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# Professionals' Perceptions of Vicarious Trauma From Working With Victims of Sexual Trauma

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## Abstract

Professionals who work with victims of sexual trauma frequently experience emotional and psychological stressors that affect their everyday life. Vicarious traumatization is an occupational risk among helping professionals, but it is not known how this phenomenon can be identified and minimized among professionals who work with victims of sexual trauma. The purpose of this qualitative narrative study was to explore the personal experiences of licensed and nonlicensed professionals who work with female victims of sexual trauma. Constructivist self-development theory and the traumagenic dynamics model provided the framework for the study. The research questions focused on the evidence of vicarious trauma among participants, the skills and techniques used to minimize the risk of vicarious trauma, and the influence of vicarious traumatization on helping professionals. Data were collected through semistructured interviews with 8 helping professionals in the Southern United States. Findings from data coding and theme analysis indicated that (a) professionals experience psychological and emotional risks in trauma work, (b) establishing boundaries and implementing self-care techniques can minimize vicarious trauma, and (c) consistent training and ongoing discussions about vicarious trauma are essential to professionals who commit their lives to helping sexual trauma victims. Findings may be used to increase awareness and education about vicarious trauma among professionals who work with victims of sexual trauma, and to develop techniques to minimize the risk of vicarious trauma.

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# Dedication

I dedicate this dissertation to God for giving me the strength, guidance, and determination to not only begin but also to complete this amazing dissertation journey.

To my daughter, Kennedi, who has been patient, understanding, and encouraging throughout this entire process. Your presence gave me the endurance I needed to keep going.

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# Chapter 1: Introduction to the Study

Traumatic experiences such as natural disasters, sexual abuse, and violence leave their victims with emotional and psychological damage. The American Psychological Association (2016) defined trauma as an emotional, physical, or psychological deterioration because of an event or occurrence such as war, violence, or natural disaster. Victims of life-altering traumatic events often seek professional counseling and/or support to aid them in rebuilding their lives after a traumatic event (Silveira & Boyer, 2015; Foreman, 2018). Vicarious traumatization (VT) is often experienced by professionals (clinical and nonclinical) who provide services to victimized clients, and who experience detrimental psychological effects that can persist long after working with clients (McCann & Pearlman, 1990).

VT can cause a destructive perspective of beliefs and values and alter a person's view of life and relationships (Tabor, 2011). Clinicians and support staff must be able to identify the risks of VT, must receive sufficient training when working with victims of sexual trauma, and must engage in practices that minimize the influence of VT on their work (Harrison & Westwood, 2009; Jones, Robins, & Minatrea, 1998). Trauma therapy must be adequate and appropriate to avoid detriment to the client and therapist (McCann & Pearlman, 1990), but limited research has been conducted on the emotional and psychological effects of working with victims of sexual trauma (Iqbal, 2015). The purpose of this study was to identify evidence of VT, distinguish skills/training needed to minimize VT, and explore how VT influences professionals who work with female victims of sexual trauma.

In this chapter, I provide an overview of the research study, the purpose of the study, and the nature of the study. Additionally, I present the research questions, the theoretical foundation and conceptual framework, relevant definitions, assumptions and limitations, and the study's significance. I also describe the semistructured interview tool used to gather data on the personal experiences of helping professionals who work with sexually traumatized individuals.

## Background

Victims of sexual trauma are often plagued with thoughts and feelings of terror, dread, and extreme mistrust of others, and professionals who work with them often mimic those same fears and thoughts by listening to numerous stories of traumatic experiences (McCann & Pearlman, 1990). VT is often used interchangeably with the terms *burnout* and *countertransference*. Burnout refers to the psychological toll on a professional who works with challenging populations, specifically victims of trauma and abuse, which can include prolonged depression and/or anxiety, drug use, decreased desire to efficiently perform job responsibilities, diminished social activities, a desire to leave the job, or examining the meaning of life (Blair & Ramones, 1996; Dombo & Gray, 2013; McCann & Pearlman, 1990). Countertransference is defined as self-conflicts or unconscious concerns within the therapist that have not been resolved (Blair & Ramones, 1996). VT is slightly different in that it focuses on the thoughts, feelings, and emotions of helping professionals who work with victims of trauma and abuse.

Childhood sexual abuse (CSA) has been associated with developing a complex pattern of psychological dysfunction and self-destructive behaviors that include risky

sexual behaviors such as sex with multiple partners, unprotected sex, inconsistent methods of birth control, and drug use in adult women, which can precede involvement in prostitution/sex work (Colangelo & Keefe-Cooperman, 2012; Wilson & Widom, 2010). Abuse and trauma history are often identified among women who participate in prostitution diversion programs (Begun & Hammond, 2012; Shdaimah & Wiechelt, 2012). In these programs, women are provided resources such as housing, medical care, employment opportunities, and counseling services (Roe-Sepowitz, Hickle, Loubert, & Egan, 2011). Victims of sexual trauma, such as prostitutes and victims of sex trafficking, need an opportunity to share their personal experiences (Orchard, Farr, Macphail, Wender, & Wilson, 2014), and research is bountiful regarding empirical evidence on the association between CSA and risky sexual behaviors in adulthood. According to Daalder, Bogaerts, and Bijleveld (2013), sexual abuse has been associated with post-traumatic stress disorder (PTSD) among female sex workers such as prostitutes who work in brothels, indicating that sex workers experience psychological trauma before entering sex work, as well as other mental health issues such as depression and anxiety (Colangelo & Keefe-Cooperman, 2012). Clinical services are needed in prostitution diversion programs, and additional support and training may be needed for clinical staff to effectively identify and minimize the risk of vicarious traumatization (Roe-Sepowitz, Hickle, & Cimino, 2012). Clinical staff provide the opportunity for these women to share their experiences, which is of great significance to the recovery process (Roe-Sepowitz, Hickle, & Cimino, 2012). The purpose of the current study was to fill a gap in the

literature by exploring the personal experiences of vicarious traumatization among clinical staff who work with female victims of sexual trauma.

VT can occur among therapists who are new to trauma work and may lead to post-traumatic symptoms comparable to the experiences of their clients (Neumann & Gamble, 1995). Professionals who work with trauma victims should be made aware of early symptoms and risk factors to prevent VT (Harrison & Westwood, 2009; Howlett & Collins, 2014). Pearlman and Mac Ian (1995) explored characteristics that may impact VT such as the individual's personal trauma history, the professional's perspective on traumatic life events, current life stressors, and social and psychological outlook. Training programs for professionals working with victims of sexual trauma often include minimal counseling skills and techniques, lack of comprehensive understanding regarding trauma and violence, and insignificant preparation regarding vicarious traumatization, which can lead to professionals' inability to develop strategies to minimize vicarious trauma (Howlett & Collins, 2014).

## Problem Statement

Vicarious traumatization is an occupational hazard among professionals who work with victims of trauma and abuse, causing the professionals to experience invasive and disturbing cognitions of their clients' traumatic life experiences, and altering their perspective of the world and themselves, prompting the professionals to question their beliefs about safety, trust, esteem, power, and intimacy (McCann & Pearlman, 1990; Neumann & Gamble, 1995). Working with traumatized clients can be a traumatic experience for the helping professional (Gartner, 2014). Vicarious trauma, which if often

referred to secondary traumatic stress, is often emotionally burdensome for professionals who work with victims of trauma (Dutton et al., 2017). Vicarious trauma ranges in severity from person to person based on variations in the person's personal history of sexual trauma, current knowledge of vicarious trauma based on education and training, personality style, and strategies for self-care (Pack, 2013). Helping professionals are empathetically engaged with their clients over an extended period of time, which makes them vulnerable to physical, emotional, and psychological stressors (Dombo & Gray, 2013). Appropriate training for professionals who work with victims of trauma must include aspects of trauma-informed supervision that include the discussion of individual and agency-related challenges and risks to professionals who perform trauma work (Berger & Quiros, 2014). Helping professionals are often unaware and uninformed about how the influence of trauma work can cause progressive changes in a person's view of the world and others (Wilson, 2016). Extensive and continuous exposure to clients' trauma can prompt the helping professional to develop defective coping mechanisms, such as hypervigilance or isolation, to create an emotional barrier (Neswald-Potter & Simmons, 2016). Despite the awareness of VT as an occupational hazard, minimal research exists on how the evidence for, training/skills needed for, and influence of VT among professionals who work with victims of sexual trauma can be identified and minimized (Chouliara, Hutchison, & Karatzias, 2009).

## Purpose of the Study

The purpose of this qualitative, narrative research study was to investigate individual experiences of professionals who work with female victims of sexual trauma

within two research sites. Narrative research was the most appropriate design for this study because it is used to examine the lived and told stories of the participants (see Creswell, 2013). Research Site 1 was a faith-based organization that provides counseling to women who are currently or were previously involved in the sex industry by way of prostituting, stripping, or sex trafficking. Research Site 2 was a nonprofit organization that provides crisis services and counseling to victims of sexual trauma. VT can occur among therapeutic staff, including anxiety-provoking feelings and thoughts (Capri, Kruger, & Tomlinson, 2013). I collected data using semistructured interviews. Data were initially transcribed by a web-based software program. Additional transcription and analysis were completed by me.

## Research Questions

The primary research questions (RQs) were the following:

RQ 1: How is the evidence of vicarious traumatization manifested among helping professionals who work with female victims of sexual trauma, as self-reported in interviews and written documentation?

RQ 2: What skills, techniques, and trainings do helping professionals who work with female victims of sexual trauma utilize to identify and minimize vicarious traumatization?

RQ 3: How does vicarious traumatization influence helping professionals who work with female victims of sexual trauma, specifically personally and professionally?

## Theoretical Framework

The constructivist self-development theory (CSDT) emphasizes how a person reacts to violence and trauma, including areas that focus on self-regulation, psychological needs, the skills needed to cope with interpersonal issues, and how people perceive their own identity and the world around them (Pearlman, 2013). CSDT considers the counselors' distinctive emotional and psychological experience of trauma as it integrates the experiences as a response that adapts to what is going on around them (Branson, Weigand, & Keller, 2014). CSDT views individuals' adjustments to trauma as connections between the individuals' comprehensive view of their personality and relevant characteristics of the traumatic experiences, allowing social and cultural components to form psychological reactions (Pearlman & Mac Ian, 1995). Saakvitne, Tennen, & Affleck stated the following:

> CSDT describes personality development 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).

As sexually traumatized victims begin the therapeutic process by conveying stories of trauma and affliction, the helping professional begins to experience psychological responses to what is heard. Professionals can often relate to clients who have experienced trauma, through empathic engagement, which may lead them to feel defenseless and unguarded (Williams, Helm, & Clemens, 2012). This theory supports the concept that the

experience of VT can alter people's views of themselves and others, and how they interact with others.

## Conceptual Framework

The traumagenic dynamics model focuses on the profound and long-lasting effects of a sexually traumatized victim (Finkelhor & Brown, 1985). The model proposes four traumagenic dynamics (betrayal, stigmatization, powerlessness, and traumatic sexualization) that facilitate the psychological outcome of sexually traumatized victims by altering their self-concept, worldview, and emotional state (Cantón-Cortés, Cortés, & Cantón, 2012). The traumagenics dynamics model states that sexual trauma weakens people's ability to develop healthy sexual relationships as an adult through blaming perpetrators for hindering their sexual development and betraying their trust, especially victims who are sexually abused by someone they know (McCann & Pearlman, 1990).

## Nature of the Study

The nature of the study was qualitative. I used the narrative design to explore participants' individual experiences of providing services to female victims who have experienced sexual trauma. The phenomenon of interest was the personal experiences of the helping professionals who work with sexually victimized females. Participants provided detailed personal narratives of working with female victims of sexual trauma. Emergent themes were identified through data analysis.

## Definitions

Sexual trauma can include, but is not limited to, acts of sexual assault, rape, prostitution, or sex trafficking. These terms are defined as follows:

*Childhood sexual abuse*: A variety of acts between a child and an adult, including body contact, exposing of one's genitals, pressuring the child for sex, and use of child pornography (National Institutes of Health: U.S. National Library of Medicine, 2017).

*Prostitution*: The act of engaging in sexual acts for the exchange of money (Merriam-Webster, 2017).

*Sex trafficking*: Engaging in the commercial sex industry by way of force, fraud, or coercion (National Human Trafficking Hotline, 2017).

*Sexual assault/rape*: Any type of sexual contact or behavior that transpires without the direct consent of the individual. Sexual assault can include rape, sodomy, and child molestation (United States Department of Justice, 2017).

## Assumptions

There were four assumptions in this research study that may have influenced the nature and extent of the data and findings. First, I assumed that there may have been variations in reports of vicarious trauma by the research participants due to different roles as helping professionals. Second, I assumed that the helping professionals who were interviewed represented a small sample of this population, and that their personal perspectives were relevant to the concept of vicarious trauma. Third, I assumed that participants would be truthful when reporting their personal experiences. Finally, I assumed that helping professionals who work with victims of sexual trauma and were interviewed for this study were experiencing symptoms of vicarious trauma.

## Scope and Delimitations

The scope of this study was the lived experiences of helping professionals who work with sexually traumatized victims, and the skills and training needed to identify and minimize vicarious trauma. Eight helping professionals who worked with victims of sexual trauma and were employed as counselors, social workers, or program directors were interviewed. Differences in how vicarious trauma can influence helping professionals with various training and educational experience were explored. There were also differences in how long each participant had been employed in the field. Some of the helping professionals were employed by an agency while working in private practice. Data were collected using a semistructured interview tool developed by me.

## Limitations

A potential limitation to the study was the sample size of participants. Eight professionals were interviewed. Creswell (2014) stated that purposely selected research participants will enable the researcher to comprehend the problem and answer the research question. Due to the demanding schedules of professionals in this area of interest, there was a concern that the sample size would be insufficient. An additional limitation to the study was the personal biases of professionals who were interviewed. Patton (2002) stated that interview data limitations can include one-sided responses due to personal feelings regarding the subject matter, such as anger and anxiety, which can affect the interviewee at the time of the interview. Although qualitative data analysis software programs, such as QSR NVivo, were appropriate for the study, data analysis was completed by one researcher, which was a limitation. Bradley, Curry, and Devers

(2007) noted that using multiple researchers for coding qualitative data can advance the extensiveness and complexity of the findings.

