grasp the significance of what is happening when adapting to encounters with the environment; thus, allowing us to choose among alternative values and courses of action. The way a person believes and understands the world around them in general and within a specific context is attributed to knowledge; whereas, appraisal is the evaluation of the significance of knowledge of what is happening within a given encounter that will impact one's personal well-being (Lazarus, 1991). Therefore, individual stressors are relational and mutually interdependent between persons and their environments.

Selye and Lazarus's theories of stress differed in that Selye viewed stress as a reaction to a stimulus; whereas, Lazarus viewed cognition and coping as key elements in a reciprocal relationship. However, these theories of stress and the stress response incorporated internal and external factors in relation to a stress response and the strategies to adapt to cognitive, behavioral, and biological changes. Each describes the challenge of adapting to stressors especially when presented with an overabundance of stress thus, providing the groundwork to study the impact of stress and the self-care practices utilized

in the coping process. Lazarus (2007) suggested that ineffective coping results in increased stress; whereas, effective coping leads to decreased stress with individuals who effectively cope extending themselves more which in turn potentially creates additional stress.

The recent literature on resilience and positive adaptation to stress has provided additional evidence into the variability of emotional responses to trauma (Benight, 2012; Bonanno, Papa, Lalande, Westphal, & Coifman, 2004; Bonanno & Mancini, 2012; Fredrickson, Tugade, Waugh, & Larkin, 2003; & Waugh, Thompson, & Gotlib, 2011) suggesting that extremely adverse experiences may not result in psychopathology. Resilience and states of positive emotion refers to the ability to cope with traumatic and/or stressful events with the capacity to positively adapt (Fredrickson et al., 2003) promoting the expectation that the outcome of a given situation will yield consistent positive results that guide stressful encounters and tendencies toward resolution.

Fredrickson et al. (2003) contended that positive emotions accompanies cognitive broadening which improves and expands the way people cope with adversity; thus, increasing the odds the people will be optimistic about the future. Bonanno and Mancini (2012) argued that individuals exposed to highly disruptive life experiences may be able to maintain emotional stability, healthy degree of psychological and physical functioning, as well as the potential for developing a positive response to the traumatic event. Emotional flexibility including the capacity to both express and suppress emotion has also been linked to successful adaptation to life changing circumstances (Bonanno et al., 2004). Fredrickson et al. (2003) and Waugh et al. (2011) concluded that psychological

flexibility, life satisfaction, positive affectivity, optimism, and the ability to find meaning in crisis are common traits in the resilience of individual adaptation to ever-changing life circumstances.

Individual ability to cultivate a sense of hope and optimism may be influenced by a number of factors. One's perception of self and their relationship with their world can be attributed to their personality styles, learned behavior, and their social environment. The manner in which people respond to life events may have a long term impact on their emotional well-being and physical health. Peterson, Seligman, and Vaillant (1988) suggested that individuals who explain the circumstances of their life as related to stable, global, and internal causes in young adulthood are more likely to be at risk for poor health later in life. Resilience and optimism therefore, may be a benefit as one engages in the processes of their lives. A proposed benefit of optimism is a positive well-being and emotional stability, consistent and effective problem solving, successful academic and occupational achievements, and good health whereas pessimism potentially foreshadows depression, failure, positivity, social isolation, and poor health (Peterson, 2000).

The research on stress and coping has offered greater understanding of the commonality and uniqueness of human responses to adversity. Although there is substantial literature promoting nomothetic perspectives that dictate causal factors of stress and adaptation that can be generalized to the greater population, there is also an abundance of research that lends itself to the individuation of human nature with each person retaining characteristics that may enhance or discourage coping strategies. From a clinical point of view, therapists strive to understand their clients' responses to trauma

with the goal of encouraging diverse coping strategies that meet the stressful demands of the event. In turn, this will lead to adaptive functioning within the social and cultural context of their clients' environment.

In order to foster successful progression, therapists must also consider relational issues that encourage support and empathic connection. Briere and Scott (2006) suggested that when a client is feeling respect, caring, and empathy from a therapist during a traumatic disclosure, they are better able to re-engage in positive relational feelings integral to the resolution of major traumas. While clients may demonstrate similarities in their reaction to trauma, they may also have a personal frame of reference creating individual meaning of their experience. As clients' response to trauma may be unique, we must consider the individualization of the therapist in response to a client's narrative of adversity.

Self-Care Practices

There is an emerging interest in the literature in identifying a need for enhancing professional and personal resources for practicing therapists and incorporating effective self-care practice (Bober & Regehr, 2006; Harrison & Westwood, 2009; Williams et al., 2012). Recognizing the risk of vicarious trauma and individual means of adaptive coping may foster an integration of self-care practices that encourage professional and personal growth; thus, improving services for survivor clients. As each survivor clients' response to a traumatic event is individualized, so will the response of the therapist to a client's account of their personal trauma experience (Saakvitne et al. 1998).

The effectiveness of the treatment process depends to a large extent on how the therapist is able to engage in their own process of integrating and transforming the traumatic experiences relayed by the client (Harrison & Westwood, 2009). Developing a sense of awareness and incorporating effective coping strategies and self-care practices to manage the diverse impact of vicarious trauma is therefore, essential. Williams et al. (2012) suggested that therapists should develop a plan to engage in regular wellness activities; thereby, diminishing cognitive distortions associated with vicarious trauma and decreasing individual vulnerability.

According to Figley (2005) personal, professional, and organizational interventions are necessary when addressing vicarious trauma. Coping skills and self-care practices may include identifying disrupted cognitive schema as an avenue toward change; maintaining a balance between work, play, and rest to encourage healthy functioning; seeking healing activities and connecting to spiritual needs (Figley, 2005). Restorative opportunities that enhance the value of trauma work and that focus on professional growth are essential for self-care practices as well as effective supervision and maintaining professional connections; thus, avoiding isolation (Figley, 2005; McCann & Pearlman, 1990). Williams et al. (2012) argued that a strong supervisory working alliance may potentially decrease therapists' risk of vicarious trauma as well as provide a safe environment in which therapists can explore their personal reactions to clients' trauma material.

Organizational strategies to address vicarious trauma may include attention to one's physical setting that encourages a comfortable and relaxed work atmosphere that

promotes self-care. Continuing educational opportunities and regular in-service training can provide an increased understanding of the impact of vicarious trauma, thereby, encouraging a sense of self-awareness and attention to potential risk factors (Harrison & Westwood, 2009). Integrating learned strategies may, therefore, diminish potential risks and symptoms of vicarious trauma and enhance therapeutic services to survivor clients. Encouraging healthy behaviors and choices through exercise and nutritional counseling within the organizational structure offers employees greater access to self-care practices.

Introducing the hazards of vicarious trauma for students pursuing a career in psychology as well as therapists specifically interested in trauma work by including the potential risks in the academic curriculum or in training opportunities may assist in the development of effective self-care practices (Sommers, 2008; Williams, 2012). Providing strategies that promote self-care and awareness of the effects of vicarious trauma are also useful preventative measures (Adams & Riggs, 2008). Bober and Regehr (2006) concluded that potential solutions to developing effective self-care may be more structural than individual in that, organizations should also consider case load and work conditions in addition to individual strategies.

Summary

The literature has introduced the impact of vicarious trauma and continues to propose useful practices that may enhance therapists' ability to successfully cope with the residual stress of their work. The research on stress and coping has a long-standing presence in the literature defining the physical, psychological, behavioral, and cognitive effect of stress and various reactions and adaptations that contribute to coping. Although

vicarious trauma has been described as a stress reaction to secondary traumatic experiences, there is limited research on how coping skills and self-care practices affect the personal and professional lives trauma therapists.

The empirical research on therapists' use of coping skills and self-care practices to reduce the risk of vicarious trauma is beginning to emerge with most research anecdotal in nature. The objective of this study is to assess whether coping skills including the therapists' beliefs that coping strategies will lead to lower levels of vicarious trauma and the amount of time spent engaging in self-care practices moderate the experience of vicarious trauma on therapists' fulfillment of psychological needs specifically, trust/dependence and control. Awareness of the risk of vicarious trauma and the significance of coping strategies and self-care will further enhance therapeutic effectiveness and productivity within an organizational structure which in turn will contribute to positive social change.

In Chapter 3, research design, methodology, and instrumentation are described. Further examination of the specific scales, administration of instruments, data collection, and processes for analyzing and presenting data for this study will be presented.

Chapter 3 - Research Method

Over the past several decades, there has been a growing interest in the phenomenon of vicarious trauma as experienced by therapists who treat survivors of trauma. McCann and Pearlman (1990) and Pearlman and Saavitne (1995) suggested that therapists who work with trauma survivors may experience disturbance in their sense of self and worldview resulting from emphatic engagement with clients' trauma material. Based on the CSDT, Pearlman and Saavitne established the foundation for understanding the phenomenon of vicarious trauma through their research, personal experiences in trauma work, and extensive interviews with professionals who work with clients. The need to incorporate effective coping skills and self-care practices that address vicarious trauma, thereby fostering personal and professional growth for trauma therapists continue to be examined in the literature (Harrison & Westwood, 2009; Newell & MacNeil, 2010; Wise, Hersh, and Gibson, 2012).

The purpose of this quantitative, correlational study was to examine how coping skills moderate the relationship between vicarious trauma on the potential disruption in the fulfillment of psychological needs of trust/dependence and control in a sample of therapists who treat trauma survivors. An analysis of the moderation effect of coping skills (measured by the CSI) (Bober et al., 2006; Regehr, 2006) in the relationship between therapists vicarious trauma and disruption to the fulfillment of their psychological needs for trust/dependence, and control (measured by TABS) (Pearlman, 2003) was completed.

In this chapter the research design and rationale for this study are identified. Variables are outlined and examined. The target population of trauma therapists is defined and sampling procedures is presented. The process of recruiting participants is described and the protection of participants is discussed. The instrumentation to be used for the current study is presented with specific publication of identified scales, permission for use, and the published reliability and validity values relevant to the study. Data for this study is analyzed and presented. This chapter concludes with a review of the threats to validity and how they were addressed in the study.

Research Design and Rationale

There are three key psychological constructs explored in this study. The first is the disruptive experience of vicarious trauma among therapist treating survivors of trauma. Building upon the CSDT, this study explored the relationship between vicarious trauma and the potential disruption in the fulfillment of two specific psychological needs identified as trust/independence and control among therapists working with client survivors. As a theoretical framework the CSDT is applicable to the experiences of trauma therapists. Specifically, the professional and personal vulnerability to vicarious trauma and its symptomatic expressions that may occur from the interaction of the therapist's personality styles with aspects of their working environment over time. Trust/dependence is further defined as self-trust and other-trust.

According to Pearlman (2003), fallout from a traumatic experience may include disrupted trust in that an individual may not trust their own judgment and perceptions as well as become suspicious of others' motives. Control is delineated self-control and

other-control. Disruptions in the need for control and feelings of irritability, depression, avoidance, anger, and helplessness to act on the behalf of clients are associated with the psychological need of control. The TABS (Pearlman, 2003) was used to measure the psychological needs of trust/dependence and control. Respondents were instructed to rate their beliefs about themselves and their world in regard to the sub-scale statements of trust/dependence and control indicating if they strongly agree, agree, agree somewhat, disagree somewhat, disagree, or strongly disagree. In reference to trauma work, it was hypothesized that vicarious trauma contributes to disruption in therapists' fulfillment of psychological needs of trust/dependence and control.

