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Vicarious Traumatization: An Empirical Study of the Effects of Trauma Work on Trauma Therapists

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This study examined vicarious traumatization (i.e., the deleterious effects of trauma therapy on the therapist) in 188 self-identified trauma therapists. Participants completed questionnaires about their exposure to survivor clients' trauma material as well as their own psychological well-being. Those newest to the work were experiencing the most psychological difficulties (as measured by the TSI Belief Scale; L. A. Pearlman, in press-a) and Symptom Checklist-90—Revised (L. Derogatis, 1977) symptoms. Trauma therapists with a personal trauma history showed more negative effects from the work than those without a personal history. Trauma work appeared to affect those without a personal trauma history in the area of other-esteem. The study indicates the need for more training in trauma therapy and more supervision and support for both newer and survivor trauma therapists.

Therapists have long treated victims of violence. It is only in recent years, however, that survivors of violent crimes, including childhood sexual abuse, war, genocide, and rape, have come forward in large numbers for psychotherapy. This burgeoning population of clients places new demands on both the expertise and the personal resources of psychotherapists, who may be ill-prepared for this work (Alpert & Paulson, 1990; Pope & Feldman-Summers, 1992). In an effort to describe the effects trauma work can have on psychotherapists, McCann and Pearlman (1990b) coined the term *vicarious traumatization,* which they conceptualized within constructivist self development theory (CSDT; McCann & Pearlman, 1990a; Pearlman & Saakvitne, 1995a, 1995b).

CSDT blends contemporary psychoanalytic theories (self-psychology and object relations theory) with social cognition theories to provide a developmental framework for understanding the experiences of survivors of traumatic life events. CSDT views individuals' adaptations to trauma as interactions between their own personalities (defensive styles, psychological needs, coping styles) and salient aspects of the traumatic events, all in the context of social and cultural variables that shape psychological responses.

We define *vicarious traumatization* as the transformation that occurs within the therapist (or other trauma worker) as a result of empathic engagement with clients' trauma experiences and their sequelae. Such engagement includes listening to graphic descriptions of horrific events, bearing witness to people's cruelty to one another, and witnessing and participating in traumatic reenactments (Pearlman & Saakvitne, 1995a). Vicarious traumatization is an occupational hazard for those who work with trauma survivors (Munroe et al., 1995), and it reflects neither pathology in the therapist nor intentionality on the part of the survivor client.

Vicarious traumatization implies changes in the therapist's enduring ways of experiencing self, others, and the world. The effects of vicarious traumatization permeate the therapist's inner world and relationships. These effects do not arise solely from one therapy relationship; we posit that they are cumulative across time and helping relationships. In keeping with CSDT, both one's vulnerability to vicarious traumatization and its specific manifestations arise from the interaction of the therapist's characteristics with aspects of the work situation over time. Therapist characteristics that might influence vicarious traumatization include personal trauma history, the meaning of traumatic life events to the therapist, psychological style, interpersonal style, professional development, and current stressors and supports. Some characteristics of the work that might contribute to vicarious traumatization include the nature of the clientele and the material they present in therapy, stressful client behaviors, work setting, and social–cultural context. Two psychological manifestations of vicarious traumatization might be disrupted cognitive schemas and intrusive trauma imagery.

Review of the Literature

The concept of vicarious traumatization is new enough that there is only a small body of literature on it. Schauben and Frazier (1995) assessed vicarious traumatization, disrupted schemas, posttraumatic stress disorder (PTSD) symptoms, burnout, and coping in 118 female psychologists and 30 female rape crisis counselors. To look specifically at vicarious traumatization, in addition to assessing disrupted schemas, they asked par-

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ticipants to indicate the extent to which they were experiencing vicarious traumatization. They found that a greater number of survivor clients in one's caseload was correlated with more disruptions in one's beliefs or schemas, with PTSD symptoms, and with the likelihood one would identify oneself as experiencing vicarious traumatization.