## Significance

This study was conducted to fill a gap in the literature by providing an in-depth understanding of the lived experiences of helping professionals who work with female victims of sexual trauma. Previous research addressed the significance of therapy among victims of trauma (Iqbal, 2015) but neglected to provide a narrative of professionals who work with female victims of sexual trauma. The goal of the study was to provide a deeper understanding of VT that is experienced by many counseling and social work professionals but is often ignored or neglected. Sexual trauma, such as sexual abuse, has been studied as a predictor for risky sexual behavior among populations such as college women (Roemmele & Messman-Moore, 2011), but limited research has been conducted on the personal stories of professionals who work with this population of women.

This study provided information on the perceptions of professionals who interact with female sexual trauma victims, such as law enforcement officers, medical professionals, counselors, and social workers, and provided a better understanding of how to offer treatment and support that is not harmful to the victim or the helping professional. Those affected by sexual trauma are often shunned and do not have the opportunity to share their personal experiences of abuse. The experience of a sexual trauma victim may be more complex than what is assumed on the surface. Professional staff should take appropriate measures to ensure that they are providing services with the utmost ethical standards, including being knowledgeable about VT (Iqbal, 2015).

## Summary

VT includes intrusive thoughts, nightmares, and psychological responses after exposure to clients' personal accounts of traumatic experiences (McCann & Pearlman, 1990; Pearlman & Mac Ian, 1995; Pearlman & Saakvitne, 1995). Professionals often enter the field of trauma work with the desire and dedication to assist victims in rebuilding their lives after trauma, without being aware of and prepared to address their own vulnerabilities (Dombo & Gray, 2013; Wilson, 2016). Chapter 2 provides a review of associated literature regarding vicarious trauma and how the helping professional can best prepare to work in the field of trauma.

# Chapter 2: Literature Review

Vicarious traumatization is the recurrence of painful images, thoughts, and feelings experienced by professionals who work with victims of trauma, which can often last long after services or treatment has concluded (McCann & Pearlman, 1990). Because of vicarious trauma, helping professionals are often plagued with disturbances in their frame of reference, which affect their sense of self, world view, and spirituality (Neswald-Potter & Simmons, 2016; Pearlman & Saakvitne, 1995; Sui & Padmanabhanunni, 2016). It is common for helping professionals to experience PTSD, which includes symptoms of recurrent and intrusive memories of the victim's traumatic experience, frequent poignant dreams, dissociative reactions such as flashbacks, intense or extended distress, and physiological reactions (American Psychiatric Association, 2013) that resemble an aspect of the victim's traumatic events (McCann & Pearlman, 1990).

Research indicated that therapists who are new to working with trauma survivors are vulnerable to vicarious traumatization due to factors such as the assignment of challenging clients to newer therapists, placement of new therapists within the organizational chain of command, and therapists' personal concerns with working in a competitive environment (Bell, Kulkarni, & Dalton, 2003; Berger & Quiros, 2014; Hernandez-Wolfe, Gangsei, Engstrom, & Killian, 2015; Neumann & Gamble, 1995). Researchers supported the recognition of vicarious trauma as an occupational hazard experienced by professionals who work with trauma victims (Branson et al., 2014; Gartner, 2014; Molnar et al., 2017); however, few qualitative studies focused on the

experiences of vicarious trauma among professionals who work with victims of sexual trauma. The purpose of the current study was to explore the personal experiences of professionals who work with victims of sexual trauma.

## Literature Search Strategy

The literature review was conducted by an expansive search of the literature through the Walden University library, Google Scholar, and journal articles and books related to the study topic. Databases that were used included Academic Search Complete, ProQuest Central, SAGE Premier, PsycINFO, and PsycARTICLES. Key words included *vicarious traumatization, countertransference, PTSD, burnout, secondary trauma, trauma, sexual trauma, childhood sexual abuse, counselors, clinicians, evidence of vicarious traumatization, training, skills,* and *narrative.* Key words were cross-referenced within each database.

Foundational aspects of vicarious traumatization were researched. Information on the identification of vicarious traumatization and the comparison of vicarious trauma to physiological reactions to working with victims of trauma, such as countertransference, burnout, and secondary trauma, was obtained. The literature search also allowed me to review studies that focused on the influence of vicarious traumatization among professionals who work with victims of trauma, while identifying the scarcity of studies related to narrative experiences of professionals who work with victims of sexual trauma. This literature review enabled me to identify common themes among the studies.

Sources published between 1990 and 2017 were included to account for the historical knowledge relating to vicarious traumatization. Researchers such as McCann,

Pearlman, and Saakvitne provided contextual information on the effects of vicarious traumatization on the helping professional. All journal articles were peer-reviewed. Many of the articles researched were more than 5 years old because I intended to provide a comprehensive review of the concept of vicarious traumatization.

## Theoretical Foundation

Vicarious traumatization is based on constructivist self-development theory (CSDT). CSDT is a combination of modern psychoanalytic theories, self-psychology, and object relations theory along with social cognition theories that present a developmental structure for understanding the perceptions of victims of trauma (Pearlman & Mac Ian, 1995). Hesse (2002) stated that according to CSDT, people formulate their personal realities that expand into schemas or compound cognitive frameworks that include beliefs, assumptions, and expectations about the individual and their world view. CSDT identifies seven schemas that include frame of reference regarding the self and the world, trust, safety, power and control, independence, esteem, and intimacy (Hesse, 2002). Other researchers identified five major schemas that include safety, trust/dependency, esteem, control, and intimacy (McCann & Pearlman,1990; Miller, Flores, & Pitcher, 2010; Saakvitne et al., 1998). Disruptions in these five schemas include the helping professionals' need to feel safe from harm, being able to trust other people and themselves, the need to feel valued or respected by others, the need to value others, the appropriate management of feelings and behaviors, and the need to feel associated with others and themselves (Dunkley & Wheelan, 2006). Vicarious

traumatization may prompt the professional to question humanity and expose the existence of sinister behavior toward others.

Saakvitne et al. (1998) identified CSDT as clinical trauma theory and suggested that the theory provides a framework to explain both devastation and resilience after trauma. Saakvitne et al. posited that according to CSDT, individuals can recognize how trauma affects them and can identify areas of tenacity after trauma. Professionals who work with victims of sexual trauma are subjected to graphic thoughts and images of abuse and violence experienced by the victims, which can lead to distortions in the professionals' perceptions of themselves and others. Saakvitne et al. stated that amid disruptions in the cognitive schemas, helping professionals will begin to ask questions of themselves, such as the following: Who am I now? How have my spiritual views changed because of this trauma? Is the world safe? Who am I to trust? Do I have any control? CSDT was relevant to the current study by providing a framework to examine how professionals' experiences of vicarious traumatization can transform their views of themselves, others, and how they interact with others.

Miller et al. (2010) examined 11 judges who experienced violent trauma after the shooting of a colleague. Miller et al. focused on short-term exposure to trauma causing distortions in the schemas. Miller et al. found that the judges' responses aligned with CSDT by noting that each judge experienced a degree of alteration in at least one of the five schemas, with all five schemas being adjusted in at least five judges. Findings indicated that helping professionals who are exposed to trauma are at risk for vicarious traumatization, which was the focus of the current study.

## Conceptual Framework

The conceptual framework for the current study was based on Finkelhor and Brown's (1985) traumagenic dynamics model, which includes four traumagenic dynamics (betrayal, stigmatization, powerlessness, and traumatic sexualization) that alter the self-concept, world view, and emotional state of a sexually traumatized victim (Cantón-Cortés et al., 2012). Kallstrom-Fuqua, Weston, and Marshall (2004) used this model to review data from a subsample of sexually abused, low-income women who had experienced sexual abuse before the age of 18. The four aspects of this model were used to examine the victims' experiences of feeling betrayed by the perpetrator, the identification of being stigmatized and feeling shame or guilt, feelings of powerlessness against the perpetrator or the judicial system if the perpetrator was not held accountable, and the lifelong emotional and physical trauma of sexual abuse (Kallstrom-Fuqua et al., 2004). The results of the study indicated that the effects of sexual abuse on relationships and psychological anguish were interceded by powerlessness and stigmatization, with betrayal having a minimal effect (Kallstrom-Fuqua et al., 2004). Victims of sexual trauma often seek psychological treatment from professionals to process thoughts and feelings of sexual abuse to assist them in rebuilding their lives (Boulanger, 2016; Dutton et al., 2017). Helping professionals who work with sexually traumatized victims are may often at risk for vicarious traumatization due to the extensive exposure to victims' experiences and pain. The current study benefited from this framework through the extensive examination of how the psychological outcome of a sexually victimized individual can affect helping professionals in their personal and professional lives. The

current study supported the notion that professionals who work with victims of sexual trauma must be able to effectively recognize vicarious trauma, employ skills/training to minimize the risk, and understand how vicarious trauma influences the helping professional.

## Literature Review

### Framework for Vicarious Traumatization

Vicarious traumatization (VT) is defined as psychological effects, such as nightmares, intrusive thoughts, and painful images, experienced by helping professionals who provide services/treatment to victims of trauma (McCann & Pearlman, 1990). Those experiencing VT can be forced to deal with these symptoms temporarily or over a longer period of time and may encounter symptoms that may be minimal or severe (Blair & Ramones, 1996). VT can lead to helping professionals' inability to complete their occupational responsibilities, often causing harm to the client and themselves (Harrison & Westwood, 2009; Iqbal, 2015).

VT is often used interchangeably with *burnout* but has a very different meaning. Burnout experienced by helping professionals affects them in ways such as providing substandard job performance, experiencing signs and symptoms of depression and/or anxiety, engaging in substance abuse, experiencing inadequate social functioning, and having a strong desire to end employment (Blair & Ramones, 1996). McCann and Pearlman (1990) defined burnout as the psychological pressure of working with challenging clients; however, this term refers to the psychological symptoms experienced by professionals who work with victims of trauma over an extended period (Blair &

Ramones, 1996). Wilson (2016) stated that social workers often experience burnout as a result of working with vulnerable populations in combination with increased workload, lack of control in their work environment, increased pressure to go against their values, differential treatment among employees, lack of fairness in the workplace, and a reduction in a cooperative workspace, which can lead to professional ineffectiveness, pessimism, and emotional debilitation.

Countertransference posits that the helping professional experiences uncertain or unconscious conflicts while listening to clients expose their experiences of trauma and terror (McCann & Pearlman, 1990). As therapists listen to sexually traumatized victims describe their experiences of graphic sexual abuse, therapists may be forced to unmask their own feelings of sexual abuse if they are victims themselves. Secondary traumatic stress (STS), closely related to VT, is defined as psychological signs and symptoms experienced by the helping professional when interacting with victims of trauma, which are often comparable to PTSD (Baird & Kracen, 2006). Secondary traumatic stress syndrome is defined as a syndrome with signs and symptoms comparable to PTSD except that exposure to a traumatic event or experience for one individual becomes a traumatic experience for the second person, who may be a friend, family member, or helping professional (Canfield, 2005). There are various definitions and descriptions of VT, STS, and compassion fatigue, which have made the study of these phenomena problematic because researchers must take into account the differences in research approaches and the variations in the work-related trauma (Molnar et al., 2017).

VT is grounded in cognitive self-development theory, which was based on numerous psychological theories, such as self-psychology, object-relations, and social cognitive theories, which have been used to treat victims of trauma (Moulden & Firestone, 2007). Trauma experienced by others alters the helping professionals' perception of themselves, others, and the world, and leads to diminished or nonexistent trust in others, mounting feelings of powerlessness and helplessness, disconnect from self and others, and feeling overwhelmed by emotions (Iqbal, 2015; McCann & Pearlman, 1990). The historical framework for VT has shown that it can be overcome when working with victims of trauma. Further research is needed to identify the skills and trainings needed by those who work with victims of sexual trauma.

**Trauma Work and the Helping Professional**

Pearlman and Mac Ian (1995) stated that several factors contribute to VT experienced by the helping professional, such as personal trauma history, the helping professional's perception of trauma, psychological style, interpersonal development, professional development, and current life stressors and support system. Additional factors that contribute to VT are components of the job, such as the nature of the clients and the specific information they share with the professional, client behaviors, work environment, and sociocultural factors (Pearlman & Mac Ian, 1995). Trauma work often exposes the helping professional to a variety of physical and psychological symptoms, such as sleeplessness, invasive imagery, headaches, nausea, sexual inadequacies, consistent lack of trust for others, and emotional paralysis or inundation (Neumann & Gamble, 1995). Professionals who are new to trauma work are vulnerable to the effects of

VT (Dunkley & Whelan, 2006). While engaging in trauma work, professionals realize their world-view has been shattered by the trepidation of others, constant fear for their own personal safety, realization of violence toward others as a common practice, and an enhanced cynicism regarding the power of psychotherapy (Neumann & Gamble, 1995; Pack, 2013). These authors posit that professionals who are new to trauma work often question their own ability to withstand a unique, but arduous field of work. It is essential that helping professionals who work with victims of trauma are made aware and appropriately trained to render services to victims of trauma, as not doing so is a detriment to the client and the professional (Pack, 2013).

Pearlman and Saakvitne (1995) state that psychotherapy is both essential and significant when dealing with adult survivors of CSA. The authors postulate that VT is similar to countertransference in that VT considers the helping professional's emotional reaction to the affective exposure and the mindful and oblivious protection against those emotions, but dissimilar in that VT is the overall effect of working with trauma clients on the helping professional (Harrison & Westwood, 2009). As professionals continuously work with victims of trauma, skills and techniques are developed that safeguard from emotional and psychological distress, as VT is not a single occurring episode, but rather a diverse assembly of signs and symptoms that occur across clients and therapeutic relationships (Pearlman & Saakvitne). The authors recommend VT be openly discussed among helping professionals, as minimizing its realization and effects can cause damage to both the client and the helping professional.