Two coping skills used by trauma therapists were also assessed. This included therapists' beliefs that coping strategies correlate with lower levels of vicarious trauma and the amount of time spent engaging in coping behaviors and self-care practices. In the current study, these coping skills were used as measurements of beliefs and self-care practices that may potentially influence the symptoms of vicarious traumatization. The CSI (Bober et al., 2006; Regehr, 2006) was used to measure beliefs and self-care practices. I assumed that the use of coping skills will be associated with the degree to which therapists' experience vicarious trauma. This study therefore, assessed whether the engagement of coping skills influence the fulfillment of psychological needs of therapists as it relates to their work with trauma survivors.

The research question in this study is: Do coping skills and self-care practices in trauma therapists moderate the potential disruptive effect of vicarious trauma on the fulfillment of their psychological needs (trust/dependence and control)? The independent

variable in this study is vicarious trauma. Vicarious trauma was be measured by years of experience in the field and percentage of caseload that includes trauma survivors. I measured the potentially disruptive effect of vicarious trauma on the fulfillment of two psychological needs including trust/dependence and control.

The dependent variable in this study is psychological needs. Two types of moderating variables were measured: beliefs and self-care practices. A correlational research design was an appropriate approach for this study in that my goal was to determine the degree to which a relationship existed between the experience of vicarious trauma and the fulfillment of two psychological needs of trauma therapists. Beliefs in the value of coping skills and the time spent participating in self-care was used to determine the strength of this relationship. Although high levels vicarious trauma may correlate with the disruption in psychological needs, the strength of this correlation was analyzed.

Methodology

Based on the research question, a correlational design was chosen to examine if there was a significant correlation between vicarious trauma (independent variable) and the potential disruption in the fulfillment of the psychological needs of trust/dependence and control (dependent variables) among trauma therapists. I examined how the use of coping skills and self-care potentially moderates the effect of vicarious trauma as it relates to the fulfillment of the psychological needs of trauma therapists. I explored the relationship between these specific variables, and observed any possible significant relationships.

Although a longitudinal design would have been the most effective approach for examining the effects of vicarious trauma over time, it was not feasible for this study. I therefore, utilized a cross-sectional survey methodology to assess the relationship between coping skills that may influence the potentially disruptive effects of vicarious trauma on fulfillment of psychological needs in therapists who treat traumatized populations. The survey design was the preferred type of data collection because it provided an economical and time-effective method of gathering information (Creswell, 2009). An additional benefit of a self-administered survey as opposed to interviews for example, was the ability to obtain a larger sample size with fewer data collection resources. The larger sample size provided a more representative view of the population of trauma therapists. The findings would therefore be more generalizable. The ability to target and identify characteristics of a larger population of therapists who treat client survivors by soliciting multiple professional groups of therapists made a survey design most advantageous.

Demographic data was collected via an online questionnaire. These variables included age, gender, license to practice, education, discipline, years of experience, and percentage of caseload that includes survivors of trauma. (see Appendix A). Variables that formed the main independent variable vicarious trauma included (a) education, (b) license to practice, (c) years of experience in the therapeutic profession, and (d) percentage of current caseload that includes trauma survivors. In addition to the demographic survey questions, two measures were used in this study: (a) TABS previously known as the traumatic stress institute beliefs scale (TSI)-revision L

(Pearlman, 1996, 2003) was used to measure psychological needs of trust/dependence and control, and (b) CSI (Bober et al., 2006) which measured coping skills.

As a psychometric Likert scale, the TABS (Pearlman, 2003) measure the five areas of psychological needs: (a) safety, (b) trust/dependence, (c) esteem, (d) control, (e) intimacy. The current study focused specifically on trust/dependence and control because these needs are hypothesized to reflect the negative transformation in the self of the therapist that emerges when empathically engaged with client survivors as well as the therapist's sense of responsibility to a client survivor (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995). The CSDT, as the theoretical background in the development of the TABS (Pearlman, 2003) posit that disrupted trust needs and compromised control needs can restrict interpersonal relations and foster unhealthy dependency as well as contribute to feelings of depression, irritability, and rigid or obsessive compulsive tendencies (Pearlman, 2003). The CSI measures beliefs and behaviors associated with coping strategies in trauma counselors (Bober et al., 2006; Regehr, 2006). The use of these specific measures allowed me to examine and measure the relationship between vicarious trauma in therapists who work with client survivors, coping skills and the fulfillment of psychological needs.

Population

The specific population of interest in this study included therapists who primarily treat traumatized populations. This sample was recruited through the National Association of Social Workers (NASW), American Psychological Association (APA), American Mental Health Counselors, National Hospice and Palliative Care Organization,

and the International Association of Trauma Professionals (IATP) mailing lists of practicing therapists. These listings represent a national directory of professional therapists. Membership listings were accessed by securing email lists from identified organization's list services. Utilizing association membership provided a potentially large participant pool from which to recruit a representative sample. Although identified organizations do not directly provide membership lists for scholarly research, specific lists were available through membership newsletters, websites, or can be purchased through the organization's list services.

The use of organizational membership lists enabled me to offer participation to associated professionals who submit their email address. Contact was made with named associations for permission to purchase lists and/or to advertise in their websites and newsletters. Survey Monkey, an internet based administrator was used to distribute surveys and collect responses.

Sampling and Sampling Procedures

A multistage sampling procedure was most useful in this study. I accessed potential therapists from the identified organizations that represent the population of those who treat client survivors. A sample was secured from a list of therapists who self-identified as working primarily with trauma populations. This included victims of physical, emotional, or sexual abuse, survivors of natural or manmade disasters, victims of terrorist acts of violence or war, victims of catastrophic injuries, disabling conditions, and life threatening or terminal medical conditions.

Inclusion criteria include licensed clinical therapists holding a masters or doctoral degree with 10 plus years of experience in the field. Selected participants' caseload must include at least 50% or more of trauma survivors. Exclusion criteria include individuals who are not licensed to practice, hold less than a master degree, and less than 10 years of experience in the field. Threats to external validity may be diminished through this sampling method allowing me to be reasonably sure that the sample is representative of the population of trauma therapists. Although response rates were difficult to predict, according to Survey Monkey, 10 to 15% response rate is a conservative estimate for a variety of online surveys. Since this researcher utilized an internet-based administration process for participation and data collection, I anticipated no less than a 10% response rate. The sample size was determined by establishing a confidence level of 95%. The margin of error (confidence interval) is estimated at +/-5% with a standard deviation of .5. Total respondents needed for our sample size is 385. Sample size = (Z-score)² – Standard deviation (1-Standard deviation) / (margin of error)².

Procedure for Recruitment, Participation and Data Collection

In consideration of the choice of a quantitative research design, a representative sample was recruited by emailing an invitation to participate in the study to a broad range of trauma therapists. A second email invitation was sent five days following the initial email invitation to potential participants who did not respond. Through self-selection, possible participants were able to choose to take part in this research study. Following agreement to participate, participants had an opportunity to complete the surveys. This strategy allowed invited trauma therapists to take part in the study on their own accord.

Although self-selection sampling is a nonprobability sampling technique, it had potential advantages for this study. There was the likelihood of securing potential participants that were willing to volunteer and commit to take part in the study. There are disadvantages in using self-selection sampling including sample bias as well as the loss of random selection. Nevertheless, self-selection sampling was an effective sample strategy for this study.

The initial step was to secure national organizational and group listings and list services of therapists who work with client survivors. An invitation to participate in the study was sent to those listings that identified email addresses recorded in their organization membership directory and list services. Specific guidelines were included, identifying the purpose of the study, expected duration and procedures, and the criteria required for involvement. Criteria for inclusion in this study were: (a) licensed clinical therapists, (b) holding masters or doctoral degree, (c) 10 plus years of experience in the field, and (d) caseload include at least 50% or more of trauma survivors. Therapists selected for this study provided baseline information including age, gender, license to practice, education, discipline, years of experience in profession, and the percentage of current caseload containing trauma survivors.

The form of data collection consisted of two self-administered surveys. A customized internet-based administration via a secure, password-protected site was used. This procedure offered a convenient and cost-effective means of collecting information. Following the completion of the self-administered surveys participants received a thank you note via email for their participation in the study. A limited license agreement for the

use of TABS (Pearlman, 2003) via internet access was signed on March 14, 2013 through the publisher Western Psychological Services (WPS). (see Appendix B). The format was adapted for online administration with data base-style scoring under WPS copyright. The CSI (Bober et al., 2006; Regehr, 2006) was secured through a PsychTESTS search. Permission by the author was sought and obtained indicating that the CSI (Bober et al., 2006; Regehr, 2006) may be reproduced and used for non-commercial research and educational purposes without seeking written permission (Regehr, 2006) (see Appendix C). Contact was made with Survey Monkey for administration of the demographic questionnaire, TABS (Pearlman, 2003), and the CSI (Bober et al., 2006; Regehr, 2006) once approval for this study was finalized.

Protection of Participants

Ethical considerations for conducting research with adults include seeking voluntary participation from each individual and ensuring the confidentiality of each participant's information. This study provided an informed consent via online outlining the objectives and procedures of the study for participants (see Appendix E). Participants were able to agree or decline participation. Once participants agreed to participate, they were directed to the questionnaire and scales. Measures were taken to ensure the protection, confidentiality and integrity of participants. This included assurances that participation in this study was voluntary with the option to discontinue as directed by the informed consent. Participants were informed that involvement in this study did not pose a substantial risk to their safety and well-being as indicated in the informed consent. Participants were recruited through the list serves provided by their professional

associations and advertisements on association newsletters and websites following review and approval by the Institutional Review Board from Walden University. A customized internet-based administration via a secure, password-protected site was used to protect the confidentiality and integrity of participants.

Participant names or any other forms of personal information were not used to identify participants. Information provided by participants was kept confidential with no personal information used outside of this study. Data was kept secure through a customized internet-based administration via a secure, password-protected site. Data will be kept for a period of five years, as required by the university. An Institutional Review Board (IRB) number from Walden University was received and was maintained on record following proposal approval. Walden University's approval number for this study is 05-23-16-0072518 and it expired May 22, 2017.

Instrumentation and Operationalization of Constructs

Grounded in the CSDT, the TABS (Pearlman, 2003) have a wide range of clinical applications. The TABS (Pearlman, 2003) assesses individual beliefs and cognitive schema about self and relationships with others following a direct or indirect trauma experience. The purpose of TABS (Pearlman, 2003) is to measure disruptions on five psychological needs identified as safety, trust/dependence, esteem, control, and intimacy when one is exposed to direct trauma or indirect trauma experiences. This study specifically measured potential disruptions in two areas of psychological needs: (a) trust/dependence and (b) control for this study. In particular, we investigated the role of vicarious trauma in predicting the scores related to these two psychological needs.

The CSDT describes universal psychological needs as safety, trust/independence, esteem, control, and intimacy. The construct validity of the TABS (Pearlman, 2003) was determined to measure the psychological needs constructs. According to a factor analysis of the TABS, Varra, Pearlman, Brock, and Hodgson (2008) concluded that "constructs of the self and other as broad guiding schemas, and disruption in the sense of safety as a specific aspect of traumatic sequelae, are represented in this scale" (p. 194). Content validity was determined by independent reviewers. Relevant data were gathered from trauma survivors reflecting the six psychological needs identified by the CSDT, specifically safety, trust, independence, power, intimacy, and self-esteem. The sample used for test development data was drawn from clinical participants (N=810) with an average age of 35.5 (SD=12.1). Normative data were collected from a heterogeneous sample of 1,743 participants from nonclinical research groups aged 17 to 78 (Pearlman, 2003). Measurement of reliability for TABS was acceptable with test-re-test reliability = .75 and internal consistency =.96 (Pearlman, 2003). The questionnaire format includes a self-report measure with 84 items that are responded to on a six point Likert scale. The response format includes a rating scale of 1 to 6 (1 = Disagree Strongly to 6 = Agree Strongly). The TABS includes ten subscales: (a) self-safety, (b) Other-Safety, (c) self-trust, (d) other-trust, (e) self-esteem, (f) other-esteem, (g) self-intimacy, (h) other-intimacy, (i) self-control, (j) and other-control (Pearlman, 2003). For this study, I measured two psychological needs: (a) self-trust and other-trust (b) self-control and other-control. User qualifications included psychologists with a master's degree or above. A limited licensing arrangement to use the TABS (Pearlman, 2003) for internet based

administration was secured through Western Psychological Services (WPS) (see Appendix B). Under limited-use licensing arrangements, WPS routinely authorizes researchers to adapt/reprint copyrighted forms for customized internet-based administration via a secure, password-protected site.