In a study of 138 therapists in Veterans Administration facilities, Munroe (1991) found that current and cumulative exposure to combat-related trauma clients (measured by hours per week and by hours per week multiplied by years doing the work, respectively) correlated significantly with intrusive symptoms.

Kassam-Adams (1994) reported findings from a survey of 100 psychotherapists. She found that their exposure to sexually traumatized clients (reported as a percentage of clients who presented this issue over the therapist's career) was directly related to therapists' PTSD symptoms. In her sample (75% of whom were women), gender (female), personal trauma history (positive), and exposure all contributed significantly to the prediction of PTSD symptoms.

Follette, Polusny, and Milbeck (1994) studied what they referred to as "secondary traumatization" among 225 mental health professionals and 46 law enforcement officers who were providing services to childhood sexual abuse survivors. These researchers assessed the relations among the respondent's own childhood abuse history, current personal stressors, current PTSD symptoms, and current coping strategies. In a multiple regression analysis, posttrauma symptoms in mental health professionals were predicted by "negative coping," level of personal stress, and negative clinical response to sexual abuse cases. Neither the individual's personal childhood abuse history nor the percentage of caseload reporting a sexual abuse history contributed significantly to the prediction of trauma symptoms.

Studies on the reactions of rape researchers, emergency workers, and hospital staff to their work have also found responses paralleling those of trauma survivors (Alexander et al., 1989; Dyregrov & Mitchell, 1992; Genest, Levine, Ramsden, & Swanson, 1990; Lyon, 1993; Raphael & Wilson, 1994). Some studies have differentiated empirically between vicarious traumatization and burnout (Gamble, Pearlman, Lucca, & Allen, 1994; Munroe, 1991; Schauben & Frazier, 1995).

This trauma-specific literature tells us that doing trauma therapy can affect therapists negatively and that its effects are different from those related to doing general psychotherapy. The research suggests that aspects of the therapist, such as personal trauma history, gender, and personal stress, may interact with exposure to trauma material to contribute to trauma-related symptoms in the therapist.

Our study was designed to explore the relations among aspects of trauma therapy, aspects of the therapist, and the therapist's current psychological functioning. The research we report in this article reflects our first attempt to operationalize and measure vicarious traumatization. We wanted to begin to develop both dependent variables that might indicate the existence of vicarious traumatization and independent variables that might predict it.

Method

Participants

Participants were 136 (72%) female and 52 (28%) male self-identified trauma therapists who volunteered to participate in a study investigating the effects of trauma work on therapists. They were primarily White (93%); ranged in age from 23 to 74 years, with a mean age of 43 (female M = 42, male M = 47); married or living with a partner (71%); in the field of psychology (58%) or social work (27%: 5% psychiatry, 4% psychiatric nursing, and the remainder other degrees); earned over $55,000 per year (59%); and had been working with trauma survivors an average of 9.59 years (SD = 9.00), with a range from 0.08 to 38 years.

Procedure

We distributed approximately 780 questionnaire packets to members of an international trauma professional organization, to participants at a day-long professional trauma training seminar, and to graduate students in New England area clinical training programs. Participants were asked to complete a packet of questionnaires and to return them in the self-addressed, stamped envelope provided. One hundred eighty-eight (24%) completed packets were returned. In addition, we received 65 blank packets in response to our instructions to complete the packet only if the participant considered himself or herself to be a trauma therapist; otherwise we asked that the blank packet be returned. Thus, our overall return rate was 32%. Other studies of therapists have obtained return rates ranging from 37% (Kassam-Adams, 1994) to 58% (Pope & Feldman-Summers, 1992).

Independent Measures

We developed a questionnaire in which we asked participants a variety of questions that examined their work with trauma survivors. The questions related to exposure to trauma material included, "How long ago did you begin working with trauma survivors?" "How many hours of your clinical work (per week) are spent doing trauma work?" and "How much exposure do you currently have to clients' trauma material?"