Knight (1997) conducted an exploratory study to determine the extent to which professionals who work with adult survivors of CSA experience a variety of emotional responses, and to identify aspects that impact those responses. CSA is defined as the sexual contact between a minor child and a person in position of control or authority (Knight). The research study included mental health professionals with concentrations in working with adult survivors of CSA in the state of Maryland, which composed of professionals who viewed themselves as working in the public or private sectors. The results from the study disclosed that the research participants recognized feelings of being overwhelmed by their work, the effects of their work on personal relationships, and an increased mistrust of others (Knight, 1997; Trippany, Kress, & Wilcoxon, 2004). Knight's research indicated that professionals who work with victims of sexual abuse must find appropriate ways to channel their feelings and increase their support system to minimize the impact of their work on their personal lives. Other common affective responses indicated in the study included strong feelings of anger and sadness concerning their client's abuse, as well as a sense of horror, fantasies that depicted the professional in the role as the rescuer, and consistent thoughts about their client outside of the work environment (Knight). The exploratory study determined that the research participants found that attending conferences or workshops and confabulation with colleagues assisted them in being able to openly discuss their reactions.

Jones et al., (1998) stated that professionals must have expectations of their own personal issues when working with victims of sexual abuse. Findings indicated that sexually traumatized victims internalize and externalize thoughts and feelings related to

the abuse, which can manifest in the form of depression, anxiety, behavioral issues, and interpersonal struggles. Professionals who work with victims of sexual trauma must receive specific education, training, and supervision to efficiently provide treatment and to be consciously aware of emotional responses in working with this population (Jones et al., 1998; Pack, 2013; Sommer, 2008; Berger & Quiros, 2014). The author explained that counselors who are themselves victims of sexual abuse are vulnerable to the effects of VT, but also offer a perspective that is directly related to the clients' own experiences. When working with sexually traumatized victims, the professional may endure feelings of rage, avoidance, overidentification, feelings of incompetency to help the client, guilt, and shock (Jones, 1998; Sexton 1999; Trippany, Kress, & Wilcoxon, 2004). The author's recommendations of minimizing the risk of VT include personal counseling, effective supervision, balance between work and personal life, appropriate spiritual life, and continued education.

Sexton (1999) stated that the effects of VT on counselors not only affect the professional, but the agency or organization can also suffer. The author stated that empathy is a necessary component of effective trauma therapy but can be challenged over the course of trauma therapy due to the profound nature of affective responses evoked in the therapist, which may lead to intense countertransference reactions that can disrupt the empathic position of the professional. Organizations can holistically suffer from professionals who work with traumatized individuals in ways such as an inadequate quality of work produced by the agency, an increase in resignations among staff, decline in commitment to work from employees, and a recognized depressing work environment

(Sexton, 1998; Dunkley & Whelan, 2006; Pack, 2013). This research suggests that in order to reduce the risk of VT among professionals who work with traumatized clients, organizations must provide adequate training for trauma therapy, recognize and acknowledge VT is a realistic concept that affects helping professionals at any time, promote effective team meetings that allow professionals to openly discuss indicators of VT, while accepting the sensitivity of the issue, provide shared responsibility of clinical work, and increased encouragement for professionals to maintain realistic boundaries regarding their work. Sexton recommends that professionals who work with trauma victims comprehend the early warning signs of VT, identify their own reactions and those prominent themes that provoke countertransference responses, develop a self-awareness for their own signs of distress, verbalize their own feelings of trauma-related internal amity, and realize that trauma-related feelings and thoughts will diminish.

Benatar (2000) conducted a qualitative study that explored the long-term effects of working with survivors of sexual abuse history on two groups of knowledgeable therapists, which included those who reported a history of CSA and those who did not. The researcher stated that the effects of secondary trauma caused disturbed professional to be vulnerable to VT, and while becoming indistinct when working with victims of trauma. The author stated that VT is not a compulsive condition but unexpected normative consequence of treating victims of trauma. Results of the study determined that all participants reported the effects of their work as distressing, however, therapists who reported a history of CSA where no more at risk for VT than those without a history

of CSA. During trauma therapy, therapists and clients experienced shared trauma, which increased the risk of VT for the therapist (Saakvitne, 2002; Canfield, 2005).

Secondary traumatization often occurs when professionals are interacting with individuals for whom they feel a sense of responsibility. Saakvitne (2002) stated that professionals often deal with vulnerability that is noticed by the clients they service and within themselves, which can lead to feelings of incompetence or shame. To protect oneself from VT, the author recommended strategies for self-care protection that foster an environment of healing and lessen the impact of trauma work, that included protection (being knowledgeable of the signs of VT), self-care (adequate balance of work and personal life, consistent positive connection to others), and transformation (examination of the meaning of our work to us) (Saakvitne, 2002; Canfield, 2005; Pack, 2013; Sommer, 2008).

Heese (2002) posited that secondary trauma is supported by the cognitive self-development theory, which emphasizes that when working with victims of trauma, the personal realities of the helping professional are transformed into multifaceted cognitive concepts, which Piaget termed as schemas. The author noted that with trauma therapy, the professional's beliefs, assumptions, and expectations are interrupted and is done so based on two different factors: aspects of the work and aspects specific to the therapist. Heese (2002) and Canfield (2005) specified that secondary trauma produces defenses such as denial, isolation, and dissociation among the helping professional, enhancing feelings of powerlessness regarding the client's recovery. The author further mentioned that professionals who are experiencing VT may begin to question their self-worth,

feeling as though that they are not as helpful to the client as they should be, experience an increased loss in humanity and cynicism, and engage in self-harm behaviors such as overeating, overspending, and overworking. Heese also makes note that professionals who are trauma survivors themselves may experience in increase in signs of VT after relieving their client's experiences and memories. Additionally, the author suggested that professionals who work in organizations and agencies should not deal with VT in isolation, as supervisors and administrators should recognize and accept secondary trauma as a realistic concept and implement strategies to protect the helping professional, the organization, and the client (Heese, 2002; Etherington, 2009).

Clemans (2004) conducted a qualitative study to gain insight on the experiences of women who work in rape crisis centers. The study included 21 female employees of rape crisis centers, who had master's degrees in social work and related fields. The results of the study indicated that all 21 participants reported feelings of personal danger and increased restriction in their behavior, while experiencing an increase in susceptibility to sexual trauma. Clemans found that 15 of the 21 research participants experienced secondary traumatic stress in the form of physical ailments such as headaches, stomachaches, increased anxiety, and indications of a panic attack. Personal relationships and increased protection for their children were common themes found among the participants, as well as, strained intimate partner relationships that precluded skepticism regarding positive non-abusive relationships were also reported by the research participants. Clemans's study identified a wide-range of coping skills utilized by the

helping professional such as activism within their community, spirituality, prosocial interactions with colleagues, humor, and revenge fantasies.

Harrison and Westwood (2009) conducted a qualitative study on the protective factors that alleviate risk of vicarious trauma among mental health workers. The researchers sought to answer the research question "How do you manage to sustain your personal and professional well-being, given the challenges of your work with seriously traumatized clients?". The authors stated that often helping professionals relinquish their professional responsibilities and obligations due to the emotional strain of working with traumatized individuals, which often results in an imbalance between work and other aspects of life. It is detrimental to the client if the helping professional continues to provide services while ignoring the signs and symptoms of vicarious trauma. It is of the utmost importance that professionals provide adequate care to their traumatized clients, as not doing so jeopardizes the ethical standards of the helping profession. The purpose of the study was to gain insight in to the protective practices utilized by helping professionals who work with traumatized clients, and how these practices can potentially prevent vicarious trauma. Research participants were either master or doctoral level individuals with at least 10 years of professional experience with traumatized clients and having identified themselves as having been well managed in this field. Harrison & Westwood for the following:

> Their clientele included survivors of sexual and or physical abuse perpetrated during childhood and or adulthood, pediatric and adult palliative care patients and their families, survivors of torture and natural disasters, refugees from countries at

> war, firefighters, bank tellers involved in robberies, and people with a history of abuse dealing with poverty, racism, substance abuse, and suicidal ideation (p. 207).

In answering the research question, the participants disclosed the following: (1) supervision played a significant role in alleviating the risk of vicarious trauma; (2) the importance of organizational structure which included adequate training, continuous professional development, and mentorship; (3) organizations should provide a platform for helping professionals to openly discuss vicarious trauma within a supportive environment; (4) maintaining other obligations such as supervision, teaching, and direct practice; (5) the influence of friends and family in assisting the helping professional in separating their work and family/personal life; (6) the importance of spirituality; (7) the practice of mindfulness as continuing shifts in mind, body, and the world, which made them aware of adjustments in interpersonal boundaries; (8) negative perceptions can be changed into positive cognitions when working with victims of trauma; (9) the redirection of positivism into action; (10) self-care is inevitable in order to maintain personal and professional well-being; (11) establishing and maintaining boundaries with their clients was essential; (12) truthful views regarding self, others, and the world were significant; (13) explicit understanding between the concepts of sympathy and empathy; (14) the appropriate use of self-management strategies to obtain and maintain boundaries when information received from the client posed a risk to their personal life or views; (15) empathic engagement was beneficial for the client and the professional; (16) working in the field of trauma was considered as both effective and purposeful (Harrison

& Westwood, 2009). The study indicated that empathic engagement, when expressed accordingly can be effective, as the helping professional must learn how to balance traumatic information received from clients without diminishing the professionals' perception of self, others, and the world. The authors concluded by suggesting that increased attention should be placed in self-reflection and self-care practices as pivotal components of ethical practice.

Maier (2011) conducted a qualitative study on the experiences of VT and burnout among Sexual Assault Nurse Examiners (SANEs) when treating rape victims and the coping strategies they utilized to reduce both. Results of the study indicated that among 39 SANEs who were interviewed, 67% reported vicarious trauma, the emotional stressors of the job, increased worry and anxiety about victims once they leave the safety of the hospital setting, and burnout. The SANEs acknowledged that they had experienced some form of VT and burnout to some degree but identified common coping skills such as communicating with family members, interacting with other SANEs, program coordinators, sexual assault advocates and detectives, participating in meetings or workshops with other SANEs, and regular prosocial activities (Maier, 2011). The author noted that it is crucial that professionals who work with sexually traumatized victims be aware of their own emotional limitations and develop healthy coping techniques to assist them reducing the risk of VT.

Coles, Astbury, Dartnall, and Limjerwala (2014) conducted a qualitative exploratory study on trauma and researchers' responses to investigating trauma. The main objective of the study was to examine the traumatic experiences of researchers from

various countries who studied sexual violence, address the origin of the trauma, and the techniques they determined to be efficient. Researchers who study sexual violence are not only privy to hearing horrific stories as victims recount their personal experiences of sexual abuse, but also sexually violent perpetrators who often describe in detail about their sexually abusive behavior. Coles et al. indicated that organizations should prepare researchers who work in the area of sexual violence by promoting techniques that protect not only participants, but researchers as well to distinguish and prevent vicarious trauma. The researchers expound on the exposure to vicarious trauma when studying sexual violence research, placing emphasis on the emotional risk and organizational concerns. "Physical symptoms and emotional distress were reported as consequences of undertaking sexual violence research. The most common emotional responses described were anger, guilt, and shame, fear, crying, and feelings sad and depressed" (Coles et al., 2014, p. 100). The research study indicated that victims of sexual trauma are not always able to access services within organizations that render assistance, which can be particularly emotionally troublesome for the researchers. The authors identified coping strategies to successfully manage vicarious trauma, such as preparation, regular debriefing, organizational support and adequate supervision, counseling, research management, appropriate education and publication, and effective self-care strategies such as the pursuance of spirituality, traveling, and time well spent with family and friends. Researchers who plan to study sexual violence should be mindful of risks such as lack of experience, age, and personal history of sexual abuse or violence, and organizations should best prepare researchers for this particular area of study by offering

psychological support and treatment, as well as adequate supervision and opportunities for peer support (Coles et al., 2014; Wilson, 2016).

Adams, Shakespeare-Finch, and Armstrong (2015) conducted a qualitative study on stress and well-being among Emergency Medical Dispatchers (EMDs) who provide crisis intervention to medical emergencies by use of telehealth support. The purpose of the study was to better understand how to encourage mental health and well-being among workers in this profession. EMDs are front-line workers whose primary responsibility is to actively retrieve information from others who are observing first-hand trauma, which exposes them to vicarious trauma. Research participants consisted of 16 EMDs who provided information on their lived experiences of providing telehealth support to victims of trauma. EMDs who were interviewed for the study had a range of 2 to 15 years of experience in their current role. Results from the study indicated that 3 superordinate themes developed, including operational stress and vicarious trauma, organizational stress, and posttraumatic growth. Research participants revealed that even when working with victims of trauma despite their physical distance, symptoms of vicarious trauma, such as intrusive thoughts, flashbacks, hyperarousal, and physical signs of anxiety and tension, plague them in their work role. The study conducted by Adams et al. (2015) concluded that although EMDS may experience vicarious trauma in their role, post-traumatic growth may subject them to the increased awareness of well-being and mental health.