The CSI (Bober et al., 2006; Regehr, 2006) was developed to measure coping skills among trauma therapists along with examining whether engagement in self-care behaviors are effective in reducing the potentially negative impact of working with trauma survivors. The CSI (Regehr, 2006) measures therapists' beliefs that the use of coping skills will lower their level of vicarious trauma as well as measures the time therapists' spend participating in self-care. The CSI is divided into two sections including beliefs held by therapists regarding the use of coping strategies (CSI-Belief Scale) and the time spent in self-care (CSI-Time Scale). The inventory contains a set of subscales for each of these components. The CSI-Belief Scale comprises a leisure subscale, self-care subscale, and a supervision subscale whereas; the CSI-Time scale includes a leisure subscale, self-care subscale, supervision subscale, and research and development subscale. For this study, I administered the CSI-Belief Scale / subscales and the CSI-Time Scale / subscales to measure the strength of the relationship between vicarious trauma and the psychological needs of therapists.

The response format of the CSI-Belief Scale includes a fourteen item inventory with check boxes to identify self-care activities therapists may participate with a rating scale of not at all helpful, rarely helpful, sometimes helpful, usually helpful and always helpful. The CSI-Time Scale includes a 17 item inventory with a list of how often

therapists may engage in self-care activities with a rating of not at all, rarely, sometimes, and frequently. A comparative analysis included a sample of 259 self-identified trauma therapists and 71 hospital workers who did not provide counseling services or psychotherapy with results demonstrating a consistent factor structure with adequate internal reliability (Bober et al., 2006). A factor analysis of the CSI concluded that the three subscales of the CSI-Belief Scale together accounted for 55.9% of the variance and had internal reliability coefficients of .71 to .82 (mildly to moderately correlated with one another) while the four subscales of the CSI-Time Scale together accounted for 45.7% of the variance with internal reliability coefficients of .67 to .80 (Bober et al., 2006; Regehr, 2006).

Examination of the professional and academic literature on vicarious trauma and the use of focus group consultations with experienced trauma therapists as well as the combined clinical and trauma related experience of the inventory developers provided content validity suggesting that the item groupings were highly consistent with recommendations found in the literature specific to healthy coping strategies and behaviors that impact secondary traumatic reactions (Bober et al., 2006). The factor structure of the CSI-Belief Scale and the CSI-Time was compared between two different groups including counselor and non-counselor groups which support underlying construct validity. Criterion validity according to Bober et al. (2006) could not be assessed by comparing the CSI with other scales measuring for coping strategies as other inventories do not specifically target stress related to trauma work or address the use of coping strategies by trauma therapists. Permission for use of the CSI (Bober et al., 2006; Regehr,

2006) was explored through PsychTESTS (see Appendix C). The test content can be used for non-commercial research and educational purposes without seeking written permission by the authors. In the current study, I used the two sections of the CSI (Bober et al., 2006; Regehr, 2006) including beliefs held by therapists regarding the use of coping strategies (CSI-Belief Scale) and the time spent in self-care (CSI-Time Scale).

Data Analysis Plan

For this study I used SPSSv23 for calculations and statistical analysis of my data. Survey Monkey distributed the demographic questionnaire, TABS (Pearlman, 2003), and the CSI (Bober et al., 2006; Regehr, 2006) as well as collected responses. Data aggregation was provided by Survey Monkey including collection of data, statistical summary of the data and exporting summary analysis via SPSS.

Research Question and Hypotheses

Do coping skills and self-care practices in trauma therapists moderate the disruptive effect of vicarious trauma on the fulfillment of their psychological needs (trust/dependence and control)?

H_1: The use of coping skills by trauma therapists will moderate the relationship between the disruptive effects of vicarious trauma on the fulfillment of their psychological need for trust/dependence.

H_0: The use of coping skills by trauma therapists is unrelated to the disruptive effect of vicarious trauma on their fulfillment of psychological need for trust/ dependence.

H_2: The use of coping skills by trauma therapists will moderate the disruptive effects of vicarious trauma on the fulfillment of their psychological need for control.

H_0: The use of coping skills by trauma therapists is unrelated to the disruptive effect of vicarious trauma on their fulfillment of psychological need for control.

H_3: The use of self-care practices by trauma therapists will moderate the disruptive effects of vicarious trauma on the fulfillment of their psychological need for trust/dependence.

H_0: The use of self-care practices by trauma therapists is unrelated to the disruptive effects of vicarious trauma on the fulfillment of their psychological need for trust/dependence.

H_4: The use of self-care practices by trauma therapists will moderate the disruptive effects of vicarious trauma on the fulfillment of their psychological need for control.

H_0: The use of self-care practices by trauma therapists is unrelated to the disruptive effects of vicarious trauma on the fulfillment of their psychological need for control.

A standard moderation model was used to test the prediction of whether the psychological needs of trust/dependence and control (dependent variable), from vicarious trauma (independent variable) differ across levels of the moderating variables of coping and self-care practices (moderating variable). The identified hypotheses was tested via hierarchical multiple regression analyses. This allowed me to determine moderation. Prior to the regression analysis, the dataset was examined and tested to determine if all

assumptions were met. Any violations of assumptions were addressed as is commonplace in the existing literature (Osborne and Waters, 2002) including normalizing scores for some variables, and replacing missing values.

Relevant demographic information was also examined for connections to any of the main study variables. If significant connections were determined, they were included in the regression model. The Baron and Kenny (1986) model of moderation testing guided the analysis. The steps involved in a moderation test via hierarchical multiple regression are as follows: (a) center each predictor and outcome variable (b) create interaction variables for each analysis by multiplying the centered predictor and moderator variables (c) conduct a hierarchical multiple regression analysis in which the centered predictor and moderator variables are entered together first, and the interaction variable is entered second (d) if the R^2 change term at the second step is significant, the moderation hypothesis is supported and, (e) for analyses showing a significant moderation effect, the specific nature of that moderation was investigated through an examination of the simple slopes for each variable.

Threats to Validity

Threats to external validity in this study include the lack of randomization in the sample selection, thereby compromising my ability to make generalizations about the population of trauma therapists. Since this study is not a longitudinal research design, I was also not able to measure the impact of vicarious trauma on the psychological needs of trauma therapists over a period of time. The long term use of coping strategies and self-care practices that may potentially influence the impact of vicarious trauma on

psychological needs could not be measured and this may create a threat to external validity.

Threats to internal validity include the recognition that a disruption in the psychological needs of trauma therapists may also be influenced by other factors such as history of personal trauma. A participant's personal stressors may therefore potentially alter their responses. Although the TABS (Pearlman, 2003) measures individual beliefs and cognitive schema about self and relationships with others following a direct or indirect trauma experience, it does not specifically address vicarious trauma. To date, there is no scale that measures vicarious trauma among therapists treating client survivors thus, threatening internal validity. Several researchers however; have used the TABS (Pearlman, 2003) in their examination of vicarious trauma among trauma workers. Based on the CSDT, the TABS (Pearlman, 2003) offer the most appropriate applications in measuring the impact of trauma on psychological needs of individuals experiencing a traumatic event directly or indirectly. The use of a survey design may also threaten internal validity as the participants were limited to given responses without the ability to ask for clarification. Responses may then be altered. Nevertheless, a survey design was the most feasible tool for this study.

Summary

The purpose of this correlational study was to quantitatively examine if coping skills and self-care practices in trauma therapists moderated the effect of vicarious trauma on the fulfillment of their psychological needs (trust/dependence and control). The independent variable is vicarious trauma. Vicarious trauma was measured by years of

experience in the field, and the percentage of trauma clients currently treated. I measured the relationship between vicarious trauma and the potential disruption in the fulfillment of two psychological needs including trust/dependence and control. The dependent variable in this study is psychological needs. Two types of moderating variables were measured: beliefs and self-care practices. The utilization of hierarchical multiple regression analysis was used to examine how the moderating effect of therapists' beliefs and self-care practices influenced the relationship between vicarious trauma and the potential disruption in the fulfillment of psychological needs areas of trust/independence and control.

Data collection was conducted through a cross-sectional survey design methodology via a secure password protected customized internet-based system. The TABS (Pearlman, 2003) and the CSI (Bober et al., 2006; Regehr, 2006) have been identified as the most appropriate self-administered surveys as they reflect the conceptual framework of the CSDT. A limited license agreement was signed for the use of TABS (Pearlman, 2003) via internet access through the publisher Western Psychological Services (WPS). I adapted this scale for online administration with data base-style scoring under WPS copyright. The CSI (Bober et al., 2006; Regehr, 2006) does not require written permission by its authors. I used Survey Monkey for administration of the demographic questionnaire, TABS (Pearlman, 2003) and the CSI (Bober et al., 2006; Regehr, 2006) once all approvals were met.

The population of interest for this study was therapists who work with trauma survivors. My sample was recruited from national organizations list services and group

email listings of trauma therapists. An invitation to participate was sent outlining specific ethical guidelines such as the purpose of the study, expected duration and procedures, and the criteria required for involvement. The criteria for inclusion in this study included an educational level of master's degree or higher, possess a professional license to practice, 10 years or more of experience in the field, and current caseload includes 50% of trauma clients.

The intensity of trauma work and the potential adverse effects on those professionals who serve trauma survivors have been generally distinguished in the literature. Earlier research has established the conceptual framework of vicarious trauma (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995). The current literature continues to examine the potential implications of vicarious trauma as well as avenues to address its deleterious effect. Although a variety of coping skills have been introduced, it was my plan to empirically evaluate the relationship between vicarious trauma and the fulfillment of psychological needs based on the moderating influence of coping skills and self-care. Positive social change implications include therapeutic effectiveness and organizational service provision to survivors of trauma. Therapeutic effectiveness may be further enhanced as therapists recognize their risk for vicarious trauma as well as incorporate personal and professional coping strategies to minimize its impact.

Chapter 4: Results

The purpose of this research study was to examine quantitatively, the role of trauma therapists' beliefs in the effectiveness of coping skills and time devoted to self-care practices as moderators of the disruptive effect of vicarious trauma on their fulfillment of psychological needs of trust/dependence and control. I defined fulfillment as the ability to develop, achieve, and sustain psychological needs, which is essential to self-development and self-identity. The sample consisted of trauma therapists who primarily worked with trauma populations. The independent variable in this study was vicarious trauma. Vicarious trauma was operationalized as years of experience in the field, along with the percentage of caseload made up of trauma survivors. The dependent variable in this study was psychological needs. Two types of moderating variables were measured: beliefs that coping skills lower the level of vicarious trauma and the time involved in self-care practices.

Based on the CSDT, I explored two psychological needs areas of trauma therapists including trust/dependence and control. It was hypothesized that vicarious trauma would be shown to contribute to disruption in these identified psychological needs areas based on the number of years of professional trauma experience and the percentage of trauma clients treated.