Other variables used in our exploratory analyses included therapist trauma history ("Do you have a trauma history?"), age, income, education, work setting, use of personal therapy to address the effects of one's trauma work, and whether or not respondent was currently receiving general or trauma-related supervision either on a regular basis or to balance his or her trauma work.

Dependent Measures

TSI (Traumatic Stress Institute) Belief Scale (Pearlman, in press-a). The TSI Belief Scale measures disrupted cognitive schemas. The scale is based in CSDT, and it assesses disruptions in psychological need areas that are hypothesized to be sensitive to traumatic experiences and to vicarious traumatization. The version of the scale (Revision F) we used has 79 items that measure disruptions in safety, trust, intimacy, esteem, and power. Participants were asked to rate, on a 6-point Likert scale (1 = *disagree strongly,* 6 = *agree strongly*), the extent to which they agreed with statements such as, "You can't trust anyone," and "Other people are no good." The two power subscales, both new to Revision F, were not deemed sufficiently reliable for inclusion in the data analyses and, thus, were dropped from the remainder of the study as well as from the final revision of the scale: Revision L.

The remaining subscales and their internal consistencies are as follows:

1. Safety (the belief that one is secure and reasonably invulnerable to harm) = .79,
2. Self-Esteem (the belief that one is valuable) = .84,
3. Other-Esteem (the belief that others are valuable) = .65,

4. Self-Trust (the belief that one can trust one's own judgment and perceptions) = .78,
5. Other-Trust (the belief that one can rely on others) = .80,
6. Self-Intimacy (the belief that one can feel connected to oneself) = .71,
7. Other-Intimacy (the belief that one can feel connected to others) = .82.

The internal consistency (Cronbach's alpha) of the entire scale for this sample was .83; with the two power subscales removed, it was .93.

Impact of Event Scale (IES; Horowitz, Wilner, & Alvarez, 1980). The IES is a 15-item scale that was developed to assess avoidant and intrusive signs and symptoms of PTSD. It has been used widely in studies of trauma survivors (Zilberg, Weiss, & Horowitz, 1982). We expected the IES to pick up trauma-related distress, which would suggest vicarious traumatization. We directed our participants to "Decide how true each item is for you these days as it applies to the traumatic material of your clients." A 4-point Likert-type scale was used (1 = *not at all*, 4 = *often*). In our study, the Avoidance and Intrusion subscales each had an internal consistency (Cronbach's alpha) of .86.

Symptom Checklist-90—Revised (SCL-90-R; Derogatis, 1977). We used the SCL-90-R to differentiate general distress from the trauma-specific distress reflected in the other dependent measures. A 5-point Likert format was used (0 = *not at all*, 4 = *extremely*). The 90 items were summed, and the total SCL-90-R score was used as a measure of general distress. The internal consistency of the scale in this study was .96 (Cronbach's alpha).

Marlowe-Crowne Social Desirability Scale (Marlowe-Crowne; Crowne & Marlowe, 1964). The Marlowe-Crowne is a 33-item scale that assesses the participant's need for approval from persons in authority. We administered it in order to assess the extent to which our participants' responses might have been shaped by concerns about others' approval.

Results

Because of the exploratory nature of the study, we used a .05 significance level in our analyses. Although we recognize the potential impact of a Type I error caused by the number of comparisons made, it seemed appropriate at this early stage in vicarious traumatization research to open future research possibilities by generating areas for investigation.

Table 1 shows the intercorrelations among the independent measures used in the study. We examined all of the objective and subjective measures of workload and exposure to trauma material, and, on the basis of their correlations with one another and with the dependent measures, we selected number of years working with trauma survivors as an indication of trauma therapy experience.

Table 2 shows the intercorrelations among the dependent measures. These included the TSI Belief Scale, the SCL-90-R, the IES Intrusion and Avoidance subscales, and the Marlowe-Crowne.

Correlations above .2 between the Marlowe-Crowne and a dependent measure indicate a desire for the approval of powerful others. The correlations between the Marlowe-Crowne and all dependent measures used in this study were less than .2.