Sui and Padmanabhanunni (2016) conducted a qualitative research study that explored the psychological impact of working survivors of trauma for South African

psychologists. The researchers suggested that traumatic occurrence happen frequently in South Africa and psychologists who work with victims of trauma are risk for vicarious trauma. As previously discussed, professionals who work with victims of trauma are often exposed to graphic descriptions of traumatic experiences, such as rape and sexual assault, childhood sexual abuse, and intimate partner violence as told by the victim, leaving the helping professional exposed to the pain and suffering endured by others. Exposure to the traumatic experiences of others can alter the helping professionals' cognitive schemas, including their beliefs and views about themselves, others, and the world. The current study focused on the lived experiences of a group of South African psychologists who work with trauma survivors. The purpose of the research study was to shed light on the influence of trauma work and include information on training programs for helping professionals who are seeking to enter the field of trauma. The research study included 6 psychologists who, during the interview, revealed not only the negative aspects of working with trauma survivors, but also positive aspects identified as post-traumatic growth, which will be later discussed in the literature review. Sui and Padmanabhanunni indicated that research participants experienced symptoms of PTSD including disruptive memories, repeated negative emotional states, various somatic reactions, and altered assumptions regarding the invulnerability of the world. The authors stated that psychologists who work with trauma survivors in South Africa reported that they experienced feelings of irritability, sadness, helplessness and powerlessness, as well as alterations in arousal and receptiveness such as variations in sleep patterns, outbursts of anger, and hypervigilance. Reported somatic symptoms included headaches and

muscle tension in the head and neck. The research concluded by acknowledging that professionals who work in the field of trauma should be mindful of the signs of vicarious trauma and employ appropriate coping techniques that will mitigate its influence.

**Implications for Introducing Vicarious Trauma**

Knight (2013) stated that the concept of indirect trauma for clinical professionals and students should be introduced by colleagues, supervisors, the employee organization, and the academic institution. The author noted that discussions regarding vicarious trauma should be sensitively conferred in a classroom setting that address self-care strategies among professionals who work with victims of trauma. Students who plan to develop a career in trauma work should be introduced to the signs of VT and should take the necessary steps to diminish its influence.

Baker (2012) conducted a qualitative study on the experiences of VT, effective coping mechanisms, and the need for graduate-level courses in trauma therapy. The research participants included 10 women and 1 man, who were all master-level trauma therapists. Baker (2012) indicated that because of VT, each participant experienced distress and insecurity in addition to increased mistrust in others, and a consent that the need for a graduate-level course regarding trauma therapy was necessary.

Etherington (2009) offered suggestions for supervisors of helping professionals who work with victims of trauma. While engaging in trauma work, professionals may experience a diminish in the existence of humanity and spirituality, along with increased fears and mistrust of others. It is essential that professionals be provided with a safe environment to express their thoughts and feelings related to their work. Etherington

stated that supervision of professionals who work with victimized clients should focus on the interrelationship between the trauma itself, the helping professional, the relationship between the supervisor and supervisee, and the context in which the work is offered. The complexity of this relationship is essential because it allows the supervisor to educate the supervisee on the risk of VT, provide necessary trainings needed to minimize its effect, and offer information on how VT can influence the life of the helping professional.

Clemans (2005) identified a single session group work session among social workers as an effective method of introducing the concept of VT. The author noted that group work sessions are essential among clinicians who provide direct care services to clients affected by sexual trauma, domestic violence or child abuse. The study suggested that group sessions among clinicians could effectively introduce the phenomenon of VT and provide guidance on coping strategies such the necessary skills for self-awareness, self-care strategies, prosocial interactions, and an adequate balance between home and work life (Clemans, 2005). Group work sessions allow professionals to convene together and discuss the shared experiences of trauma work, while obtaining additional knowledge from others on the experiences of working with victims of trauma. According to the author, group work sessions assist trauma workers in managing challenging caseloads, as well as, offer opportunities to connect with colleagues, minimize feelings of isolation, and educate each other on new self-care skills).

Bell, Kulkarni, and Dalton (2003) provided information on the reducing the risk of VT among counselors within the organizations setting. As previously discussed, professionals who work with victims of trauma can experience emotional burnout and

difficulty in providing effective counseling. The researchers declared that counselors who work with trauma victims may find the work more taxing due to the limitations and challenges within the mental health and legal systems. Organizations offer strategies to reduce the risk of VT among professionals such as providing a diverse caseload for the employees, increased and ongoing education regarding trauma work and its effects on the helping professional, implementing required self-care practices, ongoing trauma-specific workshops and conferences, learning new ways to address clients' trauma, and consistent group support in the form of consultation or team meetings (Bell, Kulkarni, & Dalton, 2003). The authors posit that organizations have a responsibility to educate and inform its employees of the challenges of trauma work to reduce the risk of VT among helping professionals.

**Vicarious Resilience and Post-Traumatic Growth**

Previous research has indicated the helping professionals who work with victims of trauma are at risk of vicarious traumatization, that may include emotional and psychological stressors, such as reoccurring dreams or nightmares based on their clients' trauma, intrusive thoughts, and the transformation of a person's beliefs and values. Vicarious trauma can negatively influence the helping professional both professionally and personally. What can also be understood about working with victims of trauma is that counselors, social workers, other helping professionals can be positively influenced as well.

Barrington and Shakespeare-Finch (2012) conducted a research study on clinicians who worked with refugee survivors of torture and trauma, examining the lived

experiences of people working daily with survivors of torture and trauma who had sought asylum in Australia. The research participants included 17 clinical, managerial, and administrative staff working within a non-profit organization. The interview protocol focused on the personal experiences of working with refugee survivors who listened daily to stories of torture and trauma, and often experienced negative and positive influences of trauma work (Barrington & Shakespeare-Finch, 2012). Several of the research participants reported that as a result of vicarious post-traumatic growth, they experienced changes in their philosophy on life, specifically obtaining a greater understanding and awareness of their work, adjustments in their priorities, an increased sense of gratitude, expanded gratitude for loved ones, and a heightened sense of spirituality. Many participants reported changes in their self-perceptions, obtaining a greater assurance about their profession, as well as, positive changes in their interpersonal relationships (Barrington & Shakespeare-Finch, 2012).

Gartner (2014) depicted his personal story of working with male victims of sexual trauma, by following his responses to interacting with this particular population. The author mentioned that as he worked with male victims of sexual trauma, he began to experience a shift in how the traumatic experiences of his clients shaped his cognitive perceptions. Gartner (2014) stated that as he experienced mental photographs after listening to stories of his clients' traumatic experiences, he began to put his own thoughts into words and coding them, just as he would for these clients; as this gave him a deeper insight into what his clients were experiencing. The author mentioned that while working with sexually traumatized victims, he engaged in various self-care activities, such as

exercise, meditation, traveling, and spending adequate time with family and friends, as helping professionals should seek an appropriate balance between work and personal life, a steady association with others, and a self-examination on the meaning of trauma work (Saakvitne, 2002; Canfield, 2005; Pack, 2013; Sommer, 2008). Gartner (2014) recognized that his clients moved past their trauma in the most valiant and resilient ways, and by processing auditory traumatic information, he began to evolve psychologically and spiritually, simultaneously giving to his clients and receiving an improved understanding of survival among sexually traumatized individuals.

Hernandez-Wolfe, Killian, Engstrom, and Gangsei (2015) conducted a qualitative study on the coexistence of vicarious resilience, vicarious trauma, and trauma work with torture survivors and specialized programs across the United States. The purpose of the research study was to examine the differences between positive and negative influences, previously identified as vicarious traumatization and vicarious resilience, in working with torture survivors and particular programs across the United States. According to the research study, there are approximately 250 programs across the world, and out of 250, 143 programs are member organizations of the International Rehabilitation Council for Torture Victims (IRCT), which is the largest organization that advocates for the prevention and rehabilitation of torture survivors around the world (Hernandez-Wolfe et al., 2015). Trauma therapists work torture survivors who have experienced sexual, psychological, and/or physical torture who have escaped from their home countries in search of safety and protection. As trauma therapists bear witness to abhorrent stories of pain and suffering endured by torture survivors, they also become aware of the client's

tenacious desire to overcome adversity and experience the process of vicarious resilience, increasing their knowledge and awareness of life after trauma. The research study included 13 mental health providers who worked as psychologists, social workers, or marriage and family therapists, and were employed within torture treatment programs in the west, east, and Midwest areas of the United States. The study indicated that as professionals experience vicarious trauma when working with torture victims, they can also begin the process of vicarious resilience, as they overcome their own personal challenges and focus on an expansive understanding of human rights (Hernandez-Wolfe et al., 2015). "Trauma work is a source of both stress and joy, involving a developing perspective of how one approaches personal challenges and one's views about larger social issues, and the stress from dealing with some attorneys and the court system, protective services, and needs that significantly exceed resources" (Hernandez-Wolfe et al., 2015, p. 163). The study concluded by mentioning that although the psychological stressors of trauma work are imminent, helping professionals can experience positive aspects of this work by transferring their clients' resilience and hope in their own.

Silveira and Boyer (2015) examined clients' resilience progressions during treatment positively influenced the personal and professional lives of helping professionals who work with child and youth victims of interpersonal trauma, which included victims of sexual abuse, violence, or neglect. The researchers utilized a qualitative instrumental multiple-case study design and thematic analysis to answer the research question: How are counselors who work with child and youth victims of interpersonal trauma (e.g., sexual abuse) affected by bearing witness to their clients'

resilience processes? Silveira and Boyer indicated that their interest in this area developed from their opinion that professionals can be positively influenced in their professional and personal lives, while witnessing shifts in their own personal perspectives regarding trauma work. The research participants included 4 counselors who had at least 3 years of experience working with trauma, having a caseload composed of children and/or youth victims of abuse, including at least 50% of clients who were survivors of interpersonal trauma (e.g., sexual abuse); and a confirmed positive impression, observed through supervision. Interview questions included the following: (a) the general impact of trauma work on counselors, (b) the ways each participant dealt with work-related stress, (c) the impact on the participant's personal life of witnessing clients' resilience processes, (d) the impact on the participant's clinical practice that client resilience processes had, and (e) participants' input about the potential usefulness of the concept of VR in each of their practices. The results from the study indicated that the counselors experienced an increased sense of hope and certainty and were encouraged by the resilience of their clients. As the participants reflected on the stressors that their clients faced, they took into account their own challenges and tenacity, as they reported positive changes in their personal relationships (Silveira & Boyer, 2015).

## Summary and Conclusions

The purpose of the literature review was to provide information on the knowledge and education regarding vicarious traumatization experienced by helping professionals who work with victims of trauma, while identifying the risk, skills and trainings needed to minimize its effect, and the influence of vicarious trauma on the helping professional

when working with victims of sexual trauma. What is now known about vicarious trauma is that professionals who are new to the field of trauma, those with an inadequate understanding and knowledge of trauma work and its effects, and professionals with a history of unresolved personal sexual trauma are at a higher risk of experiencing vicarious traumatization. What is also known is that researchers have provided recommendations for the prevention of vicarious trauma, such as appropriate college-level course work, adequate supervision, consultation, manageable caseloads among trauma workers, and constant communication regarding self-care strategies. Although extensive research regarding this topic has been studied, minimal research exists on the narratives of professionals who work with sexually traumatized victims and the influence of vicarious trauma within their life.

In Chapter 3, the methodology of the study is addressed. The study includes conducting semi-structured interviews among professionals who work with victims of sexual trauma within two research sites: a faith-based organization which provides counseling services to women who are previously or currently involved in the sex industry as a prostitute or stripper and a nonprofit organization that provides services to victims of sexual trauma.

# Chapter 3: Research Method

The design for this research study was qualitative using semistructured interviews. Eight helping professionals who work with female victims of sexual trauma were interviewed. The small number of participants was appropriate for narrative research as it allowed me to focus on the personal stories of single individuals while being able to spend sufficient time with each (see Creswell, 2013). This chapter provides information on my research design and the rationale for using the design. My role as the researcher is discussed, and I provide detailed information on my chosen methodology while describing how research participants were selected. The interview protocol and how it was used to gather the information is explained.

The purpose of this qualitative, narrative research study was to investigate individual experiences of helping professionals who work with victims of sexual trauma within two research sites. Site 1 employs professionals who offer a recovery program to women who are victims of sexual trauma, which includes services such as assistance with medical care, counseling and trauma recovery, and options for safe housing. Site 2 employs professionals who provide on-site advocacy-based crisis intervention and in-office counseling for victims of sexual trauma. Sexual trauma advocates initially interact with sexually traumatized victims in the emergency room of local hospitals. The advocates provide encouragement and support as victims are examined by the sexual assault nurse examiner. After the examination, the advocate provides the victim with information on in-office counseling conducted by licensed professionals.

## Research Design and Rationale

The research questions included the following:

RQ 1: How is the evidence of vicarious traumatization manifested among helping professionals who work with female victims of sexual trauma, as self-reported in interviews and written documentation?

RQ 2: What skills, techniques, and trainings do helping professionals who work with female victims of sexual trauma utilize to identify and minimize vicarious traumatization?

RQ 3: How does vicarious traumatization influence helping professionals who work with female victims of sexual trauma, specifically personally and professionally?

Creswell (2014) stated that the historical origins of qualitative research are grounded in anthropology, the humanities, sociology, and evaluation; narrative research allows the participant to share personal experiences about a phenomenon of interest. Qualitative inquiry can elicit a substantial amount of information about people and cases, in small numbers, which increases the complexity and understanding of a specific phenomenon (Patton, 2002). Qualitative designs have evolved since the 1990s, as researcher began to expound on the philosophical assumptions behind qualitative research designs (Creswell, 2013, 2014). Narrative research was the most suitable research design for this study because it allowed me to delve into the lived experiences of helping professionals who work with sexually traumatized victims and explore their personal stories. Creswell (2013) stated that “writers of narrative research have provided ways for analyzing and understanding the stories lived and told” (p. 70). Narrative

research allowed me to explore the concept of vicarious traumatization among helping professionals who work with victims of sexual trauma.

## Role of the Researcher

The role of the researcher includes ensuring that the study is conducted in the utmost ethical manner. The researcher must collect and analyze data from research participants, ensuring that no physical or emotional harm is done. Patton (2002) stated that the researcher is the instrument of data collection and analysis, while maintaining a position of neutrality that includes a "balance in reporting both confirmatory and disconfirming evidence with regard to any conclusions offered" (p. 51). The researcher must also be cognizant of any personal biases regarding the research topic, interview questions, and collection and analysis of data.