The research question for this study is: Do coping skills and self-care practices in trauma therapists moderate the disruptive effect of vicarious trauma on the fulfillment of their psychological needs (trust/dependence and control)?

H_1: The use of coping skills by trauma therapists will moderate the relationship between the disruptive effects of vicarious trauma on the fulfillment of their psychological need for trust/dependence.

H_0: The use of coping skills by trauma therapists is unrelated to the disruptive effect of vicarious trauma on their fulfillment of psychological need for trust/ dependence.

H_2: The use of coping skills by trauma therapists will moderate the disruptive effects of vicarious trauma on the fulfillment of their psychological need for control.

H_0: The use of coping skills by trauma therapists is unrelated to the disruptive effect of vicarious trauma on their fulfillment of psychological need for control.

H_3: The use of self-care practices by trauma therapists will moderate the disruptive effects of vicarious trauma on the fulfillment of their psychological need for trust/dependence.

H_0: The use of self-care practices by trauma therapists is unrelated to the disruptive effects of vicarious trauma on the fulfillment of their psychological need for trust/dependence.

H_4: The use of self-care practices by trauma therapists will moderate the disruptive effects of vicarious trauma on the fulfillment of their psychological need for control.

H_0: The use of self-care practices by trauma therapists is unrelated to the disruptive effects of vicarious trauma on the fulfillment of their psychological need for control.

In this chapter, the process of data collection, including the recruitment process used to secure a sample of trauma therapists and response rates, is presented. Specific characteristics of my sample including demographic features are discussed as well as how my sample is representative of the population of trauma therapists. Discrepancies in data collection as presented in Chapter 3 will also be described. The descriptive statistics that characterize my sample of trauma therapists and an evaluation of statistical assumptions of this study will be presented. Statistical analysis of the proposed hypothesis via hierarchical regression analysis to assess the moderation effect specific to my research question and hypothesis will be discussed. I will conclude this chapter with a summary of my findings.

Data Collection

The population of interest in this study was therapists with 10 years or more experience in the field, which primarily treated traumatized populations. The sample was recruited through list services that represented associations of mental health counselors, licensed psychologists, and hospice counselors and social workers. The use of organizational membership lists offered participation to professionals who had submitted their email addresses to their organizations. A total of 20,000 email invitations detailing the purpose of the study as well as criteria for participation were sent via Survey Monkey as well as the Walden University participant pool. Advertisements were placed in various professional newsletters and websites as well, including the National Association of Social Workers (NASW) and the International Association of Trauma Professionals (IATP) newsletter. I attempted to recruit therapists from the APA but was informed that

the APA does not provide listings of their members. Advertisements placed in identified association newsletters and websites outlined the purpose, instructions, and criteria of the study thereby encouraging potential participants to participate directly. Through self-selection, respondents were given the choice to participate.

Through Survey Monkey, a cross-sectional survey design methodology via a customized internet-based system was used to send invitations to participate in study; administration of surveys; and data collection. The TABS (Pearlman, 2003), CSI (Bober et al., 2006; Regehr, 2006), and a demographic data questionnaire were distributed via Survey Monkey beginning on June 20, 2016 with a closing date of August 16, 2016. The TABS was used to measure the psychological needs of self-trust/dependence/other trust/ dependence and self-control/other control. Respondents were instructed to rate their beliefs about themselves and their world by responding to statements on a 6-point scale for the sub-scale statements of trust/dependence and control indicating if they strongly agree, agree, agree somewhat, disagree somewhat, disagree, or strongly disagree. The CSI (Bober et al., 2006; Regehr, 2006) was used to measure two types of coping skills that might be used by trauma therapists: beliefs that coping strategies would correlate with lower levels of vicarious trauma and reports about the amount of time spent engaging in self-care practices. Respondents were instructed to rate self-care activities on a 5-point scale (1: not at all helpful to 5: always helpful). Participants could respond with a rating of not at all helpful, rarely helpful, sometimes helpful, usually helpful or always helpful. Responses were also given to list of how often they engage in self-care activities on a 4-point scale (1: not at all to 4: frequently) with a rating of not at all, rarely,

sometimes, or frequently. A demographic questionnaire was used to gather general information including age, gender, license to practice, education, discipline, years of experience in their profession, and the percentage of current caseload containing trauma survivors. Responses to the study: $n = 313$. The average years of work experience among the 308 respondents was 21 years with a standard deviation of 11.20 years. See Table 1 for Trauma Therapists Report of Demographic Variables.

Table 1

Trauma Therapists Report of Demographic Variables (N=313)

Variables	Frequency	Percentage
Gender		
Male	75	23.96%
Female	232	74.12%
Missing	6	1.92%
Total	313	100%
Licensed Professional		
Yes	285	91.05%
No	15	4.79%
Missing	13	4.15%
Total	313	100%
Education		
Doctorate	70	22.36%
Master's Degree	232	74.12%
Bachelor's Degree	6	1.92%
Some College	2	0.64%
Missing	3	0.96%
Total	313	100%

(*table continues*)

(*table continues*)

Variables	Frequency	Percentage
Professional Discipline		
Private Practice Counselor	36	11.50%
Agency Counselor	54	17.25%
Private Practice Social	54	
Worker		17.25%
Agency Social Worker	112	35.78%
Private Practice Psychologist	29	9.27%
Agency Psychologist	22	7.03%
Missing	8	1.92%
Total	313	100%
Trauma Caseload		
Less than 10%	32	10.22%
10% to 25%	29	9.27%
25% to 35%	24	7.67%
35% to 50%	42	13.42%
50% to 75%	94	30.03%
Over 75%	90	28.75%
Missing	2	0.64%
Total	313	100%

Inclusion criteria for the current study included licensed clinical therapists holding a master's degree or doctoral degree with 10 plus years of experience in the field with a caseload of at least 50% or more of trauma survivors. Licensed therapist represented 91.05% of the sample. Educational level included 22.36% with a doctoral degree and 74.12% with a master's degree. Percentage of caseload with at least 50% or more made up of trauma survivors was represented.

The sample distribution of private practice social workers, psychologists and counselors in the current study are in line with reported national statistics. Females dominate the field of behavioral health as compared with their male counterparts. According to the NASW (2010) Fact Sheet, there are approximately 2.34 million community and social service workers in the USA with 697,000 counselors; 725,000 social workers; and 349,000 other community and social service specialists. Females represented in the field of social work are reported to be higher than males. The United States Department of Labor's Bureau of Labor Statistics (2015) and the US Department of Health and Human Services Health Resources and Services Administration National Center for Health Workforce Analysis (2013) reported that there are over 552,000 licensed mental health professionals practicing in the USA today with psychologists making up the largest group of mental health providers who diagnose and treat individuals with mental health concerns. Psychologists who are self-employed as primarily private practitioners and independent consultants make up 34% of this population. Females in the practice of psychology and counseling are reported to be higher than males. Based on the demographic characteristics of the study sample and the

national statistics presented, I can argue that my sample adequately represented my target population of therapists.

In the following section, results of the current study, including statistical analysis, model summary for hierarchical regression analysis, statistical assumptions, and summary of findings are presented.

Results

In the previous section, the research question, hypotheses and summary of the collection of data was presented. Descriptive statistics that characterized my sample of trauma therapists was outlined. Statistical analysis of the proposed hypothesis via hierarchical regression analysis to assess the moderation effect specific to my research question and hypothesis will follow with conclusion of the summary of findings.

Statistical Analysis

Data analysis was conducted using SPSS-23. The independent variable in this study was vicarious trauma. Vicarious trauma was measured by years of experience in the field, and the percentage of trauma clients currently treated. I measured the relationship between vicarious trauma and the potential disruption in the fulfillment of two psychological needs including trust/dependence and control. Vicarious trauma was operationalized by creating standard scores for the number of years the respondent worked as a therapist, and the percentage of caseload made up by trauma survivors; the extent of vicarious trauma was calculated by multiplying those two scores (Vicarious Trauma). The outcome variables in this study were two individual types of psychological needs: self-trust; other trust; self-control; other control. A different regression analysis

was conducted for each of the four outcome variables. Two moderating variables were measured: beliefs that coping skills lower the level of vicarious trauma (cope belief) and the time involved in self-care practices (cope time). See Table 2 for Descriptive Statistics for Study Variables.

Table 2

Descriptive Statistics for Study Variables

	Mean	SD	*n*	Percent
Self-control	4.80	0.57	267	
Self-trust	5.07	0.56	267	
Other control	5.00	0.55	307	
Other trust	4.95	0.66	267	
Cope Belief	3.67	0.53	296	
Cope Time	2.63	0.48	284	
Vicarious multiplied	-0.10	1.06	307	
Time Trauma	-0.23	2.63	281	
Belief Trauma	-0.33	3.68	291	
Gender			313	
Male			75	23.96%
Female			232	74.12%
Education			313	

Model Summary for Hierarchical Regression Analysis

In the hierarchical regression analysis constructed to test the moderation hypothesis, three successive models were evaluated (Table 3). This procedure was repeated 4 times to address the outcome variable. Each hierarchical regression analysis followed the same form. The first model included variables representing gender and education; Model 2 added the predictor and moderator variables: cope belief, cope time, and Vicarious Trauma; Model 3 added the interaction variables representing the potential moderating effect: time Trauma (vicarious trauma multiplied by time coping score) and Belief Trauma (vicarious trauma multiplied by belief (coping score). The same set of models (sets of equations) just described were used in the subsequent hierarchical regression analysis for each of the different outcome variables.

Table 3

Model Summaries for Hierarchical Regression Analysis

	Mean	SD	*n*
Model 1			
Gender	1.76	0.43	307
Education	3.19	0.48	310
Model 2			
Cope Belief	3.67	0.53	284
Cope Time	2.63	0.48	284
Vicarious Trauma	-0.10	1.06	308
Model 3			
Time Trauma	-0.23	2.63	281
Belief Trauma	-0.33	3.68	291

Statistical Assumptions

Appropriate assumptions for the hierarchical multiple regression analyses that were designed to test the hypotheses were evaluated. The Durbin-Watson statistic for all four dependent variables was calculated to be approximately 2.0, indicating a lack of serial correlation. Scatter plots of the residuals of the independent and dependent variables were examined for linearity and homoscedasticity. In all cases, relationships were linear and no signs of heteroscedasticity were seen. Co-linearity was assessed by calculating VIF and tolerance scores with each regression analysis; in all cases the scores were well within acceptable range. The dataset was checked via casewise diagnostics for outliers that were ± 3.0 standard deviations from the mean for all dependent variables. No consistent outliers were found. Finally, the normality of the distributions of the residuals for all of the variables was checked using P-P and Q-Q plots, and all plots were showed acceptable normality.

Moderation of Vicarious Trauma by Coping: Self-Trust

Hypothesis 1, that the use of coping skills by trauma therapists would moderate the relationship between vicarious trauma and the fulfillment of psychological need for self-trust, was evaluated with the use of hierarchical multiple regression analysis. See Table 4 for full details on each part of the hierarchical regression for self-trust. Model 1 containing the variables gender and education was not significant, R^2 Change = .007, $\underline{F}(2, 258) = .854$, $p > .05$; adjusted $R^2 = -.001$. Model 2 which added the variables Cope Belief, Cope Time, and Vicarious Trauma, R^2 Change = .026, $F(5, 255) = 1.717$, $p < .05$;

adjusted R^2 = .014. Model 3 which added interaction terms to represent the hypothesized moderators contributed significantly to the explanation of variance in therapists' Self-Trust scores, R^2 Change = .085, $F(97, 253) = 4.807$, $p < .05$, adjusted R^2 = .093.