Relations Among Dependent and Independent Measures

The mean TSI Belief Scale score for the entire sample was 184. This is the lowest score (indicating the least disruption) of the criterion groups for which we have collected data over the past several years. The mean TSI Belief Scale total score for the therapists with a personal trauma history was 190 ($SD = 38$); it was 174 ($SD = 34$) for those without a trauma history, a significant difference, $F(1, 182) = 9.41$, $p < .01$.

Table 3 shows the correlations between two possible contributing variables—length of time doing trauma work and percentage of survivors on caseload—to vicarious traumatization and the dependent measures. In the sample as a whole, only the self-trust scores correlated significantly with percentage of survivors ($r = -.22$, $p < .01$); the greater proportion of one's clinical work devoted to trauma work, the fewer disruptions in self-trust schemas. Length of time doing trauma work yielded more significant correlations in the sample as a whole. Those newer to the work had more disruptions in self-trust, self-intimacy, and self-esteem as well as higher overall symptoms as measured by the SCL-90-R.

On the basis of the studies reviewed above and the burnout literature, we selected the following independent variables to enter into a multiple regression equation: gender, personal trauma history, therapy (a variable that indicates participants' responses to the question, "Have you ever addressed the effects of your trauma work in your own personal therapy?"), age, length of time doing the work, income, level of education, and work

Table 1
Pearson Product-Moment Intercorrelations Among Independent Variables

Variable	1	2	3	4	5	6
1. Work	—					
2. Exposure	.1679*	—				
3. Therapy	−.0658	−.2356***	—			
4. Work setting	−.2730****	−.2229***	.0994	—		
5. Supervision	−.3630****	.0370	−.1338*	.2464****	—	
6. Education	.4189****	.1332*	.0423	−.2650****	−.4098****	—

Note. $N = 179$. Work = "How long ago did you begin working with trauma suvivors?" (# of years); Exposure = "How much exposure do you currently have to clients' trauma material?" (none, moderate amount, great deal, enormous amount); Therapy = "Have you ever addressed the effects of your trauma work in your own personal therapy?" (yes or no); Work setting = solo or group practice, clinic, hospital, multiple work settings; Supervision = anyone receiving trauma-specific or general supervision coded *yes*, otherwise *no*; Education = highest degree obtained.
* $p < .05$. *** $p < .001$. **** $p < .0001$.

Table 2
Intercorrelations Among Dependent Measures

Measure	1	2	3	4	5
1. TSI Belief Scale	—				
2. SCL–90–R	.6136****	—			
3. Intrusion	.2466****	.4382****	—		
4. Avoidance	.2907****	.3943****	.6772****	—	
5. Marlowe–Crowne	−.0144	−.0156	−.1228	−.0774	—

Note. $N = 181$. Higher scores indicate greater disruption on all measures. TSI = Traumatic Stress Institute; SCL–90–R = Symptom Checklist–90—Revised; Intrusion = subscale of the Impact of Event Scale (IES); Avoidance = subscale of the IES; Marlowe–Crowne = Marlowe–Crowne Social Desirability Scale.
**** $p < .0001$.

setting. We used these variables in stepwise multiple regression analyses to predict our dependent variables. Taken together, these variables predicted SCL–90–R scores ($R^2 = .22$, $p < .001$), total IES scores ($R^2 = .14$, $p < .01$), and total TSI Belief Scale scores ($R^2 = .12$, $p < .01$). Those variables contributing at least at the .05 level were therapy (which contributed significantly to SCL–90–R and IES scores) and trauma history (which contributed to SCL–90–R and TSI Belief Scale scores). In other words, those trauma therapists who were talking about the effects of their trauma work in their personal therapies and who had a personal trauma history showed the most disturbances on general and trauma-specific measures.