## Methodology

The research participants for the study were employed by one of two agencies the Southern region of the United States that provide services to victims of sexual trauma. Site 1 is a faith-based organization that provides counseling to women who are currently or were previously involved in the sex industry by way of prostituting, stripping, or sex trafficking. Site 2 is a nonprofit organization that provides crisis services and counseling to victims of sexual trauma. Participants worked with sexually traumatized victims as licensed or nonlicensed professionals. Both sites include helping professionals who provide counseling and trauma recovery. Site 1 utilizes eye movement desensitization and reprocessing (EMDR) as their preferred treatment modality. EMDR is a

psychotherapy program that empowers people to heal from the symptoms and emotional suffering that are the result of distressing life experiences (EMDR Institute, 2017).

Patton (2002) stated that purposeful sampling involves selecting cases for study, such as people or organizations, because they are well-informed about a specific phenomenon of interest. I was allowed to attend staff meetings at each of the research sites and speak with their staff about my study. I explained that participation in the study was strictly voluntary, and that participants must satisfy the selection criteria to participate in the study. While on-site, I informed the staff that I was available immediately after the staff meeting to obtain signatures on consent forms from anyone who wanted to volunteer. Participants included their name and phone number on the consent form. Once I obtained consent forms, I contacted each participant by phone to schedule a date and time for the interview. All participants received a copy of their consent form before the interview. The participants were information-rich sources who were able to describe their lived experiences of working with female victims of sexual trauma and their risk of vicarious trauma. The number of participants selected allowed me an appropriate amount of time to collect and analyze the data, as well as increase the opportunity to achieve data saturation by collecting information-rich data. Patton (2002) indicated that no guidelines had been established for sample size in qualitative inquiry, as purposeful samplings should be based on the purpose and justification for the study.

I collected data using an interview tool. The interview tool was developed to answer all research questions. Data were collected in the private offices of each research participant to accommodate their busy work schedules. Each office was resistant to high

levels of noise. Data were collected over a period of 3 weeks to allow for flexibility with the participants' schedules. Data were recorded via tape recorder. The participants were given the opportunity to discuss their thoughts and feelings about participating in the study. No participant desired counseling services to discuss their risk or experiences of vicarious traumatization with a licensed professional counselor, whom I would have referred. Data were stored, recovered, coded, and compared using a master Excel spreadsheet that included each participant's transcribed responses to each interview question.

## Issues of Trustworthiness

Consent forms were obtained from each participant prior to the interview. I informed each participant that participation in the study was strictly voluntary. Consent forms included contact information, confidentiality disclosure, benefits and risks of participating in the study, information on the right to withdraw from the study, and an incentive for participation. Consent forms were kept in a secure file cabinet. Patton (2002) stated that a credible researcher must be experienced and trained in qualitative research. For guidelines on coding and theme identification, I referenced Saldana (2008). A gift card to a local bookstore was provided to each participate who completed the study.

## Summary

This chapter included information relating to the research design and rationale, role of the researcher, and participant selection. I also discussed why narrative research was the most appropriate design for this study and discussed how data were collected.

Chapter 3 also addressed concerns of trustworthiness. Chapter 4 contains the research findings from data analysis.

# Chapter 4: Results

The purpose of this study was to explore the lived experiences of helping professionals who work with female victims of sexual trauma. The data analysis answered the following research questions:

RQ 1: How is the evidence of vicarious traumatization manifested among helping professionals who work with female victims of sexual trauma, as self-reported in interviews and written documentation?

RQ 2: What skills, techniques, and training do helping professionals who work with female victims of sexual trauma utilize to identify and minimize vicarious traumatization?

RQ 3: How does vicarious traumatization influence helping professionals who work with female victims of sexual trauma, specifically personally and professionally?

This chapter presents the findings from interviews with helping professionals who work with female victims of sexual trauma. This chapter also includes information on the sample size, selection criteria of participants, and the data collection and analysis process. This chapter also addresses evidence of trustworthiness, including credibility, transferability, dependability, and conformability.

## Setting

After receiving approval from Walden University's institutional review board (05-02-18-0117347), I began to recruit potential participants. I contacted program directors from each of the research sites and asked to attend staff meetings, so I could explain my study. During the staff meetings, I explained the purpose of my study and

read the consent form in its entirety. Individuals who were interested in participating returned the consent form and provided me with their contact information. I began to contact participants and set up interview dates and times that coordinated with each participant's schedule. Participation in the study was voluntary. I conducted each interview in the private office of each participant, where good sound quality and confidentiality were ensured.

## Data Collection

The interviews took place in the Southern region of the United States. Using a semistructured interview tool, I interviewed eight helping professionals who worked with female victims of sexual trauma. Interviews took place from June 27 to July 20, 2018, and each interview lasted 15-25 minutes. I allowed participants to ask questions regarding information on the consent form. I used a digital voice recorder to record the interviews, and I also used the voice memo recorder on my iPhone 7 as a secondary recording device. Each participant agreed to have the interview recorded and was aware that two different voice recording devices would be used. All participants met the selection criteria: (a) licensed or nonlicensed professional, (b) at least 18 years old, (c) fluent in English, (d) directly employed by the agency, and (e) currently working with female victims of sexual trauma.

## Data Analysis

Interview data were transcribed using a transcription analysis software program entitled Transcription Puppy. This software was chosen based on client reviews that indicated the software's ability to transcribe accurate results promptly. Recorded

interviews were uploaded to the software's transcription portal, and each interview was identified only by number (e.g., Participant1, Participant2). Each transcribed interview was returned in a Word document. I listened to each of the interviews and compared the transcribed Word document with the original recorded interview to ensure accuracy and to remove unnecessary inaudible sounds and phrases, such as coughs and laughter.

I reviewed the transcribed data multiple times to ensure that each interview question had been answered in its entirety. Once I obtained transcribed interview data for all research participants, I created a master spreadsheet that included each interview question and responses to each of those questions from every participant. The master spreadsheet contained columns that reflected each participant's response to the interview question. As I reviewed each transcribed interview, I copied from the transcribed Word document and pasted the response into the spreadsheet under the designated column. I began to look for common themes and codes that represented the participant's lived experiences of working with female victims of sexual trauma.

## Evidence of Trustworthiness

The participants described their lived experiences of working with female victims of sexual trauma and the risks associated with their work. The participants described how vicarious traumatization influenced their work, both personally and professionally. The following sections will discuss the credibility, transferability, dependability, and confirmability of the study.

## Credibility

Credibility in this research study was confirmed by comparing the transcribed interview responses with the interview questions to ensure relevance. Participants experienced the same thoughts and feelings regarding their exposure to vicarious trauma, from which overlapping themes emerged. These themes answered the three research questions.

## Transferability

The study was conducted in the Southern region of the United States where participants were employed as licensed and nonlicensed professionals who worked with female victims of sexual trauma. Participants were recruited from a nonprofit organization and a faith-based organization. The research questions and the participants' lived experiences confirmed that the study results could be transferable to comparable populations in different environments, as adequate information on the context of the research was provided.

## Dependability

The results confirmed that this qualitative study could be replicated and that researchers could expect similar findings. The coding process was extensive and repeated numerous times to ensure themes were captured with accuracy. All aspects of the study were documented, including interview dates and times, transcribed responses to the interview questions, and participants' body language during the interviews.

## Confirmability

Confirmability was ensured by basing the findings on the participants' personal stories rather than on researcher bias. An audit trail was established that providing information on the collection, analysis, and interpretation of the interview data.

## Demographics and Field Experience of Participants

Table 1 provides demographic information on the research participants, including the field experience of each participant. Information regarding participants' gender, role as a helping professional, number of years worked in the field of trauma, and client population is included in the table.

Table 1

*Demographics and Field Experience of Participants*

| Participant | Gender | Role | Years worked in the field of trauma | Client population |
|---|---|---|---|---|
| 1 | Female | Survivor advocate | 7 | Women |
| 2 | Female | Therapist | 25 | Men, women, and children |
| 3 | Male | LPC | 21 | Any victim of sexual trauma |
| 4 | Female | LMSW | 3 | Men, women, and children |
| 5 | Female | Counselor/executive director/program director | 18 | Men, women, and children |
| 6 | Female | Director | 7 | Women and girls leaving the sex industry |
| 7 | Male | LPC | 8 | Adults and children |
| 8 | Female | Domestic violence and sexual assault advocate | 19 | Women and children |

## Results

### Interview Questions

The interview questions addressed the lived experiences of professionals who work with female victims of sexual trauma. The following interview questions were developed to answer the three RQs. A summary of the results for each interview question and emergent themes are included in the following sections.

**Interview Question 1**. What criteria must be met to receive services from your agency?

Each participant provided details of the criteria that must be met to provide services to victims of sexual trauma. Two out of eight participants explained that they provided services to women and girls who were leaving the sex industry by way of prostitution, sex trafficking, or exotic dancing. Five out of eight participants stated that their agency provided services to anyone who identified as a victim of sexual trauma or anyone who had been affected by prior negative experiences. One out of eight participants stated that services could be provided to anyone who was not identified as a domestic violence or sexual assault perpetrator.

Participant 1 stated, "They have to be women coming out of the sex industry. They have to be victims of sex trafficking to qualify."

Participant 4 said, "Anybody that is looking to live a better life essentially. So, anybody that has anything in their life that is holding them back from leading a happy, fulfilling life. It could be prior experiences from childhood that were negative or bad or any kind of abuse."

Participant 7 stated, "We don't see perpetrators. So domestic violence perpetrators or sexual predators, and we don't treat in-patient psychiatric care, but pretty much anybody else."

**Interview Question 2**. How many weekly hours of services do you provide to your clients?

Two out of eight research participants stated that they provided "1 hour per week or every other week" per client. One out of eight participants stated that clients received

"about 15 hours" per week per client. One out of eight participants stated that 32 hours of weekly service are provided.

Participant 1 stated, "between 40 and 60."

Participant 5 said, "The work week, the work week is 40 hours. My phone never stops ringing texts in, so I will say a hundred plus."

Participant 6 stated, "So I would say 35 to 40 per week for adults. For juveniles, it's probably 15 to 20."

Participant 8 stated, "Probably about 70."

**Interview Question 3**. What topics are discussed while providing those services?

The participants' narratives indicated similar topics of discussion that included sexual trauma, immediate needs, and forgiveness.

Participant 1 said, "So, inner healing is a major topic, forgiveness, offense, recovery from addiction, recovery from trauma, recovery from sexual trauma, sexual abuse, ending the game which is learning the lifestyle that they were in because some of them may not even know it was a lifestyle they brought them here."

Participant 2 stated, "Any topic that is of concern and need of the client. That's just pretty much all kinds of stuff."

Participant 3 remarked, "An education first of all about what sexual assault is about; any impact symptoms that they're dealing with such as nightmares, flashbacks; any of the guilt; myths that comes out of being assaulted, boundary setting; safety planning, education; anything that affects their thought process today."

Participant 4 commented, “Any kind of prior negative experiences. So, any kind of traumatic experiences that they might have had.”

Participant 5 stated, “Normalcy back after being traumatized, how to move forward after being hurt, how to trust again, the children, am I going to be able to love again, intimacy, lots of different things.”

Participant 6 said, “Trauma; addiction recovery; overall mental health; emotional management; Bible studies; forgiveness.”

Participant 7 commented, “Current family relational situations, history of abuse trauma, emotional intelligence education, psychoeducation.”

Participant 8 stated, “Self-care; counseling; children’s advocacy; legal advocacy.”

**Interview Question 4**. What training have you had to prepare you for working with clients you serve?

All participants provided responses that referenced their educational background, licensure (if applicable), required work training, and volunteer experience.

Participant 1 stated, “I was a volunteer for a couple of years first then I went to school on my own and got a bachelor’s in general studies and a master’s in counseling and Guidance, with a concentration on human service work.”

Participant 2 remarked, “Self-education, continuing education units, specific courses in universities and then just experience, practical experience; supervise provisional license professional counselors; LMFT; licensed vocational rehabilitation counselor; K to 12 counselor certified lifetime school guidance counselor.”

Participant 3 said, “Licensed person; Continuing Education Units required to have as a professional counselor zoned in on sexual assault and domestic violence; videotapes, movies that come out educating us and helping us to see the public’s view of what’s going on.”

Participant 4 commented, “master’s degree in social work; EMDR; cognitive behavior therapy; life experiences.”

Participant 5 stated, “Initial 40 hour required training; thousands of hours of training as mandated.”

Participant 6 remarked, “Yearly staff development; TBRI; Trauma training; faith-based leadership conferences.”

Participant 7 mentioned, “bachelor’s in psychology, a masters in marriage and family therapy. I’m a licensed professional counselor. I’m a clinically certified trauma professional. I’m a certified sexual addiction therapist, a certified multiple addiction therapist and I’m trained in EMDR for trauma--and I’m ordained.”

Participant 8 said, “Mental health training; trauma-informed care; various domestic violence and sexual assault training.”

**Interview Question 5**. Are you aware of the concept of vicarious traumatization?

All nine participants reported “yes” when asked if they were aware of the concept of vicarious traumatization.

**Interview Question 6.** Have you received training on vicarious traumatization? If so, when was the training provided, who conducted the training, and what did the training entail?

Participant 1 said, “Yes, that training is provided every second and third Monday of the month through our employer. It entails learning our clients, learning what vicarious trauma is, learning how we can carry vicarious trauma, learning to recognize heart and pain and what causes trauma, learning to be aware of ourselves and do self-care, things to take care of us and to recognize when we are taking on others trauma.”

Participant 2 stated, “Couple of seminars; R3 Continuum training; you talk about the what the when and what to expect as far as experience in a post-traumatic stress and its crisis; critical incident stress management training.”

Participant 3 commented, “Training on, burnout, recognizing counter transference with events that happen to me in my lifetime. But I cannot say that we have specifically had a zoned-in training for that.”

Participant 4 remarked, “I don’t think I have; PTSD knowledge.”