Table 4

Coefficients for Moderation Analysis of the Relationship Between Vicarious Trauma and Self-Trust

		Unstandardized Coefficients		Standardized Coefficients		
Model		B	SEM	Beta	t	Sig
1	(Constant)	4.689	.295		15.899	.000
	Gender	.066	.082	.051	.811	.418
	Education	.083	.073	.073	1.151	.251
2	(Constant)	4.060	.395		10.289	.000
	Gender	.054	.081	.042	.666	.506
	Education	.104	.073	.090	1.427	.155
	Cope Belief	.186	.078	.177	2.380	.018
	Cope Time	-.037	.085	-.032	-.435	.664
	Vicarious Trauma	-.008	.033	-.014	-.233	.816
3	(Constant)	3.351	.405		8.273	.000
	Gender	.004	.079	.003	.048	.962
	Education	.236	.075	.205	3.151	.002
	Cope Belief	.273	.077	.260	3.535	.000
	Cope Time	-.015	.083	-.013	-.183	.855
	Vicarious Trauma	.661	.225	1.258	2.932	.004
	Time Trauma	-.346	.081	-1.637	-4.287	.000
	Belief Trauma	.052	.080	.345	.649	.517

Summary of Findings: Self-Trust

Examination of the coefficients table (Table 4) from the hierarchical multiple regression on the psychological need for self-trust indicated the following: (a) trauma therapists' education and gender were not significant predictors of the psychological need

for self-trust (b) trauma therapists' belief that coping activities (including leisure, self-care, supervision, and professional research) was a significantly positive predictor of the fulfillment of the psychological need for self-trust; (c) time spent in coping activities was not a significant predictor of the psychological need for self-trust; (d) there was no direct relationship between trauma therapists' experience of vicarious trauma and the fulfillment of the psychological need for self-trust alone; (e) the interaction between experience of trauma and belief in coping strategies did not predict the psychological need for self-trust; (f) the interaction between experience of trauma and the time spent in coping activities was a significant negative predictor of the psychological need for self-trust; (g) in the context of the interaction effect, the experience of vicarious trauma, on its own, was significantly related to the psychological need for self-trust.

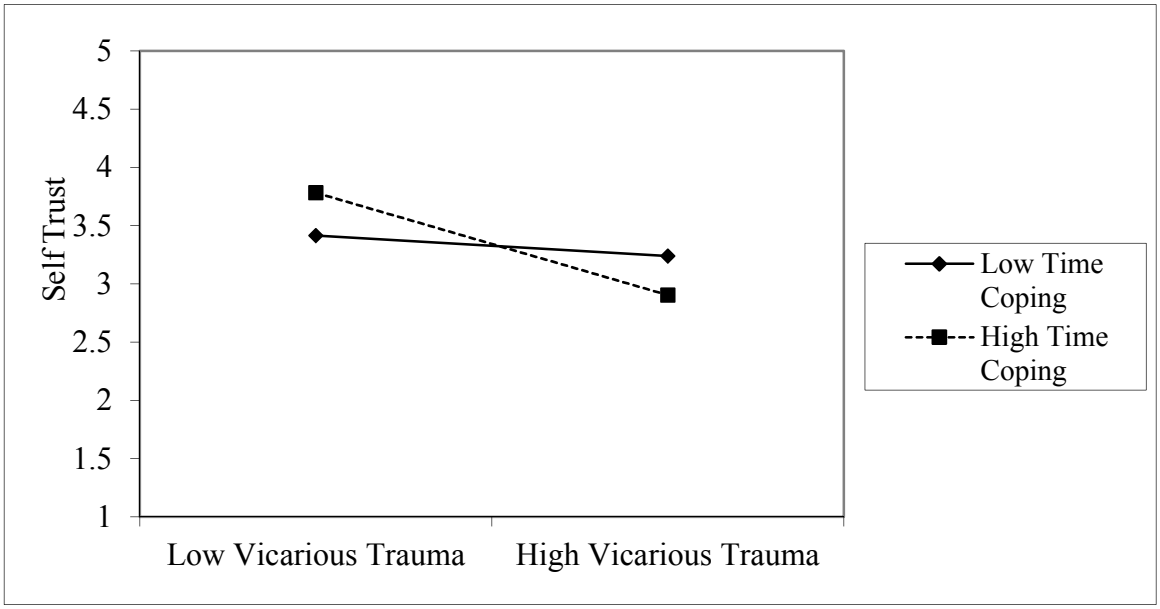

Figure 1

Moderation effect of time coping on the relationship between vicarious trauma and self – trust.

Examination of the interaction in Figure 1, showing the moderation effect, indicates that time spent coping impacts the fulfillment of self-trust needs differently for individuals with lower vicarious trauma than higher vicarious trauma. This effect can be seen specifically in the case when more time is spent coping. Fulfillment of self-trust needs was similar for those with high and low levels of vicarious trauma when a lower amount of time was spent coping. On the other hand, a greater amount of time spent coping was associated with better fulfillment of self-trust needs for those with low levels of vicarious trauma, than those with higher levels of vicarious trauma. This is consistent with hypothesis 1, in that more time spent in coping practices showed less disruption in the psychological need for self-trust when vicarious trauma was reported to be low.

Moderation of Vicarious Trauma by Self-Care: Other Trust

Hypothesis 3, that the use of self-care by trauma therapists would moderate the relationship between vicarious trauma and the fulfillment of psychological need for other trust, was evaluated with the use of hierarchical multiple regression analysis. See Table 5 for full details on each part of the hierarchical regression for other trust. Model 1 containing variables gender and education was not significant, R^2 Change = .009, $F(2, 258) = 1.194$, $p > .05$; adjusted $R^2 = .001$. Model 2 added variables Cope Belief, Cope Time, and Vicarious Trauma and the model was significantly better at predicting therapists' psychological need for other trust, R^2 Change = .081, $F(5, 255) = 5.030$, $p < .05$; adjusted $R^2 = .072$. Model 3 which added interaction terms to represent the hypothesized moderators contributed significantly to the explanation of variance in therapists' Other-Trust, R^2 Change = .040, $F(7,253) = 5.402$, $p < .05$, adjusted $R^2 = .106$, supporting the hypothesis that coping variables would moderate the relationship between vicarious trauma and the fulfillment of psychological needs.

Table 5

Coefficients for Moderation Analysis of the Relationship Between Vicarious Trauma and Other Trust

		Unstandardized Coefficients		Standardized Coefficients		
Model		B	Std. Error	Beta	T	Sig
1	(Constant)	4.422	.349		12.683	.000
	Gender	.071	.096	.047	.740	.460
	Education	.126	.086	.092	1.466	.144
2	(Constant)	3.100	.453		6.842	.000
	Gender	.040	.094	.026	.427	.670
	Education	.173	.083	.127	2.069	.040
	Cope Belief	.391	.090	.314	4.360	.000
	Cope Time	-.079	.098	-.057	-.802	.424
	Vicarious Trauma	.013	.037	.020	.337	.737
3	(Constant)	2.600	.476		5.462	.000
	Gender	.010	.093	.006	.105	.917
	Education	.261	.088	.192	2.973	.003
	Cope Belief	.469	.091	.377	5.156	.000
	Cope Time	-.084	.098	-.061	-.858	.392
	Vicarious Trauma	.199	.265	.320	.750	.454
	Time Trauma	-.324	.095	-1.294	-3.413	.001
	Belief Trauma	.176	.094	.983	1.863	.064

Summary of Findings: Other Trust

Examination of the coefficients table (Table 5) from the hierarchical multiple regression on the psychological need for other trust indicated the following: (a) trauma

therapists' education and gender were not significant predictors of the psychological need for other trust in the first model but education was a significant predictor of other trust in subsequent models such that higher levels of education were associated with better fulfillment of the psychological need for other trust; (b) trauma therapists' belief that coping activities (including leisure, self-care, supervision, and professional research) was a significant and positive predictors of the fulfillment of the psychological need for other-trust; (c) time spent in coping activities alone was not a significant predictor of the fulfillment of the psychological need for other trust; (d) there was no direct relationship between trauma therapists' experience of vicarious trauma and the fulfillment of the psychological need for other-trust alone; (e) the interaction between experience of trauma and belief in coping strategies did not predict the psychological need for other-trust; (f) the interaction between experience of vicarious trauma and the time spent in coping activities was a significant negative predictor of the psychological need for other-trust; (g) in the context of the interaction effect, the experience of vicarious trauma, on its own, was not significantly related to the psychological need for other-trust.

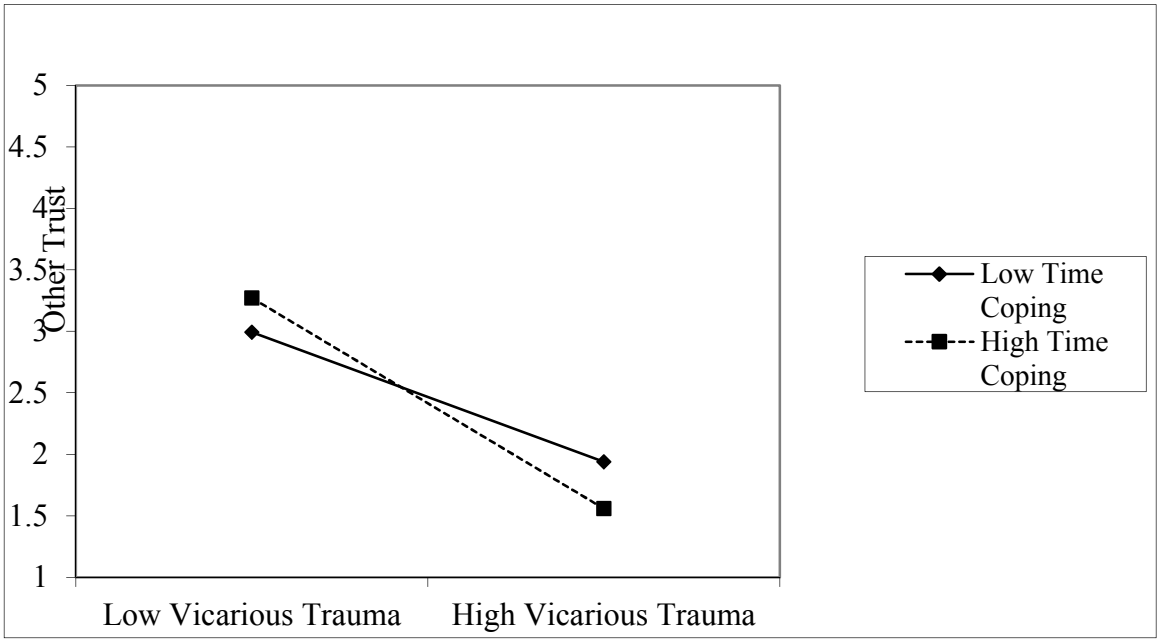

Figure 2

Moderation effect of time coping on the relationship between vicarious trauma and other trust.

Examination of the interaction in Figure 2 indicates that the time spent coping has a different impact on other trust when individuals have lower vicarious trauma than when they have higher vicarious trauma. The amount of time spent coping appears to interact in opposite directions with vicarious trauma in predicting other trust needs fulfillment. At low levels of vicarious trauma, more time spent coping is associated with a higher score for other trust needs and the opposite is true for higher levels of vicarious trauma. In that case, less time spent coping are associated with higher fulfillment of the other trust need. This is consistent with Hypothesis 3 in that more time spent in coping practices was associated with greater fulfillment of the psychological need of other trust when vicarious

trauma was reported to be low. In the instance of low level of vicarious trauma, time spent coping did not directly predict other trust.