Comparisons Between Those With and Those Without a Personal Trauma History

We found therapist's personal trauma history to be such a powerful variable that we divided the sample into two subsamples: those with and those without a personal trauma history. Table 3 shows significant negative correlations within the trauma history group between length of time doing the work and the total TSI Belief Scale score, as well as the Safety, Self-Trust, Self-Intimacy, and Self-Esteem subscales. In addition, the percentage of survivors on caseload variable correlated negatively and significantly with Self-Trust, Self-Intimacy, and Self-Esteem.

Table 4 shows comparisons of scores for those therapists with and without a personal trauma history on the dependent measures. A multivariate analysis of variance was significant, $F(12, 169) = 2.25$, $p < .05$. We performed analyses of variance to explore specific comparisons. Significant differences were found in the following scores: the Safety, Self-Trust, Self-Esteem, Other-Trust, and Other-Intimacy subscales of the TSI Belief Scale; the SCL–90–R; and the Intrusion subscale of the IES. In all of these cases, those therapists with a personal trauma history showed more disruption than those without a personal trauma history.

Therapists With a Personal Trauma History

Of the total sample, 60% (80 women and 32 men) answered yes to the question, "Do you have a trauma history?" The only demographic variable on which survivors differed significantly from those without a trauma history was marital status, with survivors more likely to be married ($p < .03$).

Within the trauma history group, newer therapists (those with less than 2 years of therapy experience) tended to show more disrupted schemas; the correlation between length of time

Table 3
Correlations Between Trauma Work Variables and Vicarious Traumatization Measures

	Length of time doing trauma work			% of survivors on caseload		
Variable	All participants ($n = 172$)	Trauma history ($n = 106$)	No trauma history ($n = 66$)	All participants ($n = 181$)	Trauma history ($n = 110$)	No trauma history ($n = 71$)
TSI Belief Scale						
Total	−.09	−.22*	.06	−.07	−.13	.02
Safety	−.07	−.20*	.06	−.05	−.01	−.08
Self-trust	−.20**	−.31**	−.04	−.22**	−.27**	−.15
Self-intimacy	−.14*	−.21*	.25*	−.12	−.20*	−.02
Self-esteem	−.15**	−.22**	−.07	−.09	−.20*	.10
Other-esteem	.10	.00	.23*	.14	.17	.12
SCL–90–R	−.15*	−.28**	−.01	−.09	−.16	.04

Note. Results are reported only for those subscales with significant correlations. TSI = Traumatic Stress Institute; SCL–90–R = Symptom Checklist–90—Revised.
* $p < .05$. ** $p < .01$.

Table 4
Comparisons Between Trauma History and No Trauma History Groups on Dependent Measures (MANOVA)

Measure	n[a]	Trauma history	M	SD	$F(9, 163)$
TSI Belief Scale					
Safety	110	Yes	2.25	.74	5.25*
	75	No	1.98	.84	
Self-trust	110	Yes	1.86	.71	5.48*
	75	No	1.62	.61	
Other-trust	109	Yes	1.89	.70	5.61*
	74	No	1.67	.50	
Self-esteem	110	Yes	1.45	.59	5.71*
	75	No	1.26	.46	
Other-esteem	109	Yes	3.39	.60	2.70
	74	No	2.54	.58	
Self-intimacy	110	Yes	1.68	.59	2.36
	75	No	1.54	.52	
Other-intimacy	109	Yes	1.85	.86	5.00*
	74	No	1.58	.75	
Impact of Event Scale					
Intrusion	109	Yes	7.57	4.3	10.11**
	74	No	5.62	3.7	
Avoidance	109	Yes	7.33	5.3	5.83*
	74	No	5.58	4.2	
SCL-90-R	109	Yes	45.13	32.68	17.88***
	74	No	26.62	22.91	

Note. MANOVA = multivariate analysis of variance; TSI = Traumatic Stress Institute; SCL-90-R = Symptom Checklist-90—Revised.
[a] Analysis only includes participants who completed an entire subscale.
* $p < .05$. ** $p < .01$. *** $p < .001$.