Participant 5 stated, “Yes, the coalitions for domestic violence and sexual assault, they did a training a few years ago about just kind of watching yourself as a service provider, by hearing all those sad stories and all the trauma from different people that we serve, how to take care of yourself, how we take that on as service providers and take on their pains, so. I don’t remember the exact year, but we had something, it went along I wish it had been very extensive, but it was very short.

Participant 6 stated, “No, not formal training.”

Participant 7 commented, “Self-read; Certified Sexual Addiction Therapist training (International Institute of Trauma and profess--and Addiction Professionals)-vicarious trauma, vicarious addiction triggering trauma education.”

Participant 8 said, “Somewhat. Not a whole lot. Probably not nearly as much as probably necessary that we probably need.”

**Interview Question 7.** What skills and/or techniques do you utilize to minimize the risk of vicarious traumatization?

Based on the responses of the research participants, identified skills and/or techniques identified were establishing and maintaining boundaries between work and personal life, self-care maintenance, awareness of vicarious trauma, acknowledgment of a higher deity or spiritual presence, peer consult, participation in debriefing sessions, and recreational activities.

Participant 1 stated, “I set boundaries, and I maintain boundaries, and as self-care is, I make sure I spend my time with God, and I make sure I do self-care things like relaxing, turning my phone off, going for walks, things like that. But in my profession, I maintain boundaries, and when I’m going across those boundaries, I’m able to become aware and get back in line with those boundaries.”

Participant 6 commented, “Talking about bad dreams to my husband; Prayer; scripture.”

Participant 7 remarked, “Exercise regularly. I eat healthy; therapy at least every two weeks. I’m in a mentorship. I staff cases weekly with other therapists. I don’t work after five. I don’t work on the weekends. I don’t answer my phone unless it’s a crisis. I do jiu-jitsu which is a very good self-care for me. I spend a lot of time with my kids and my wife making sure that’s in good shape. I pray and read my bible and you know staying in a community with God.”

**Interview Question 8.** From what you know about vicarious traumatization, how have you experienced emotional and/or psychological distress in working with victims of sexual trauma?

One out of eight participants responded "Yes" to this interview question but did not identify how she had experienced emotional and/or psychological distress in working with victims of sexual trauma. Four out of eight participants stated that they had experienced emotional and /or psychological distress by being forced to deal with their own personal trauma of losing a son, dreams of abuse or being trafficked, maladaptive thoughts, and difficulty detaching from the client once you hear their personal story of sexual trauma. Two out of eight participants had not experienced psychological and/or emotional distress.

Participant 3 stated, "I don't think psychological distress, however, if I allow it, it could consume me, did I help this lady, and was there something I could have, prevented this from happening if I had thought this or these, even after the events, because it seems to me that when oftentimes a sexual assault has happened, we've had them over and over, and I just consider my responsibility when they come in the first time.

**Interview Question 9.** Have family members or friends observed signs of emotional and/or psychological distress in you, as you work with victims of sexual trauma? If yes, please explain?

Two out of eight research participants commented that family members or friends had not observed signs of emotional and/or psychological distress in them as they work with victims of sexual trauma. Four participants reported that family members or friends

observed signs of emotional and /or psychological distress in them and questioned them about their mood, their work day, altered demeanor, or increased avoidance from others.

Participant 1 stated, “Yes, shorter temper; quiet or to go the opposite way and just be very quiet and introverted; not wanting to talk about work, not want to be there for them when I’ve been being there for people all day every day. They have known me to pick up old habits like when I’m stressed, I may smoke so they would know things like that. Things that I haven’t and don’t used to do in a while.

Participant 3 said, “Maybe so. So, when the granddaughter wanted to go to the condo, those are motions of “Please don’t let it happen, please don’t let it happen to some, one of my loved ones, as it has with all those that I’ve worked with.” So, I would say, yes, they’ve noticed it, when they comment on it, “You know mom, that’s just because you work with sexual assault that you don’t want him to go in the bathroom by himself.”

**Interview Question 10**. Do you believe that there is emotional and/or psychological risk in working with victims of sexual trauma? If yes, please explain. All eight participants agreed that there is emotional/psychological risk in working with victims of sexual trauma. Each participant provided detailed narratives based on their own experience of providing services to this population.

Participant 1 stated, “Yes, because you hear this horror stories or you get to know these ladies and you get to know their stories and you feel sad for them. You feel sorry for them and if you want help and then when you have to watch those you’re helping not help themselves or go back into a traumatic lifestyle and then it’s always hard and it’s

always, you know, you second guess, are you doing enough? Are you doing the right thing? Like you take on their decision making. When you see them making the wrong decisions, you receive that as you're not teaching them how to make the right decision or you haven't done all that you were supposed to do in their lives.

Participant 2 remarked, "Yes. There's risk, psychological risk working in any population in the helping profession. I don't care if it's you know medical or education, it crosses over the same in many fields like that."

Participant 3 commented, "Absolutely. I believe that if we don't stay very much aware of it and keep ourselves in that truly professional role if we even migrate to the middle between clinician and victim."

Participant 4 said, "Absolutely because if you're like any other empathetic, highly sensitive caring individual that works with these individuals, you've got to be careful about not wanting to fall into the reparenting trap. Remind yourself that your role is not that. It's to empower them and approach them from mastering space perspective and kind of help them process with that trauma so they can, in turn, reparent themselves.

Participant 5 remarked, "Absolutely, you take on their burdens, and you want to help, and unfortunately a lot of doors are closed. The waiting process is hard for the victim, but it's also hard for the service provider to get doors open for them or you know, justice served whatever justice looked like, it looks different for everybody."

Participant 6 said, "Yes, for anyone I would say, especially, if you've had experience in that yourself which most people, everyone has had experience with trauma,

like abuse and things like that. What I've noticed is that if you also have a history to that and you haven't dealt with that yet, that's really going to come up, so yes."

Participant 7 commented, "100% yes. I think there's psychological and emotional risk in therapy in general. You know, and I said it in my declaration, this is a risk, you know. You're opening up things that, you know, you're not in control of, and that may get worse before they got better."

Participant 8 stated, "Absolutely; the Christian side of it. The spiritual side that we do bear one another's burdens, and so, we're taught that, you know, and a lot of times when someone's pained, you know, you want to fix it, you want to help them, but that doesn't always happen, and sometimes you really can't fix it. And even trying to fix it, you'd get caught up in it."

**Interview Question 11**. How does the risk of vicarious traumatization influence your work as a clinician who works with victims of sexual trauma?

Participant 1 stated, "It makes me aware. I'm aware of the risk now. I'm aware of it, so I'm able to, you know, be self-aware and to watch when I'm overexerting or when I'm crossing my boundaries. Now that I'm aware of it, I know the safe, clear boundaries and know that those boundaries are not to harm anyone but to make sure I'm safe from the risk of vicarious trauma. I make sure when I'm safe and healthy from the risk of vicarious trauma then I'm not pouring unhealthiness unto the client."

Participant 2 said, "It makes me aware to self-monitor myself, to not forget that I'm a human being before anything else. And to be aware of certain life situations happened that I'm involved to be a helper that I have to self-monitor to make sure that

I'm getting plenty of rest afterward. My diet, sleep, rest and positive diversions, you know. Reading or music or whatever and keeping the inner-child alive."

Participant 3 remarked, "I'm very careful when I leave here; I'm very hyper-vigilant about my safety, the safety of any other clients I have here, or anyone waiting in the car of those clients, relatives, or the staff here; I want to know that when I sleep at night, I've done everything, taught everything, any kind of safety things that I've done, all of that to protect my client and anybody else that's going to suffer the fallout of it."

Participant 4 commented, "I think it just makes me more aware. I think just recognizing that need is critical, but also being incredibly self-aware and realizing that it's hard work but it's like important work and somebody has to do it, you know? And if you love it, you know, then that's great. Some people can't do this. Some people can be great at it, but it's very, very important work that needs to be done."

Participant 5 stated, "I think if I don't watch it as speaking for myself, we start crossing boundaries, you can start taking it too personal and too personally connected with this person and start crossing boundaries like doing things that you normally wouldn't do this out of the realm of your work professional duties, taking it on, giving me your personal number, you know. I've never taken invite to my house, I wouldn't do that, but I have given somebody my number or have thought about them and call them while I was out and exposed my personal number so it's a lot of different things that you can do, or I have done when I'm on edge."

Participant 6 said, "I think it helps and hurts, so it depends on the day. I think it helps in the sense of helping to understand empathy, right? Being able to relate things

like that which I mean everyone's story is so different, right? And so, it helps them and then I think where it hurts -- this line of work is really heavy, and it's really dark, and it's a lot to take in. And I know that obviously because faith-based, we believed that no one was created to be exploited, right? And so specifically with this population, it's going against every single thing that we believe God created human beings to be, right? And so, we're constantly fighting that battle. And sometimes fighting it for the women. I mean getting them to understand that this is not what you were designed to do, and that's hard some days, you know? And so, I think that's where it kind of hurts. It's like, because what we've realized is that you really have to be, not on top of your game in the sense of you always have to be on, but you have to be on top of your game in. You need to the make sure that you're healthy and that you dealt with your vicarious trauma, your trauma, your pain, your past, whatever that looks like. And for me, I think that's a life-long process."

Emergent themes are displayed in Table 2, and explanations of the themes are followed.

Table 2

*Emergent Themes*

| Research Questions | Themes |
|---|---|
| 1. How is the evidence of vicarious traumatization manifested among helping professionals who work with female victims of sexual trauma, as self-reported in interviews and written documentation? | a. Come to terms with personal trauma<br>b. Maladaptive thoughts and dreams<br>c. Inability to detach<br>d. Increased responsibility to protect others from sexual trauma<br>e. Changes in mood, behavior, or demeanor; avoidance from others |
| 2. What skills, techniques, and trainings do helping professionals who work with female victims of sexual trauma utilize to identify and minimize vicarious traumatization? | a. establishing and maintaining boundaries between work and personal life<br>b. self-care maintenance; participation in recreational activities/exercise<br>c. awareness of vicarious trauma<br>d. acknowledgement of a higher deity or spiritual presence,<br>e. peer consult/participation in debriefing sessions<br>f. Processing intrusive dreams with loved ones<br>g. Family time |

*(table continues)*

| | |
|---|---|
| 3. How does vicarious traumatization influence helping professionals who work with female victims of sexual trauma, specifically personally and professionally? | a. Awareness of risks associated with work; recognition of the significance of the work<br>b. Ability to self-monitor; being mindful of overexertion<br>c. Awareness of boundaries<br>d. Increased rest and healthy diet<br>e. Increased concern with safety/lack of education on sexual trauma safety for others<br>f. Identified personal trauma |

**Research Question 1**

How is the evidence of vicarious traumatization manifested among helping professionals who work with female victims of sexual trauma, as self-reported in interviews and written documentation?

The research participants reported that vicarious traumatization is displayed among helping professionals who work with female victims of sexual trauma in numerous ways. One participant reported that listening to personal stories of trauma made him more aware of his own trauma of losing a son to murder. The trauma of others can often force remind us of our personal traumas. Some participants stated that they experienced horrific dreams based on their client's stories, and maladaptive thoughts with one participating referencing "Evil, darkest things you can deal with and hear about and talk about." One participant commented that the inability to detach from her client's personal stories of sexual trauma is one way that she experienced vicarious trauma. Additional themes identified were the participant's increased responsibility to protect others from sexual frequently heard from their clients, and altered mood, behavior, and

demeanor. Participants stated that family members and friends frequently observe signs of vicarious trauma among them, as one participant said, “They have known me to pick up old habits like when I’m stressed.” Another participant reported that her husband would observe changes in her mood and ask “Hey, did you sleep okay?” One participant identified vicarious trauma in her when family members asked “Hey, wait a minute. You just went off for nothing. What’s going on?” The personal narratives of the research participants revealed that vicarious traumatization is manifested among helping professionals who work with female victims of sexual trauma in ways that affect how one may deal with personal trauma, their personality, behaviors, and interactions with others. All information was self-reported, as no evidence was identified in written documentation.

**Research Question 2**

What skills, techniques, and trainings do helping professionals who work with female victims of sexual trauma utilize to identify and minimize vicarious traumatization?

Several themes emerged when exploring what skills, techniques, and trainings were utilized to identify and minimize vicarious trauma among helping professionals who work with female victims of sexual trauma. Establishing and maintaining boundaries were reported, as several participants mentioned that boundaries allowed them to maintain balance between work life and personal life. Several participants commented that spending time with God, praying, and reading the bible were techniques used to minimize vicarious trauma, as those were also identified as methods of self-care.

Additionally, self-care was recognized was participation in recreational activities and exercise, as one participant stated, “I’m a runner and I do cycling a lot, and I do weights and kettlebells about 4 or 5 days a week”. The awareness of vicarious trauma was also mentioned, as one person stated “I think you just have to be really cognizant of transference and counter transference. What that looks like being very self-aware and knowing when to bring something out to your supervisor.” Several participants reported that peer consultation and debriefing would help to minimize the risk of vicarious trauma, although detailed information regarding client’s personal stories could not be shared with others to maintain confidentiality. An additional theme developed to include spending time with family members, as one participant stated that she would frequently process her intrusive dreams with her husband to minimize the risk of continued vicarious trauma.

The research participants identified common trainings that prepared them to work with victims of sexual trauma. Many participants received a formal education that included degrees in social sciences and social work. Participants who were licensed received additional training through their specific licensing board, required continuing units, or required agency mandated training. Several participants received faith-based training to best prepare them for working with female victims of sexual trauma, as they were employed by a faith-based organization. Non-licensed participants received agency mandated training, which included mental health and trauma-informed care. The research participants reported various skills, techniques, and training utilized to identify and minimize vicarious trauma while working with female victims of sexual trauma.

**Research Question 3**

How does vicarious traumatization influence helping professionals who work with female victims of sexual trauma, specifically personally and professionally?