Model of Vicarious Trauma by Self-Control

Hypothesis 2, that the use of self-care by trauma therapists would moderate the relationship between vicarious trauma and the fulfillment of psychological need for self-control, was evaluated with the use of hierarchical multiple regression analysis. See Table 6 for full details on each part of the hierarchical regression for self-control as an outcome variable. Model 1 containing variables gender and education were not significant, R^2 Change = .011, $F(2, 258) = 1.473$, $p > .05$; adjusted $R^2 = .004$. Model 2 added variables Cope Belief, Cope Time, and Vicarious Trauma and the model was significantly better at predicting were psychological need for self-control, R^2 Change = .52, $F(5, 255) = 3.422$, $p < .05$; adjusted $R^2 = .004$. Model 3 which added interaction terms to represent the hypothesized moderators contributed significantly to the explanation of variance in therapists' Self-Control scores, R^2 Change = .56, $F(7,253) = 4.862$, $p < .05$, adjusted $R^2 = .094$.

Table 6

Coefficients for Moderation Analysis of the Relationship Between Vicarious Trauma and Self-Control

		Unstandardized Coefficients		Standardized Coefficients		
Model		B	Std. Error	Beta	T	Sig
1	(Constant)	4.347	.303		14.329	.000
	Gender	.026	.084	.019	.305	.761
	Education	.128	.075	.108	1.716	.087
2	(Constant)	3.385	.400		8.453	.000
	Gender	.013	.083	.010	.156	.876
	Education	.152	.074	.128	2.056	.041
	Cope Belief	.203	.079	.187	2.559	.011
	Cope Time	.061	.087	.051	.707	.480
	Vicarious Trauma	-.031	.033	-.057	-.930	.353
3	(Constant)	2.835	.417		6.792	.000
	Gender	-.023	.081	-.017	-.277	.782
	Education	.251	.077	.212	3.257	.001
	Cope Belief	.282	.080	.260	3.539	.000
	Cope Time	.064	.086	.054	.748	.455
	Vicarious Trauma	.287	.232	.530	1.237	.217
	Time Trauma	-.325	.083	-1.490	-3.905	.000
	Belief Trauma	.138	.083	.888	1.672	.096

Summary of findings: Self-Control

Examination of the coefficients table (Table 6) from the hierarchical multiple regression on the psychological need for self-control indicated the following: (a) trauma

therapists' education and gender were not significant predictors of the psychological need for self-control in the first model, but education did predict better needs fulfillment related to self-control in the second and third models; (b) trauma therapists' belief in the advantage of coping activities (including leisure, self-care, supervision, and professional research) was a significant positive predictor of the fulfillment of the psychological need for self-control; (c) time spent in coping activities was not a significant predictor of the psychological need for self-control; (d) there was no direct relationship between trauma therapists' experience of vicarious trauma and the fulfillment of the psychological need for self-control alone; (e) the interaction between experience of trauma and belief in coping strategies did not predict the psychological need for self-control; (f) the interaction between experience of trauma and the time spent in coping activities was a significant negative predictor of the psychological need for self-control; (g) in the context of the interaction effect, the experience of vicarious trauma, on its own, was not significantly related to the psychological need for self-control. The combination of these findings indicated that there is a moderation effect of time spent in coping activities on the relationship between vicarious trauma and the fulfillment of the psychological need for self-control.

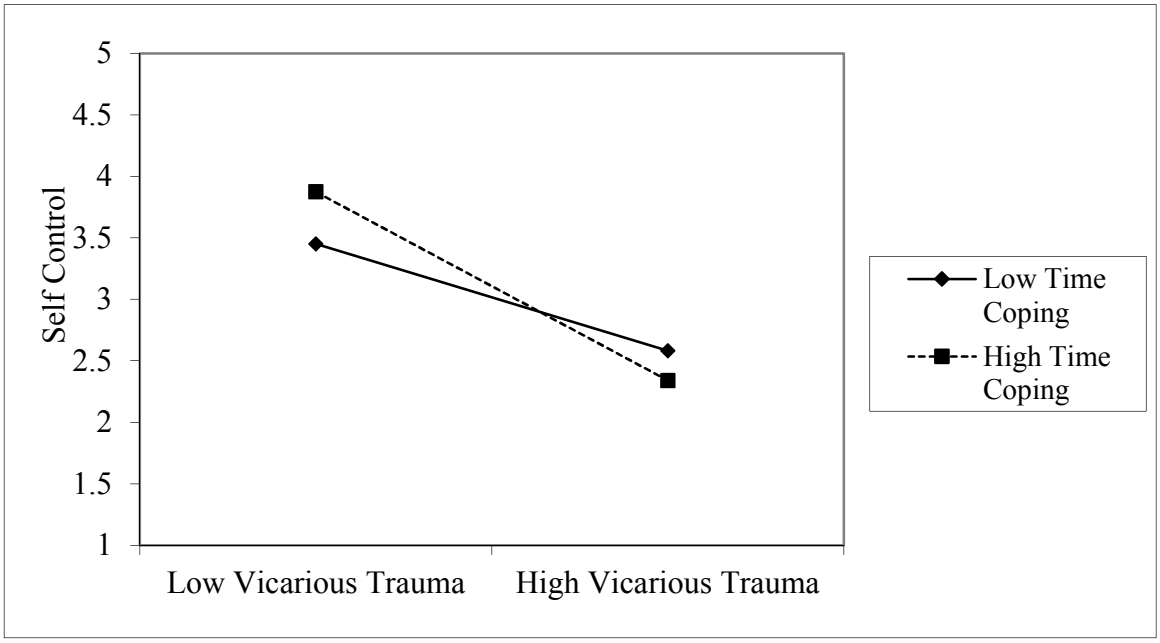

Figure 3

Moderation effect of time coping on the relationship between vicarious trauma and self – control.

Examination of the interaction in Figure 3 indicates that the time spent coping is related differently to self-control when individuals have lower vicarious trauma than when they have higher vicarious trauma. At low levels of vicarious trauma, less time spent coping is associated with a lower score for self-control needs than when more time is spent coping are endorsed by respondents with low vicarious trauma. In that case, self-control needs scores are higher. On the other hand, the relationships are reversed when participants were at the higher level of the vicarious trauma scale. In this instance, less time spent coping predicted higher self-control needs, and more time spent coping predicted lower fulfillment of self-control needs. This is consistent with Hypothesis 2 in that more time spent in coping practices was related to less disruption in the

psychological need for self-control in those with high levels of vicarious trauma. On the other hand, the less time spent in coping practices showed more disruption in the fulfillment of the psychological need for self-control when vicarious trauma was high. In the instance of low level of vicarious trauma, time spent coping did not directly predict self-control.

Moderation of Vicarious Trauma by Self-Care: Other Control

Hypothesis 4, that the use of self-care by trauma therapists would moderate the relationship between vicarious trauma and the fulfillment of psychological need for other control, was evaluated with the use of hierarchical multiple regression analysis. See Table 7 for full details on each part of the hierarchical regression for other control. Model 1 containing the variables gender and education was not significant, R^2 Change = .004, $F(2, 258) = .529$, $p > .05$; adjusted $R^2 = .004$. Model 2 that added the variables cope belief, cope time, and vicarious trauma predicting therapists' psychological need for self-trust was significantly more predictive than in Model 1, R^2 Change = .058, $F(5, 255) = 3.380$, $p < .05$; adjusted $R^2 = .004$. Model 3 that further added the time trauma, and belief trauma interaction variables showed a marginally significant effect that was positively predictive of the fulfillment of therapists' psychological need for other control, R^2 Change = .030, $F(7,253) = 3.673$, $p < .05$, adjusted $R^2 = .067$.

Table 7

Coefficients for Moderation Analysis of the Relationship Between Vicarious Trauma and Other Control

		Unstandardized Coefficients		Standardized Coefficients		
Model		B	Std. Error	Beta	t	Sig
1	(Constant)	4.750	.292		16.276	.000
	Gender	.078	.081	.061	.972	.332
	Education	.036	.072	.032	.504	.615
2	(Constant)	3.823	.384		9.957	.000
	Gender	.051	.079	.040	.644	.520
	Education	.073	.071	.064	1.026	.306
	Cope Belief	.267	.076	.257	3.511	.001
	Cope Time	-.045	.083	-.039	-.539	.590
	Vicarious Trauma	.033	.032	.064	1.040	.299
3	(Constant)	3.427	.406		8.443	.000
	Gender	.025	.079	.020	.318	.751
	Education	.144	.075	.127	1.926	.055
	Cope Belief	.322	.078	.310	4.157	.000
	Cope Time	-.041	.083	-.036	-.493	.623
	Vicarious Trauma	.289	.226	.557	1.279	.202
	Time Trauma	-.226	.081	-1.081	-2.791	.006
	Belief Trauma	.086	.081	.577	1.070	.286

Summary of Findings: Other Control

Examination of the coefficients table (Table 7) from the hierarchical multiple regression on the psychological need for other control indicated the following: a) trauma

therapists' education and gender were not significant predictors of the psychological need for other control in the first model, but education did predict better needs fulfillment related to other control in the second and third models; b) trauma therapists' belief that coping activities (including leisure, self-care, supervision, and professional research) was a significantly positive predictor of the fulfillment of the psychological need for other control; c) time spent in coping activities was not a significant predictor of the psychological need for other control; d) there was no direct relationship between trauma therapists 'experience of vicarious trauma and the fulfillment of the psychological need for other control alone; e) the interaction between experience of trauma and belief in coping strategies did not predict the psychological need for other control; f) the interaction between experience of trauma and the time spent in coping activities was a significant negative predictor of the psychological need for other control; g) in the context of the interaction effect, the experience of vicarious trauma, on its own, was not significantly related to the psychological need for other control.

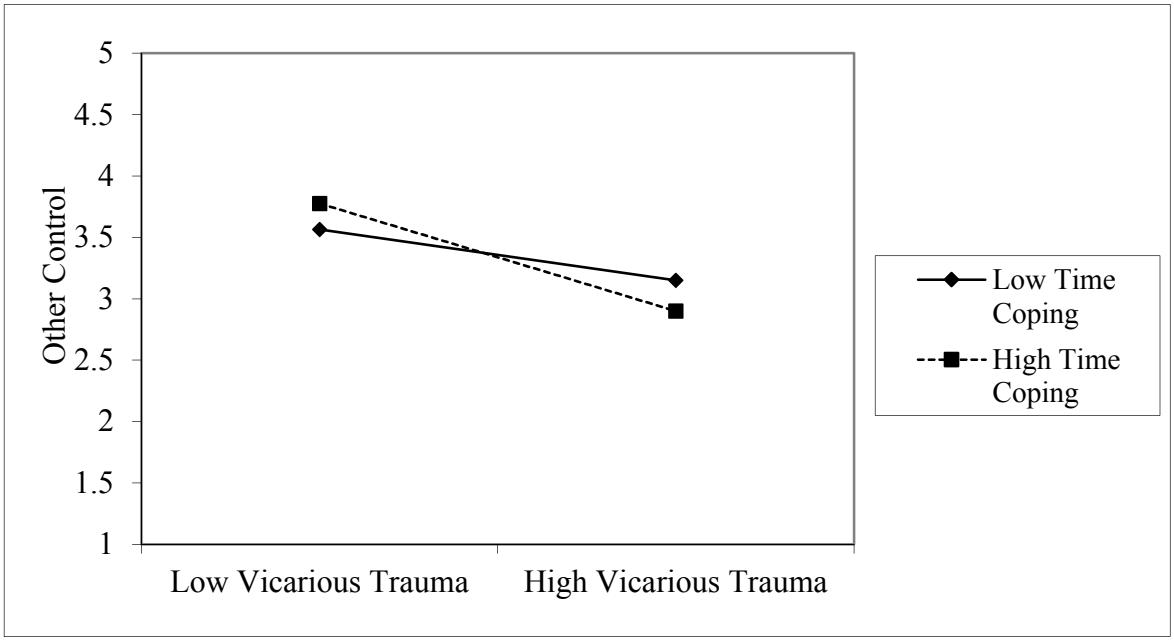

Figure 4

Moderation effect of time coping on the relationship between vicarious trauma and other control.