Table 5
Predictors of Dependent Variables in Trauma History Group

Dependent variable and predictor variable	Multiple regression analysis: F test F	df	Multiple R	R^2	β
TBI Belief Scale					
Self-Trust	9.97***	2, 110	.3979	.16	
Exposure					−.2631
Work					−.2559
Other-Trust	5.18***	4, 107	.4077	.17	
Education					.2502
Therapy					.1901
Work					−.2526
Supervision					−.2247
Self-Esteem	6.96**	1, 110	.2471	.06	
Exposure					−.2471
Other-Esteem	5.45*	1, 110	.2201	.05	
Education					.2201
Self-Intimacy	4.97*	1, 109	.2117	.05	
Work setting					.2117
Other-Intimacy	5.77**	2, 109	.3133	.10	
Supervision					−.3236
Work					−.2235
SCL-90-R	7.81**	1, 109	.2608	.07	
Work					−.2608
Impact of Event Scale					
Avoidance	7.13**	1, 111	.2489	.06	
Work setting					.2489
Intrusion	4.61*	2, 110	.2817	.08	
Work setting					.2140
Therapy					.1858

Note. TSI = Traumatic Stress Institute; SCL-90-R = Symptom Checklist-90—Revised.
* $p < .05$. ** $p < .01$. *** $p < .001$.

doing trauma therapy and the TSI Belief Scale score was −.22 ($p < .05$). There was also a significant relation between newness to the work and symptoms as measured by the SCL-90-R ($r = -.27, p < .01$).

Table 5 provides data on the therapists with a personal trauma history; these therapists reported more disruptions in schemas and higher general distress levels than those who did not have a personal trauma history. The results of a simultaneous multiple regression analysis revealed the following about the therapists with a personal trauma history who showed more disruptions: They had less experience in working with trauma survivors; they had moderate exposure to trauma material; they had addressed the effects of their trauma work in their own personal therapy; they were not receiving supervision; and they were working in a hospital setting. With respect to disrupted schemas specifically, we found that those therapists who had been doing the work for a shorter time and who were not being supervised had the highest TSI Belief Scale scores (indicating greater disruption).

Therapists Without a Personal Trauma History

The remaining 40% of the sample (57 women and 19 men) answered no to the question, "Do you have a trauma history?" In this group, only the Other-Esteem subscale correlated significantly with length of time doing the work, and this was a positive correlation (more time doing trauma therapy correlated .23 with disruptions in Other-Esteem, $p < .05$). The general level of distress, as measured by the SCL-90-R, did not correlate significantly with the length of time doing trauma therapy in those without a personal trauma history.

The results of our multiple regression analysis for the subsample of therapists without a trauma history are shown in Table 6. Those who showed more disrupted schemas and higher distress levels on the dependent measures tended (a) to have less training, (b) to work in a clinic setting, and (c) to have addressed the effects of their trauma work in their own personal therapy.

Discussion

All of these findings must be interpreted with caution. Because the sample is a self-selected group of self-identified "trauma therapists," the findings should be generalized only with great care. Twenty-five percent of our questionnaire packets were returned blank, presumably because of the instructions to complete the packet only if one considered oneself to be a trauma therapist. These may be therapists who treat survivors but for whom this is not a major portion of their work, or they may be therapists who have a different professional identity. We cannot know how their responses would have differed; this unanswered question is an unfortunate limitation of our sampling

Table 6
Predictors of Dependent Measures in No Trauma History Group

Dependent variable and predictor variable	Multiple Regression Analysis				
	F test				
	F	*df*	Multiple *R*	R^2	β
TSI Belief Scale					
Safety	7.95***	2, 74	.44	.19	
Education					−.5037
Work					.3066
Self-Trust	4.88*	1, 75	.26	.07	
Work setting					.2607
Self-Esteem	5.29*	1, 75	.27	.07	
Work setting					.2705
Self-Intimacy	5.07*	1, 75	.26	.07	
Education					−.2652
Other-Trust	5.38*	1, 74	.27	.08	
Education					−.2744
Other-Intimacy	5.32*	1, 75	.27	.07	
Work setting					.2712
SCL–90–R	7.11***	2, 74	.42	.18	
Supervision					.2783
Therapy					.2578
Impact of Event Scale					
Avoidance	9.77**	1, 75	.36	.13	
Therapy					.3568
Intrusion	9.13**	1, 75	.35	.12	
Therapy					.3463