The research provided information on how vicarious trauma influences their work as helping professionals who work with female victims of sexual trauma. Some themes that emerged were the awareness of risks and significance associated with their work, as one participant stated, "…. being incredibly self-aware and realizing that it's hard work to do but it's like important work and somebody has to do it……it's very important work that needs to be done." Being able to monitor oneself and being mindful of hypervigilance also influenced helping professionals who work with female victims of sexual trauma, as one participant stated, "I'm very hypervigilant about my safety, the safety of any other clients I have here, or anyone waiting in the car of those clients, relatives, or staff here." Vicarious trauma was also reported to be influential when working with female victims of sexual trauma, as helping professionals are often concerned about the need for education about sexual trauma. The importance of establishing boundaries and implementing self-care maintenance, such as rest and a healthy diet were reported as being significant when providing services to sexual trauma victims, as one participant reported, "I'm involved to be a helper…that I have to self-monitor to make sure that I'm getting plenty of rest afterward." Vicarious trauma can influence helping professionals who have experienced their own personal trauma, specifically when that trauma has not been addressed. One participant said, "The people who are drawn to this work are actually survivors themselves. So, you have to avoid

triggers, and you have to avoid those triggers that may trigger something in you that happened to you."

## Summary

Chapter 4 provided detailed information on the data collection and analysis process, which intended to provide substantial information on helping professionals who work with female victims of sexual trauma. Additionally, this chapter discussed how the research participants were recruited and interviewed. This chapter also provided information on the evidence of trustworthiness. Referencing research question 1 of the study, the analysis of the themes determined that helping professionals who work with female victims of sexual trauma experience vicarious trauma, both psychologically and emotionally, and can be self-identified or observed by others. In answering research question 2, helping professionals utilized specific skills, techniques, and training to help them minimize the risk of vicarious trauma, which was common among participants despite being employed by a non-profit organization or a faith-based organization. Referencing research question 3 of the study, the analysis of the themes determined that vicarious traumatization influenced helping professionals who work with female victims of sexual trauma both personally and professionally, as helping professionals maintained that awareness of boundaries between work and personal life is essential. The findings from this research study are expounded on in Chapter 5. Also, in Chapter 5 I provide information on the limitations of the study, recommendations for future research, the impact for positive social change, and the conclusion.

# Chapter 5: Discussion, Conclusions, and Recommendations

The purpose of this qualitative, narrative study was to investigate individual experiences of helping professionals who work with female victims of sexual trauma. A narrative design was used to examine the phenomenon of vicarious trauma among the sample of research participants.

## Interpretation of the Findings

McCann and Pearlman (1990) defined vicarious traumatization (VT) as the recurrence of painful images, thoughts, and feelings experienced by professionals who work with clients who are victims of trauma. VT can often last longer after services or treatment has concluded (McCann & Pearlman, 1990). The participants in the study reported that they were aware of the concept of vicarious trauma as it relates to their work. Vicarious trauma is supported by the cognitive self-development theory (CSDT), which identifies seven schemas that include a frame of reference regarding the self and the world, trust, safety, power and control, independence, esteem, and intimacy (Hesse, 2002). Participants explained that hearing stories of sexual trauma often disturbed the way they view themselves in the world, causing them to question the safety of themselves and others. The traumagenic dynamics model (Finkelhor & Brown, 1985) was used to examine how sexually traumatized victims view themselves. Participants identified challenges in trauma work regarding helping female victims of sexual trauma understand that they were not created to be exploited or abused.

The research participants identified ways in which vicarious trauma can manifest among helping professionals who work with female victims of sexual trauma, including

invasive thoughts and dreams, altered psychological and emotional responses, and recognition of personal trauma. Previous research indicated that professionals who engage in trauma work often experience physical and psychological symptoms, invasive imagery, consistent lack of trust for others, fear for their own safety and the safety of others, and realization of violence toward others (Neumann & Gamble, 1995; Pack, 2013). Participants in the current study reported that vicarious trauma introduced feelings of avoidance from others, awareness of harm to others, reported distress, and observed changes in mood or behavior from family and friends. These findings confirmed previous studies that indicated that vicarious trauma, often used synonymously with secondary trauma, can elicit feelings of denial, isolation, personal danger for self and others, and distressed relationships with partners (Canfield, 2005; Clemans, 2004; Hesse, 2002).

Participants provided information on the skills, techniques, and trainings used to minimize the risk of vicarious trauma. One of the key findings indicated that establishing and maintaining boundaries between work and personal life minimized the risk of vicarious trauma. This finding is supported by Harrison and Westwood's (2009) study that indicated that helping professionals often abandon their work as helping professionals due to the emotional burden of working with traumatized individuals, which often results in an imbalance between work and personal life. Previous research indicated that professionals who worked with sexual trauma victims coping skills such as communicating with family members, intermingling with other helping professionals in the field of trauma, participating in meetings or workshops with other helping professionals, and regular prosocial activities (Maier, 2011). These results support

findings from the current study, in which participants identified skills and techniques such as peer support and debriefings, talking to loved ones, participation in recreational activities, and engaging with a higher deity. The participants reported receiving training that prepared them to work in the field of trauma and that was provided in either a formal education setting, agency required training, or self-education. This finding confirmed previous findings which indicated that helping professionals who work with victims of sexual trauma must receive detailed education, training, and supervision to provide treatment and to be aware of emotional responses when working with victims of sexual trauma (Berger & Quiros, 2014; Jones et al., 1998; Pack, 2013; Sommer, 2008).

Findings from the current study revealed that vicarious trauma influenced professionals who work with female sexual trauma victims by increasing their awareness of the concept and risks of vicarious trauma, mindfulness of boundaries, acknowledged safety of self and others, advocacy for the victim, and awareness of triggers and personal trauma. These findings are supported by previous research that indicated that helping professionals are influenced personally and professionally when working with victims of trauma and should be mindful of the risks and signs (Etherington, 2009; Knight, 2013; Sui & Padmanabhanunni, 2016).

## Limitations of the Study

One limitation of the current research study was the sample size. Eight individuals participated in the study, and because of the small number of participants, I was unable to generalize the results. The number of years worked in the field of trauma ranged from 3 years to 25 years, which was an extensive range. Additionally, the sample included only

two men out of the eight participants. Professionals who work with female sexual trauma victims are mostly female, as victims whose attackers are male may find it difficult to receive services from men. Due to small sample size, the degree of transferability was limited, and the results of the study may not be applicable to comparable individuals. A second limitation of the study was the process of coding and data analysis, which was completed by me. Bradley et al. (2007) stated that employing multiple researchers for coding rich qualitative data can enhance the depth and complexity of the findings. An additional limitation of the study was the self-selection of research participants. It was possible that helping professionals who do not implement adequate self-care strategies did not volunteer for the study.

## Recommendations

Helping professionals who work with female victims of sexual trauma may frequently experience vicarious trauma. It is recommended that agencies and organizations provide adequate training that prepares helping professionals to work with victims of sexual trauma, and that provides helping professionals with opportunities to discuss vicarious trauma and promote the importance of self-care in trauma work. It is recommended that supervisors and managers implement regular check-ins with staff who work with victims of sexual trauma to ensure that they are psychologically and emotionally prepared for trauma work. Being able to identify the signs and symptoms of vicarious trauma could contribute to the well-being of the helping professional and the client. It is also recommended that universities and institutions introduce course work related to vicarious trauma to individuals in helping professions. Education is essential to

professionals pursuing careers in forensic psychology, as victim services is a unique aspect of this field. It is further recommended that future researchers conduct qualitative research on helping professionals in other geographical regions in the United States. Expanding the current research study to other regions may generate different themes and findings.

## Implications

Results of this research study may inspire positive social change within the community of helping professionals. Forensic psychology is an extensive field that focuses on the behavior of the criminal; professionals may be unaware of the victimology aspect of the field, which includes helping victims rebuild their lives. The topic of vicarious traumatization should be widely discussed among helping professionals who work with victims of sexual trauma to ensure that the risks are identified and minimized.

This study may be used as a resource by helping professionals, leadership and administrative staff, organizations, and agencies to develop and implement training protocols for individuals entering trauma work. Agencies and organizations should educate helping professionals on the importance of implementing appropriate coping techniques that minimize the risk of vicarious trauma. The goal of this study was to fill a gap in the literature regarding the lived experiences of helping professionals who work with female victims of sexual trauma. The information from this study provided new information on the personal experiences of those who provide services to a vulnerable population. The participants in the study were eager to learn that their stories would be heard and would contribute to the knowledge base of forensic psychology. Because of

this study, helping professionals may learn the process of transitioning from experiencing vicarious trauma to vicarious resilience and post-traumatic growth.

## Conclusion

Findings from this narrative study helped to close a gap in the literature by addressing the lived experiences of eight helping professionals who work with female sexual trauma victims. The results indicated that professionals could experience psychological and emotional risks in trauma work. Analysis of their individual experiences revealed the ways of helping professionals in the Southern region of the United States manage vicarious trauma.

The research questions were essential to understanding the lived experiences of the research participants. Various skills and techniques were being used to minimize the risks of vicarious trauma, as participants identified their psychological and emotional responses to trauma work. The identified themes may be beneficial to other professionals who are new to trauma work and have an interest in working with sexual trauma victims.

Establishing boundaries and implementing self-care techniques were reported skills used to help minimize vicarious trauma. Consistent training and ongoing discussions about vicarious trauma are essential to professionals who commit their lives to helping sexual trauma victims. This study showed how professionals were professionally and personally influenced by working with victims of sexual trauma. These findings may be beneficial to those who have an interest in entering the field of trauma work.

# References

Adams, K., Shakespeare-Finch, J., & Armstrong, D. (2015). An interpretative phenomenological analysis of stress and well-being in emergency medical dispatchers. *Journal of Loss and Trauma*, *20*(5), 430-448. doi:10.1080/15325024.2014.949141

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author.

Pearlman, L. A. (2013). Restoring self in community: Collective approaches to psychological trauma after genocide. *Journal of Social Issues, 69*(1), 111-124. doi:10.1111/josi.12006

Arnold, D., Calhoun, L. G., Tedeschi, R., & Cann, A. (2005). Vicarious posttraumatic growth in psychotherapy. *Journal of Humanistic Psychology, 45*(2), 239-263. doi:10.1177/0022167805274729

Baird, K., & Kracen, A. (2006). Vicarious traumatization and secondary traumatic stress: A research synthesis. *Counselling Psychology Quarterly, 19*(2), 181-188.

Baker, A. A. (2012). Training the resilient psychotherapist: What graduate students need to know about vicarious traumatization. *Journal of Social, Behavioral & Health Sciences, 6*(1), 1-12. doi:10.5590/JSBHS.2012.06.1.01

Begun, A. L., & Hammond, G. C. (2012). CATCH Court: A novel approach to "treatment as alternative to incarceration" for women engaged in prostitution and substance abuse. *Journal of Social Work Practice in the Addictions*, *12*(3), 328-331. doi:10.1080/1533256X.2012.703920

Bell, H., Kulkarni, S., & Dalton, L. (2003). Organizational prevention of vicarious trauma. *Families in Society: The Journal of Contemporary Social Services, 84*(4), 463. https://ezp.waldenulibrary.org/login?url=https://search.ebscohost.com/login.aspx?direct=true&db=edsgea&AN=edsgcl.112588296&site=eds-live&scope=site

Benatar, M. (2000). A qualitative study of the effect of a history of childhood sexual abuse on therapists who treat survivors of sexual abuse. *Journal of Trauma & Dissociation, 1*(3), 9-28. doi:10.1300/J229v01n03_02

Berger, R., & Quiros, L. (2014). Supervision for trauma-informed practice. *Traumatology, 20*(4), 296-301. doi:10.1037/h0099835

Blair, D. T., & Ramones, V. A. (1996). Understanding vicarious traumatization. *Journal of Psychosocial Nursing and Mental Health Services, 34*(11), 24-30. doi:10.3928/0279-3695-19961101-15

Bradley, E. H., Curry, L. A., & Devers, K. J. (2007). Qualitative data analysis for health services research: Developing taxonomy, themes, and theory. *Health Services Research, 42*(4), 1758–1772. doi:10.1111/j.1475-6773.2006.00684.x

Branson, D., Weigand, D., & Keller, J. (2014). Vicarious trauma and decreased sexual desire: a hidden hazard of helping others. *Psychological Trauma-Theory Research Practice and Policy, 6*(4), 398-403. doi:10.1037/a0033113

Canfield, J. (2005). Secondary traumatization, burnout, and vicarious traumatization: A review of the literature as it relates to therapists who treat trauma. *Smith College*

*Studies in Social Work, 75*(2), 81-101. Retrieved from https://search-proquest-com.ezp.waldenulibrary.org/docview/216186400?accountid=14872

Cantón-Cortés, D., Cortés, M. R., & Cantón, J. (2012). The role of traumagenic dynamics on the psychological adjustment of survivors of child sexual abuse. *European Journal of Developmental Psychology, 9*(6), 665-680. doi:10.1080/17405629.2012.660789

Capri, C., Kruger, L., & Tomlinson, M. (2013). Child sexual abuse workers' emotional experiences of working therapeutically in the Western Cape, South Africa. *Child & Adolescent Social Work Journal, 30*(5), 365-382. doi:10.1007/s10560-012-0295-8

Chouliara, Z., Karatzias, T., & Gullone, A. (2014). Recovering from childhood sexual abuse: A theoretical framework for practice and research. *Journal of Psychiatric and Mental Health Nursing, 21*(1), 69-78. doi:10.1111/jpm.12048

Clemans, S. E. (2004). Life changing: The experience of rape-crisis work. *Affilia: Journal of Women and Social Work, 19,* 146-159. doi:10.1177/0886109903262758

Clemans, S. E. (2005). Recognizing vicarious traumatization: A single session group model for trauma workers. *Social Work With Groups, 27*(2-3), 55-74. doi:10.1300/J009v27n02.05

Colangelo, J., & Keefe-Cooperman, K. (2012). Understanding the impact of childhood sexual abuse on women's sexuality. *Journal of Mental Health Counseling, 34*(1), 14-37. doi.org/10.17744/mehc.34.1.e045658226542730

Coles, J., Astbury, J., Dartnall, E., & Limjerwala, S. (2014). A qualitative exploration of researcher trauma and researchers' responses to investigating sexual violence. *Violence Against Women, 20*(1), 95-117. doi:10.1177/1077801213520578

Creswell, J.W. (2013) Data analysis and representation. In *Qualitative inquiry & research design: Choosing among five approaches* (pp. 187-188). Thousand Oaks, CA: Sage.