Examination of the interaction in Figure 4 indicates that time spent coping had a different association with the fulfillment of other control needs for individuals who reported lower vicarious trauma than those who had higher vicarious trauma. At low levels of vicarious trauma, the less time spent coping is associated with a lower score for other control needs, and the opposite is true when more time was spent coping that are endorsed by respondents with low vicarious trauma. In that case, other control needs scores are higher. This is consistent with Hypothesis 4 in that the more time spent in coping practices showed less disruption in the psychological need for other control when vicarious trauma was reported to be high. In the instance of low level of vicarious trauma, time spent coping did not predict other control.

Summary

In this chapter I reviewed the process for recruitment of our sample of trauma therapists and the collection of our data. Descriptive data on the variables contained in the hypothesis and demographic information about our sample was presented. A statistical analysis was completed. Data were analyzed using SPSS 23. A hierarchical multiple regression analysis was completed to address the research question and hypotheses. In the hierarchical regression analysis constructed to test the moderation hypothesis, three successive models were evaluated. This procedure was repeated 4 times to address the outcome variable. Each hierarchical regression analysis followed the same form. Following data analysis, I observed that my sample was predominately female (75.57%) and had an average of 21 years of work experience with a standard deviation of 11.20 years. The sample percentage of caseload that included trauma survivors were 50% and over.

The central focus of this study was to assess whether or not, and how coping skills and self-care practices in trauma therapists moderated the disruptive effect of vicarious trauma on the fulfillment of their psychological needs (trust/dependence and control). The moderation of vicarious trauma by coping for self-trust addressed hypothesis 1 specifically, that the use of coping skills by trauma therapists would moderate the relationship between vicarious trauma and the fulfillment of psychological need for self-trust. The results of analysis supported this hypothesis. Time spent participating in coping and self-care was a significant predictor of the fulfillment in the psychological need for self-trust when vicarious trauma was reported to be high. The moderation of vicarious

trauma by self-care for other trust addressed hypothesis 3 which stated that the use of self-care by trauma therapists would moderate the relationship between vicarious trauma and the fulfillment of psychological need for other trust. The results of analysis supported this hypothesis. The time spent participating in coping and self-care was a significant predictor of the fulfillment in the psychological need for other trust when vicarious trauma was reported to be high. The moderation of vicarious trauma by self-control addressed hypothesis 2 which stated that the use of self-care by trauma therapists would moderate the relationship between vicarious trauma and the fulfillment of psychological need for self-control. The results of the regression analysis supported this hypothesis. The time spent participating in coping and self-care was a significant predictor of the fulfillment in the psychological need for self-control trust when vicarious trauma was reported to be high. The moderation of vicarious trauma by self-care as this was related to other control was addressed hypothesis 4. Specifically, it was proposed that the use of self-care by trauma therapists would moderate the relationship between vicarious trauma and the fulfillment of psychological need for other control. The results of regression analysis supported this hypothesis. The time spent participating in coping and self-care in conjunction with different levels of vicarious trauma was a significant predictor of the fulfillment in the psychological need for other control.

The results of this study are in line with the research on vicarious trauma and the disruptive impact of vicarious trauma on the psychological needs of therapists who treat trauma survivors. I have examined the use of coping skills and self-care practices as a means of moderating the effect of vicarious trauma specifically on the psychological

needs of self-trust/other trust; self-control/other control. I have determined that the use of personal self-care and creating coping skills and strategies may represent effective means of addressing vicarious trauma as well as enhancing the lives of trauma therapists and the provision of services to their clients.

In chapter 5, I will review the purpose and significance of this study. Key findings will be presented and interpreted including analysis of data in relation to the theoretical framework of the CSDT. Limitations will be discussed and recommendations for further research will be explored. Finally, implications for positive social change will be presented as I discuss the need for increased awareness of vicarious trauma and the risk for trauma therapists. The well-being of trauma therapists is necessary as a means of enhancing therapeutic effectiveness and organizational service delivery.

Chapter 5: Discussion, Conclusions, and Recommendations

The purpose of this quantitative study was to examine whether trauma therapists' coping skills and self-care practices moderate the disruptive effect of vicarious trauma on the fulfillment of psychological needs of trust/dependence and control. The exploration into this phenomenon is crucial as client survivors depend upon their well-functioning therapists for effective treatment and service delivery in their healing process. Acknowledging their susceptibility to vicarious stress and recognizing individual limitations are essential for therapists who treat trauma populations. Additionally, exploring self-care and developing coping skills to address vicarious trauma through the use of self-care practices may decrease the risk to therapists of vicarious trauma which in turn, would be expected to improve the therapeutic relationship and treatment outcomes.

Using a sample of therapists who had 10 or more years of experience in practice and primarily worked with trauma clients, I assessed the relationship between vicarious trauma and its effect on the psychological needs of trust (self-trust/other trust) and control (self-control/other control). Hypothesized moderating variables were time spent in self-care and the belief in the use of coping skills and these were tested to see how their interaction with vicarious trauma was associated with the fulfillment of psychological needs.

In this study I expected that trauma therapists would be vulnerable to the disruptive effects of vicarious trauma as they engaged in the therapeutic process with client survivors. I expected that the cumulative effect of secondary exposure to trauma (vicarious trauma) would be especially disruptive to the fulfillment of psychological

needs of therapists, and that this would affect their personal and professional functioning. I further predicted that the use of coping skills and participation in self-care would have a moderation effect on therapists' experience of vicarious trauma as evidenced by greater fulfillment of psychological needs.

The hierarchical multiple regression analysis that was conducted to test this prediction supported the assumptions. The results showed that time spent coping moderated the effect of vicarious trauma on therapists' need for trust (self-trust/other trust) and control (self-control/other control). Belief in coping did not serve as a moderator, although it did have a direct effect on the fulfillment of all four needs categories. The moderation effects were demonstrated by the significant change in R^2 when the interaction term (e.g., time spent in self-care multiplied by vicarious trauma) was included in the final regression model. The moderation on the relationship between levels of vicarious trauma and for both self-trust and other trust showed that more time spent in coping practices was associated with greater fulfillment of those psychological needs when vicarious trauma was reported to be high.

I also determined that the moderation effect for self-trust and other trust showed that more time spent in coping practices showed less disruption in the fulfillment of psychological need for self-control and other control when vicarious trauma was reported to be high. I therefore, concluded: (a) belief in coping was a significant direct predictor of all four types of psychological needs; (b) time spent in self-care was not a direct predictor of any of the types of psychological needs; (c) the effect of vicarious trauma on all four types of psychological needs was moderated by time spent in self-care (evidenced by the

significant increase in R^2 in third model and the significant coefficient for the interaction terms); (d) the effect of vicarious trauma on all four types of psychological needs was not moderated by belief in coping (evidenced by the lack of a significant interaction coefficient in Model 3 of each analysis).

Interpretation of the Findings

In this study, I concluded that vicarious trauma is related to the disruption in trauma therapists' psychological need for trust and control. I found that the belief in the effectiveness of coping skills and the use of self-care is a significant predictor in lessening the disruptive effects of vicarious trauma. The literature has established that vicarious trauma is a stress reaction to secondary traumatic experiences; however, research exploring how coping skills and self-care practices affect the personal and professional lives of trauma therapists is an emerging interest.

The conceptualization of vicarious trauma evolved following the introduction of PTSD as a diagnostic category during the 1980s. The fifth edition of the 2013 Diagnostic and Statistical Manual of Mental Disorders (DSM-5) further developed the initial criteria of PTSD to include repeated and extreme indirect exposure to aversive details of event(s) usually in the course of professional duties. The early research of Pearlman and Saakvitne (1995) focused on the adverse effects placed on the therapist as a consequence of empathic engagement with clients' trauma material arguing that trauma work may result in cumulative, transformative, and deleterious effects as well as cognitive shifts and reactions.

McCann and Pearlman (1990) and Pearlman and Saakvitne (1995) developed the concept of vicarious trauma to explain the emotional experience of trauma therapists as they directly engage with traumatized clients. The emerging research further identified changes in self-identify, world view, spirituality, and disruption in one's belief system, including safety, personal vulnerability, interpersonal relationships, benevolence of the world, and feelings of powerlessness as indicators of vicarious trauma (Figley, 1995; McMann & Pearlman, 1990). According to Boscarino et al. (2010) constructs to describe the impact of secondary exposure to client narratives within the practice of trauma work appeared when therapists discovered occupational hazards of experiencing the effects of their clients' trauma vicariously. Although the impact of vicarious trauma is seen in the literature, empirical research that offers effective means for coping with and managing vicarious trauma is limited (Bober el al., 2006). The current study is therefore, reflective of the current literature in that vicarious trauma can be disruptive to the fulfillment of psychological needs of therapists affecting their personal and professional selves; and, the need to explore coping strategies and self-care is necessary.

The CSDT was identified as a useful and comprehensive framework to define vicarious trauma as experienced by trauma therapists. The CSDT provided a construct that characterized the impact of traumatic life experiences either directly or indirectly on psychological needs within relational and socio-cultural contexts (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995). There are five psychological needs identified by the CSDT that may be vulnerable to the disrupted effects associated with a traumatic event including safety, trust/dependence, esteem, intimacy, and control. For my purposes, I

examined two psychological needs area of trust/independence and control using the framework of the CSDT to measure the disruption associated with traumatic stress. I was specifically interested in examining the potential effects of vicarious trauma on the psychological needs of trust and control. I was also interested in exploring coping and self-care practices that may moderate its potential effects.

The CSDT allowed me to examine the individualized experience of a trauma including the construction and the meaning of the event. Various areas of personality affected by trauma could also be identified including belief and capacity for safety; trust in self, the world, and dependency on others; self-esteem as in a strong sense of self and feeling appreciated; intimacy in personal connection to self and others; and control of self-thoughts and behaviors as well as those of others. The CSDT was especially effective to address the nature of this study and to analyze the results. I was able to measure the potentially disruptive effects of secondary traumatic stress on psychological needs and the potential opportunities to develop healthy coping strategies and self-care. The results of my analysis determined that the belief in the efficacy of coping skills and the time spent on self-care were significant predictors of lower levels of disruption on the psychological needs of my sample of trauma therapists.

Limitations of the Study

In this study I used the method of non-random sampling to secure my sample of trauma therapists. Potential participants were recruited through the email list services associated with professional associations and organizations of therapists as well as advertisement in newsletters and websites of related associations. The Walden University

participant pool was also used for recruitment purposes. Participants were able to make the decision to participate in this study; however, the limitation of self-selection bias, lack of random selection or the rationale of probability theory was a consideration. The lack of randomization in my sample selection was a threat to external validity compromising my ability to make generalizations about the population of trauma therapist; however, I am reasonably certain that my sample was representative of the population of trauma therapists considering the respondents' demographic information compared with those of national demographics. Reported licensed therapist represented 91.05% of my sample. The average years of work experience among the 308 respondents was 21 years with a standard deviation of 11.20 years. The reported percentage of case load that included trauma survivors was 28.75% with 75% and over and 30.03% with 50% to 75%. The educational level reported included 22.58% with a Doctorial Degree and 74.84% with a Master Degree. I believe that my inclusion criteria of licensed clinical therapists holding a masters or doctoral degree with 10 plus years of experience in the field and has a caseload of at least 50% or more of trauma survivors was met.