Note. TSI = Traumatic Stress Institute; SCL–90–R = Symptom Checklist–90–Revised.
* $p < .05$. ** $p < .01$. *** $p < .001$.

procedure. In addition, the .05 significance level used in our analyses invites future research in areas noted in this study, but such future research should use more conservative significance levels in testing the hypotheses.

Our study results replicate findings from other studies that indicate that, despite more extensive trauma histories than the general population, psychotherapists seem to be functioning well psychologically (Elliott & Guy, 1993; Follette et al., 1994). It is evident, however, that the subsample of therapists with a personal trauma history showed greater disruptions than those without a personal trauma history. Their higher scores on five of the seven subscales on the TSI Belief Scale could be predicted by their trauma survivor status. In addition, however, our study shows that they are also more affected by the length of time they have been doing the work and, to a lesser degree, by the percentage of survivors in their caseloads. It is also noteworthy that, within our sample, participants who were doing worse were using their personal therapies to discuss the impact of their trauma work. This finding may be indicative of the extent to which the deleterious effects of trauma work can spill over into one's personal life.

Why did the two groups show such different patterns? It is likely that those without a trauma history know less about what they will encounter as trauma therapists than do their counterparts with trauma histories. It is possible that the newest therapists without trauma histories experience very high levels of distress and leave the field or reshape their career paths quite early before they have the opportunity to self-identify as trauma therapists. This possibility could be tested with a larger group of newer trauma therapists than we had in our sample (in which only 13% had less than 2 years experience doing trauma therapy), with longitudinal data, or with interviews of trauma therapists with a range of experience.

The newest therapists in the trauma history group were experiencing the most difficulties. This finding is consistent with the burnout literature, which shows that being younger or newer to the work is correlated with the highest levels of burnout (Ackerley, Burnell, Holder, & Kurdek, 1988; Deutsch, 1984) and with the most negative reactions to doing therapy (Rodolfa, Kraft, & Reilley, 1988). In our study, these newest trauma therapists were not receiving supervision, and they tended to be working in hospitals. Only 17% of those therapists working in hospitals, where the most acutely distressed patients are treated, were receiving any supervision.

Why did the more experienced therapists in the trauma history group have less disrupted schemas? Although those with more disrupted schemas may have left the field earlier, it is also possible that schemas become less disrupted over time. If so, perhaps those survivor therapists who enter this field in order to find meaning in their own trauma actually accomplish this goal through their work, and then they demonstrate a resolution of previously disrupted schemas.

This latter possibility may be supported by the finding that the significant correlations in the trauma history group with length of time doing trauma work were with the three self-schema areas assessed by Revision F of the TSI Belief Scale (i.e., more time doing the work correlated with fewer disruptions in self-trust, self-esteem, and self-intimacy). Another way of stating this finding is that those survivor therapists for whom beliefs about relationship with self were most strongly positive had been doing the work the longest.

The more experienced survivor therapists also showed significantly less general distress. Again, this may reflect self-selection: The more distressed individuals may leave the field early. Or it may be that as experience and competence increase, symptoms abate. Also, it seems possible that by contributing to another person's personal development, a trauma therapist may also achieve better self-functioning; that is, survivor therapists may, to some degree, contribute to their own healing as they share in their clients' growth and change. Finally, it may be that survivor therapists continue to engage in a process of personal development and healing over time that is reflected in their decreasing symptomatology. Therapists who have done the work longer are likely to have engaged in continuing professional education and consultation. This may help survivor therapists maintain clearer psychological boundaries between themselves and their clients, allowing the evolution of stronger self-schemas.