Creswell, J. W. (2014). Qualitative methods. In *Research design: Qualitative, quantitative, and mixed methods approaches* (pp. 195-196*).* Thousand Oaks, CA: Sage.

Daalder, A. L., Bogaerts, S., & Bijleveld, C. C. (2013). The severity of childhood abuse and neglect in relationship to post-traumatic stress disorder among female sex workers in the Netherlands. *Journal of Aggression, Maltreatment & Trauma, 22*(9), 935-949. doi:10.1080/10926771.2013.834017

Dombo, E. A., & Gray, C. (2013). Engaging spirituality in addressing vicarious trauma in clinical social workers: A self-care model. *Social Work & Christianity, 40*(1), 89-104. https://ezp.waldenulibrary.org/login?url=https://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=85443979&site=eds-live&scope=site

Dunkley, J., & Whelan, T. A. (2006). Vicarious traumatization: Current status and future directions. *British Journal of Guidance & Counselling, 34*(1), 107-116. doi:10.1080/03069880500483166

Dutton, M. A., Dahlgren, S., Franco-Rahman, M., Martinez, M., Serrano, A., & Mete, M. (2017). A holistic healing arts model for counselors, advocates, and lawyers serving trauma survivors: joyful heart foundation retreat. *Traumatology, 23*(2), 143-152. http://dx.doi.org.ezp.waldenulibrary.org/10.1037/trm0000109

Etherington, K. (2009). Supervising helpers who work with the trauma of sexual abuse. *British Journal of Guidance & Counselling, 37*(2), 179-194. doi:10.1080/03069880902728622

Finkelhor, D., & Browne, A. (1985). The traumatic impact of child sexual abuse: A conceptualization. *American Journal of Orthopsychiatry*, *55*(4), 530-541.

Foreman, T.F. (2018). Wellness, exposure to trauma, and vicarious traumatization: a pilot study. *Journal of Mental Health Counseling*, *40*(2), 142-155. doi:10.17744/mehc.40.2.04doi:10.1111/ j.1939-0025.1985.tb02703.x

Gartner, R. B. (2014). Trauma and countertrauma, resilience and counterresilience. *Contemporary Psychoanalysis, 50*(4), 609-626. doi:10.1080/00107530.2014.9450639

Harrison, R. L., & Westwood, M. J. (2009). Preventing vicarious traumatization of mental health therapists: identifying protective practices. *Psychotherapy: Theory, Research, Practice, Training, 46*(2), 203-219. doi:10.1037/a0016081

Hernandez, P., Gangsei, D., & Engstrom, D. (2007). Vicarious resilience: a new concept in work with those who survive trauma. *Family Process, 46*(2), 229-241.

https://ezp.waldenulibrary.org/login?url=https://search.ebscohost.com/login.aspx?direct=true&db=mnh&AN=17593887&site=eds-live&scope=site

Hernandez-Wolfe, P., Gangsei, D., Engstrom, D., & Killian, K. (2015). Vicarious resilience, vicarious trauma, and awareness of equity in trauma work. *The Journal of Humanistic Psychology, 55*(2), 153. doi: 10.1177/0022167814534322

Hesse, A. R. (2002). Secondary trauma: how working with trauma survivors affects therapists. *Clinical Social Work Journal, 30*(3), 293-309. Retrieved from https://search-proquest-com.ezp.waldenulibrary.org/docview/227767498?accountid=14872

Howlett, S.L. & Collins, A. (2014). Vicarious traumatization: Risk and resilience among crisis support volunteers in a community organization. *South African Journal of Psychology, 44*(2), 180-190. doi:10.1177/0081246314524387

Iqbal, A. (2015). The ethical considerations of counselling psychologists working with trauma: Is there a risk of vicarious traumatization? *Counselling Psychology Review, 30*(1), 44-51.

Jones, K. D., Robinson, E. I., Minatrea, N., & Hayes, B. L. (1998). Coping with reactions to clients traumatized by child sexual abuse. *Journal of Mental Health Counseling, 20*(4), 332-343.

Kallstrom-Fuqua, A. C., Weston, R., & Marshall, L. L. (2004). Childhood and adolescent sexual abuse of community women: mediated effects on psychological distress and social relationships. *Journal of Consulting and Clinical Psychology, 72*(6), 980-992. doi:10.1037/0022-006X.72.6.980

Knight, C. (1997). Therapists' affective reactions to working with adult survivors of child sexual abuse: An exploratory study. *Journal of Child Sexual Abuse*, *6*(2), 17-41. Retrieved from https://search-proquest-com.ezp.waldenulibrary.org/docview/217505393?accountid=14872

Knight, C. (2013). Indirect trauma: implications for self-care, supervision, the organization, and the academic institution. *Clinical Supervisor, 32*(2), 224-243. doi:10.1080/07325223.2013.850139

Maier, S. L. (2011). The emotional challenges faced by sexual assault nurse examiners: 'ER nursing is stressful on a good day without rape victims'. *Journal of Forensic Nursing, 7*(4), 161-172. doi:10.1111/j.1939-3938.2011.01118.x

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

Miller, M. K., Flores, D. M., & Pitcher, B. J. (2010). Using constructivist self-development theory to understand judges' reactions to a courthouse shooting: An exploratory study. *Psychiatry, Psychology & Law, 17*(1), 121-138. doi:10.1080/13218710902930309

Molnar, B. E., Sprang, G., Killian, K. D., Gottfried, R., Emery, V., & Bride, B. E. (2017). Advancing science and practice for vicarious traumatization/secondary traumatic stress: A research agenda. *Traumatology*, *23*(2), 129-142. doi:10.1037/trm0000122

Moulden, H. M. & Firestone, P. (2007). Vicarious traumatization: The impact on therapists who work with sexual offenders. *Trauma, Violence, & Abuse*, *8*(1), 67-83. doi: 10.1177/1524838006297729

Neswald-Potter, R. & Simmons, R.T. (2016). Regenerative supervision: a restorative approach for counsellors impacted by vicarious trauma. *Canadian Journal of Counselling and Psychotherapy, 50*(1), 75-90. https://cjc-rcc.ucalgary.ca/cjc/index.php/rcc/article/view/2817

Neumann, D. A., & Gamble, S. J. (1995). Issues in the professional development of psychotherapists: countertransference and vicarious traumatization in the new trauma therapist. *Psychotherapy: Theory, Research, Practice, Training, 32*(2), 341-347. doi:10.1037/0033-3204.32.2.341

Orchard, T., Farr, S., Macphail, S., Wender, C., & Wilson, C. (2014). Expanding the scope of inquiry: exploring accounts of childhood and family life among sex workers in London, Ontario. *The Canadian Journal of Human Sexuality, 23*(1), 9-18. doi:10.3138/cjhs.2323

Pack, M. (2013). Vicarious resilience: A multilayered model of stress and trauma. *Affilia, 23*(1), 18-29. doi:10.1177.0886109913510088

Patton, M.Q. (2002). Fieldwork strategies and observation methods. In C. Deborah Laughton & V. Novak & D.E. Axelson (Eds.), *Qualitative research and evaluation methods* (pp.259-338). Thousand Oaks, CA: Sage Publications.

Pearlman, L. (2013). Restoring self in community: collective approaches to psychological trauma after genocide. *Journal of Social Issues, 69*(1), 111-124. doi: 10.1111/josi.12006

Pearlman, L. A., & Mac Ian, P. S. (1995). Vicarious traumatization: An empirical study of the effects of trauma work on trauma therapists. *Professional Psychology: Research and Practice, 26*(6), 558-565. doi:10.1037/0735-7028.26.6.558

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

Roemmele, M., & Messman-Moore, T. L. (2011). Child abuse, early maladaptive schemas, and risky sexual behavior in college women. *Journal of child sexual abuse*, *20*(3), 264-283. doi:10.1080/10538712.2011.575445

Roe-Sepowitz, D. E., Hickle, K. E., Loubert, M. P., & Egan, T. (2011). Adult prostitution recidivism: risk factors and impact of a diversion program. *Journal of Offender Rehabilitation, 50*(5), 272-285. doi:10.1080/10509674.2011.574205

Saakvitne, K. W. (2002). Shared trauma: The therapist's increased vulnerability. *Psychoanalytic Dialogues, 12*(3), 443-449. doi:10.1080/10481881209348678

Saakvitne, K. W., Tennen, H., & Affleck, G. (1998). Exploring thriving in the context of clinical trauma theory: constructivist self-development theory. *Journal of Social Issues, 54*(2), 279-299.

Saldana, J. (2008). *The Coding Manual for Qualitative Researchers*. Thousand Oaks, CA. Sage Publications, Inc.

Senn T. E., Carey, M. P., & Coury-Doniger, P. (2012). Mediators of the relation between childhood sexual abuse and women's sexual risk behavior. A comparison of two theoretical frameworks. *Archives of Sexual Behavior, 41*(6). 1363-1377. doi:10.1007/s10508-011-9897-z

Sexton, L. (1999). Vicarious traumatization of counsellors and effects on their workplaces. *British Journal of Guidance & Counselling, 27*(3), 393-403. doi:10.1080/03069889908256279

Shdaimah, C.S, & Wiechelt. (2012). Crime and compassion: women in prostitution at the intersection of criminality and victimization. *International Review of Victimology*, 19(1), 23-35. doi:10.1177/0269758012447217

Sommer, C. A. (2008). Vicarious traumatization, trauma-sensitive supervision, and counselor preparation. *Counselor Education and Supervision, 48*(1), 61-71. doi:10.1002/j.1556-6978.2008.tb00062.x

Sui, X., & Padmanabhanunni, A. (2016). Vicarious trauma: The psychological impact of working with survivors of trauma for South African psychologists. *Journal of Psychology in Africa, 26*(2), 127-133.

Tabor P. D. (2011). Vicarious traumatization: concept analysis. *Journal of Forensic Nursing, 7*(4), 203-208. doi: 10.1111/j.1939-3938.2011.01115.x

Trippany, R. L., White Kress, V. E., & Wilcoxon, S. A. (2004). Preventing vicarious trauma: what counselors should know when working with trauma survivors. *Journal of Counseling & Development, 82*(1), 31-37.

Williams, A. M., Helm, H. M., & Clemens, E. V. (2012). The effect of childhood trauma, personal wellness, supervisory working alliance, and organizational factors on vicarious traumatization. *Journal of Mental Health Counseling, 34*(2), 133-153. doi:10.17744/mehc.34.2.j3l62k872325h583

Wilson, F. (2016). Identifying, preventing, and addressing job burnout and vicarious burnout for social work professionals. *Journal of Evidence-Informed Social Work, 13*(5), 479-483. doi:10.1080/23761407.2016.1166856

Wilson, H. W., & Widom, C. S. (2010). The role of youth problem behaviors in the path from child abuse and neglect to prostitution: A prospective examination. *Journal of Research on Adolescence (Wiley-Blackwell), 20*(1), 210-236. doi:10.1111/j.1532-7795.2009.00624.x

Wilson, H. W., & Widom, C. S. (2011). Pathways from childhood abuse and neglect to HIV-risk sexual behavior in middle adulthood. *Journal of consulting and clinical psychology, 79*(2), 236. doi/10.1037/a0022915

Zwickl, S., & Merriman, G. (2011). The association between childhood sexual abuse and adult female sexual difficulties. *Sexual and Relationship Therapy, 26*(1). 16-32. doi:10.1080/14681994.2010.530251

American Psychological Association, 2016; www.apa.org; http://www.apa.org/about/gr/issues/women/trauma.aspx

"Prostitution." Merriam-Webster.com, Merriam-Webster, www.merriam-webster.com/dictionary/prostitution. Accessed 2017

National Human Trafficking Hotline, 2017; www.https://humantraffickinghotline.org/ https://humantraffickinghotline.org/type-trafficking/sex-trafficking

National Institutes of Health: U.S. National Library of Medicine, 2017; www.nih.gov https://medlineplus.gov/childsexualabuse.html

The United States Department of Justice, 2017; www.justice.gov https://www.justice.gov/ovw/sexual-assault

# Appendix A: Interview Tool

1. How do you define your role as a helping professional? (Counselor, social worker, psychologist, professional (e.g., counselor, social worker, psychologist)?
2. How many years have you worked in the field of trauma?
3. Please define your client population.
4. What criteria must be met to receive services from your agency?
5. How many weekly hours of services do you provide to your clients?
6. What topics are discussed while providing those services?
7. What type of training have you had to prepare you for working with the clients you serve?
8. Are you aware of the concept of vicarious traumatization?
    a. If yes, proceed to ask question #9.
    b. If no, define vicarious traumatization: "Vicarious traumatization is the risk associated with working with victims of trauma that manifests emotionally and psychologically, causing potential harm to the client and the counselor, which is also associated with burnout or compassion fatigue" (Howlett & Collins, 2014). Proceed to question #9
9. Have you received training on vicarious traumatization?
    a. When was the training provided?
    b. Who conducted the training?
    c. What did the training entail?

10. What skills and/or techniques do you utilize to minimize the risk of vicarious traumatization?

11. From what you know about vicarious traumatization, how have you experienced emotional and/or psychological distress in working with victims of sexual trauma?

12. Have family members or friends observed signs of emotional and/or psychological distress in you, as you work with victims of sexual trauma? If yes, please explain?

13. Do you believe that there is emotional and/or psychological risk in working with victims of sexual trauma? If yes, please explain.

14. How does the risk of vicarious traumatization influence your work, personally and professionally, as a helping professional, who works with victims of sexual trauma?