Although a longitudinal research design would have enabled me to measure the impact of vicarious trauma on the psychological needs of trauma therapists over a period of time, it was not practical for my purposes. As such, the long term use of coping strategies and self-care practices that may potentially influence the impact of vicarious trauma on psychological needs could not be measured thus, creating a threat to external validity.

The use of self-reporting measures for data collection was also determined to be a possible limitation. I depended on the honesty and forthrightness of the participants who were asked to introspectively assess their beliefs, coping behaviors, and self-care practices as accurately as possible. The potential for varied interpretation of abstract concepts including personality, psychological needs, behaviors, and differences in utilization and comprehension of the self-reporting scales may have limited the accuracy of reporting.

The TABS was used to determine how the experience of vicarious trauma impacts the psychological needs of trust and control among therapists who treat client survivors. However, to date, there is no tool that measures vicarious trauma specifically for therapists. This is a potential threat to internal validity. Through my literature search I discovered that that the TABS were used by several researchers as a measurement of vicarious trauma (Cunningham, 2003; McCann & Pearlman, 1990; Pearlman & Mac Ian, 1995; Van Deusen & Way, 2006; Vrklevski & Franklin, 2008). Based on the CSDT, the TABS (Pearlman, 2003) offered the most appropriate applications in measuring the impact of trauma on psychological needs of individuals experiencing a traumatic event directly or indirectly. Given these limitations I concluded that the TABS (Pearlman, 2003) remained the most reliable and valid measurement of the disruptions in psychological needs associated with the experience of a traumatic life event. As survey design instruments, the TABS (Pearlman, 2003) along with the CSI (Bober et al., 2006; Regehr, 2006) may have also threaten internal validity limiting participants to response categories presented. Potential time constraints in completing the surveys were also a

consideration as well as the inability for participants to ask for clarification which may have lead to altered responses. This may have affected the responses to the surveys contributing to further limitations in this study. A survey design nonetheless, was the most feasible tool for this study.

Recommendations

The results of this study concluded that an occupational hazard for trauma therapists is their vulnerability of vicarious trauma. Therapists risk disruption in the fulfillment of their psychological needs for trust and control if vicarious trauma is not addressed individually and organizationally. My analysis indicated that the belief in coping skills and the time spent in self-care influences the experience of vicarious trauma lessening the disruption in the psychological needs for trust and control. Although trauma work can be a rewarding and a highly worthwhile profession, it can also be overwhelmingly stressful for the helping professional. Individual and organizational attention to the wellness of trauma therapists is essential as it can reduce the negative effects of work stressors including the demands of the therapeutic relationship.

Learning to integrate coping strategies and self-care practices should be a consideration for therapists entering the practice of trauma work and for those who have extensive years of practice in the field. Specific curriculum for students entering the field of psychology as well as continuing education about the risk of vicarious trauma and training opportunities for self-care should be the standard. This may include a personal and professional wellness inventory supported by organizational interventions. Restorative opportunities that promote the value of trauma work while focusing on

professional growth such as supported self-care practices, effective supervision, and maintaining professional connections especially for those therapists who work in isolation will enhance a sense of well-being and therapeutic effectiveness. Cultivating an organizational climate that fosters a comfortable and supportive work environment in an emotionally taxing practice may encourage healthy choices, time for exercise, and nutritional counseling. It is necessary to consider the extensive work load and the financial constraints for organizational services to address the risk of vicarious trauma; however, the cost of burn out, sick leave, and turn over cannot be overlooked.

Further research into the potentially disruptive effects of vicarious trauma is necessary for the enhancement of the profession of psychology and for the individual trauma practitioner in particular. The literature has provided considerable research about the negative and transforming effect of trauma work as well as the need for developing coping skills and self-care practices on part of the therapist and organization. Strategies to integrate coping skills to manage vicarious trauma is now emerging. I recommend that the development of a scale that measures vicarious trauma specifically for clinical therapists would be a useful tool in expanding the research about this phenomenon. A longitudinal study to empirically examine the cumulative effect of vicarious trauma on the psychological needs of therapists will also be helpful in developing a fuller understanding of the emotional cost of trauma work as well.

Implications for Positive Social Change

The literature has established that vicarious trauma can have a potentially disruptive impact on therapists who treat survivors of trauma. This disruption can have

devastating consequences for the personal and professional well-being of therapist and may result in the diminished capacity to effectively treat clients. Research to thoroughly examine and empirically validate vicarious trauma can be beneficial to the profession of psychology in general, and specifically, therapists who work with traumatized populations. The social change implications for this study include further contribution and awareness of the risk of vicarious trauma and the need for integrating coping skills and self-care to enhance the professional and personal functioning of trauma therapists. Therapeutic effectiveness and positive treatment outcomes that encourages recovery and healing for client survivors can be further enhanced when therapists are able to manage their personal wellness and decrease their emotional exhaustion and stress. Organizational service delivery to traumatized client populations will then foster a positive direction and healing for traumatized client populations.

Conclusion

Trauma therapists are routinely and indirectly exposed to crisis and critical events experienced and reported within the therapeutic relationship. The therapeutic process can be stressful and is often fraught with professional and personal challenges as therapists frequently engage empathically with clients' traumatic experiences; and facilitate psychotherapeutic interventions that encourage progression and healing. The trauma therapist provides supportive interventions and tangible resources for their clients offering a path toward a healthy emotional adjustment to considerable loses and trauma associated with a life changing event. The commitment necessary in the treatment process for trauma clients is critical to achieving effective treatment outcomes. However,

in doing so, therapists may lose sight of their personal needs and neglect their own self-care which may lead to vicarious trauma. Therapeutic effectiveness may be jeopardized when symptoms of vicarious trauma are ignored. The ethical necessity of self-care is paramount as the essence of the therapeutic relationship may be compromised when a therapist is faced with working with the effects of vicarious trauma. Examining the balance of psychological needs and developing a wellness plan to maintain a sense of well-being may have a transforming effect on the personal and professional growth of trauma therapists and in turn, enhance the process of healing for client survivors.

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Demographic Questionnaire

Appendix A

Age

25 or under _____

26-40 _____

41-55 _____

56 or older _____

Gender

Female _____

Male _____

Licensed professional

Yes _____

No _____

Highest Level of Education

Some college _____

Bachelor's degree _____

Master's degree _____

Doctoral degree _____

Professional discipline

Private practice

Counselor _____

Agency employed

Counselor _____

Social Worker _____

Years of professional experience

Less than 9 years _____

10 to 19 years _____

20 to 29 years _____

30 to 39 years _____

More than 40 years _____

Percentage of caseload that includes trauma survivors

Less than 10 % _____

10% to 25% _____

25% to 35% _____

35% to 50% _____

50% to 75% _____

Over 75% _____

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Appendix B

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April 11, 2013

Annette M. Zaccari
Walden University
10833 N 42nd St.
Phoenix, AZ 85028

Re: *Trauma and Attachment Scale (TABS), Adult Form*

Dear Ms. Zaccari—

WPS has processed your license for a specific web-based application of *TABS* material. By surface mail, you will soon receive a paid-in-full WPS invoice/receipt, which will serve as your license to use the *TABS* items and scoring key in a secure, password-protected, on-line environment, permitting adaptation, administration and scoring of the instrument up to three hundred (300) times total. This authorization is for sole use in your registered scholarly study, examining coping strategies and self-practices impact on the symptoms of vicarious trauma among therapists who work with trauma populations -- with no authorization for continued or commercial use -- subject to the provisions of terms and conditions provided to you 11Feb'13.

With reference to condition (4) of WPS's February 11th terms letter, please affix the following copyright notice in its entirety, on the screen of item presentation, to each reprint/viewing of the *TABS:*

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On behalf of WPS, I hope the *TABS* well serves your study, and look forward in due course to learning of your research results.

Sincerely yours,

Fred Dinkins

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3/18/13

Annette Zaccari
Student- Walden University

1717 North 77th St., Ste. 14
Scottsdale, Arizona 85257

Re: *Trauma and Attachment Belief Scale (TABS)*

Dear Ms. Zaccari –

In follow-up to your email of 22Jan'13, supported by Dr. Tracy Mallet's letter of support on 22Jan'13, this serves to provide terms that will permit you to adapt the format of the TABS for administration and scoring via a secure, password-protected on-line environment, for sole application within your registered graduate study, examining coping strategies and self-practices impact on the symptoms of vicarious trauma among therapists who work with trauma populations.

Western Psychological Services will authorize you to adapt and arrange for delivery of English TABS material as described – parallel with and consistent to the entire prevailing item set, and using prevailing response categories – including your administering the scale a specific number of times within the project, and your creating a scoring-only computerized key for tabulation of item responses, as based on our proprietary hand-scoring key. Our authorization is for the sole purpose of conducting the above-described study, and not for continued or commercial use, and is subject to satisfaction of the following conditions:

(1) You must purchase from WPS a non-exclusive license for the anticipated number of TABS administrations.

(2) The license fee for this described use of the TABS will be based on prevailing prices for the hand-scored TABS Test Form (W-393A), less 20% Research Discount. Note that we license this instrument in units of twenty-five (25) with a minimum licensed fee of one hundred dollars ($100.00); shipping and handling fees are not applicable to licensing fees (e.g., 100 total adapted TABS administrations @ $41.25/25 = $190.00 x 80% = $152.00 total license fee).

(3) The license fee must be prepaid in U.S. dollars drawn on a U.S. bank or by international money order (Visa, MasterCard and American Express are accepted and swiftest), and is non-refundable. To ensure proper handling of your licensing arrangements, and to guarantee the rate in condition 2 above, please send the payment to my attention with a signed copy of this letter, within the next sixty (60) days. *Allow the emphasis that you must contact WPS Rights and Permissions to arrange payment of your license fees; please do not contact WPS Customer Service for this purpose.*

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(5) With specific regard to the on-line administration, access to the TABS items must be granted only by a secured password that you provide solely to participants in the study.

Annette Zaccari
Student
Walden University

(6) You agree to provide WPS with one copy of all articles (including research reports, convention

should be marked to the attention of the WPS Rights & Permissions. WPS reserves the right to use or reference such reports; you will of course receive proper acknowledgment if we use your research

(7) WPS acknowledges that you will need to adapt our copyrighted scoring key for the purpose of computerized evaluation of responses to your research instrument -- and you have our authorization to do so provided you agree to destroy the adapted key following completion of your research. Also, documentation for your computerized adaptation of the TABS key must bear the required copyright notice that will be provided to you by WPS.

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Upon receipt of your license payment with signature to this letter (see below), WPS will send to you the required copyright notice (see conditions #4 and #7), and we'll issue and send to you a license to create the online adaptation and to administer and score it the specified number of times.

NOTE: To source the administration instructions, item content, and scoring guidelines needed for your customized application, please refer to the TABS Manual. In case you do not have (or have direct access to) the TABS Manual (W-393B), this message serves for the next 60 days as your authorization to purchase one at 20% Research Discount (and note that discounted orders cannot be completed over our website); if you have questions about ordering the Manual, contact WPS Customer Service at 800/648-8857 or 424/201-8800, weekdays 7:30am to 4:00pm Pacific.

WPS appreciates your research interest in the TABS, as well as your consideration for its copyright. Please feel free to contact me if you have any questions. I look forward to your reply.

Sincerely yours,

Susan Weinberg
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WPS Rights and Permissions
e-mail: sweinberg@wpspublish.com

SDW:sdw

I agree to the terms stated herein.

3/14/13
Date

Annette Zaccari
Annette Zaccari, Walden University

Constructive Self-Development Theory (CSDT)

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Coping Strategies Inventory

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