Those therapists without a trauma history who had been doing trauma work longer experienced greater disruptions in self-intimacy and other-esteem. The former represents a disconnection from one's inner experience, which may be the trauma therapist's way of not feeling as much pain related to the work. Unfortunately, this solution has costs that extend into and beyond the work of therapy, such as difficulties being aware of countertransference and enjoying time spent alone.

It is not difficult to understand the loss of esteem for others as individuals are exposed, perhaps for the first time, to the horrors of people's capacity for cruel behavior against others. That which formerly may have been defended against can no longer remain unknown, unseen. Alternatively, those with negative other-esteem schemas may remain in the field longer as they do not experience a conflict between the stories they hear and their preexisting negative beliefs about others.

We asked participants to complete the questionnaire packet only if they considered themselves to be trauma therapists. This label may be a self-description that one does not take up early in one's work treating survivors, or it may be one that survivor therapists are more likely to claim. It may account for some of the differences between our results and those of other studies. It almost certainly contributed to our very low response rate.

Implications

The top research priority is the development of clear operational definitions of constructs that can be used by all researchers. The notion of vicarious traumatization is complex, and its measurement will require a multivariate approach. Important future directions include defining and developing a measure of empathic engagement and continuing to find ways of measuring the many therapist, work, and work-context variables that may contribute to or mitigate vicarious traumatization. Refining assessment of exposure includes asking about specific aspects of the work that therapists may find traumatic. Our definition suggests that important questions relate to dealing with clients' graphic descriptions of traumatic events, observing and participating in traumatic reenactments, and bearing witness to human cruelty. Such research will allow us to develop our understanding of vicarious traumatization and ways to ameliorate it for the mutual growth of therapist and client.

The varied findings across studies on the relation between the therapist's trauma history and the impact of trauma therapy work speak to the need for clearer definitions. A constructivist perspective requires that the participant (or client), rather than the researcher (or clinician), define what is traumatic. We prefer a subjective question about the person's perception of his or her history to an approach in which the researcher lists events and decides whether or not they were traumatic for the respondent. Our study also points to a need for a thorough examination of the interaction between a trauma history and doing trauma therapy for the survivor therapist.

Important clinical implications of this work are that we need training in trauma therapy for those new to the field, more supervision by experienced trauma therapists for all trauma therapists, and more support for survivor therapists (Neumann & Gamble, in press; Pearlman & Saakvitne, 1995a). Training and supervision of trauma therapists should include a solid theoretical foundation that includes an understanding of the effect of psychological trauma, a relational perspective, and attention to countertransference and vicarious traumatization (Pearlman & Saakvitne, 1995a). Therapists who work with trauma survivors need supportive, confidential, professional relationships within which they can process the horrific stories, graphic imagery, and destructive reenactments that are an inevitable part of the work (Pearlman & Saakvitne, 1995a, 1995b). Finally, trauma therapists should pay attention to their own self-care in the service of providing high-quality, ethical services and of protecting themselves and their nonprofessional lives (Pearlman, in press-b).

Trauma therapies are sensitive relationships requiring the best of both parties; we can do our part only with an adequate map and colleagues to help us hold the flashlight.

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1996 APA Convention *Call for Programs*

The *Call for Programs* for the 1996 APA annual convention appears in the September issue of the *APA Monitor.* The 1996 convention will be held in Toronto, Ontario, Canada, from August 9 through August 13. The deadline for receipt of program and presentation proposals is December 1, 1995. Additional copies of the *Call* are available from the APA Convention Office, effective in September. As a reminder, agreement to participate in the APA convention is now presumed to convey permission for the presentation to be audiotaped if selected for taping. Any speaker or participant who does not wish his or her presentation to be audiotaped must notify the person submitting the program either at the time the invitation is extended or before the December 1 deadline for proposal receipt.