

Vicarious Trauma

A Comparison of Clinicians Who Treat Survivors of Sexual Abuse and Sexual Offenders

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This study compared vicarious trauma in a random sample of male and female clinicians who treat survivors (n = 95) and those who treat offenders (n = 252). A national survey was conducted with members of the Association for the Treatment of Sexual Abusers (ATSA) and the American Professional Society on the Abuse of Children (APSAC). These data were used to test the relative contribution of variables theorized to contribute to two vicarious trauma effects (avoidance and intrusions) using the Impact of Event Scale. The sample reported high levels of avoidance and intrusions. Variables associated with vicarious trauma differed based on client population served. Sequential regression analyses were used to examine theoretically derived variables. Implications for practice and further research are discussed.

Keywords: vicarious trauma; sexual abuse treatment; clinicians; survivors; sexual offenders

The term vicarious traumatization was first used by McCann and Pearlman (1990) to describe pervasive changes that occur within clinicians over time as a result of working with clients who have experienced sexual trauma. These include changes in the clinician's sense of self, spirituality, worldview, interpersonal relationships, and behavior (Chrestman, 1999; Freeman-Longo, 1997; Kassam-Adams, 1999).

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A number of terms have been used to describe the negative effects that result from working with traumatized clients. Common terms include compassion fatigue or secondary traumatic stress, countertransference, and burnout. Figley (1995) suggested compassion fatigue as the most appropriate term to describe secondary traumatic stress effects. He suggested that clinicians who treat traumatized clients are particularly vulnerable to developing compassion fatigue as a result of empathic engagement with clients and exposure to their traumatic material. Countertransference refers to a clinician's unconscious and conscious affective, behavioral, and cognitive response to a particular client's transference (not specific to trauma clients) within the treatment relationship (Figley, 1999; Pearlman & Saakvitne, 1995; Wilson & Lindy, 1994). Burnout refers to a generalized emotional exhaustion that helping professionals may develop over time related to various work-related stressors (Figley, 1999; Pearlman & Saakvitne, 1995; Sexton, 1999).

Features of compassion fatigue or secondary traumatic stress, countertransference, burnout, and vicarious traumatization overlap and have an interactional effect (Pearlman & Saakvitne, 1995). Vicarious traumatization is a process that requires continual self-assessment and monitoring, prevention, and intervention (Pearlman, 1999). Unique features of sexual abuse treatment that contribute to the development of vicarious traumatization include listening empathically as survivors share graphic details of their victimization experiences and the intensity of their pain (McCann & Pearlman, 1990; Pearlman & Mac Ian, 1995; Sexton, 1999).

The effects of vicarious traumatization, also termed *vicarious trauma* (Schauben & Frazier, 1995), are far-reaching. An ethical concern is that vicarious trauma may interfere with clinicians' ability to work effectively with clients (Pearlman & Saakvitne, 1995). In addition, clinicians and researchers who experience these negative effects may stop working with traumatized individuals (Figley, 1999). Therefore, Pearlman and Saakvitne (1995) suggest that it is crucial to the well-being of clients and clinicians to recognize and resolve vicarious traumatization:

Unaddressed vicarious traumatization, manifest in cynicism and despair, results in a loss to society of that hope and the positive actions it fuels. This loss can be experienced by our clients, as we at times join them in their despair; by our friends and families, as we no longer interject optimism, joy, and love into our shared pursuits; and in the larger systems in which we were once active as change agents, and which we may now leave, or withdraw from emotionally in a state of disillusionment and resignation. (p. 33)

REVIEW OF THE LITERATURE

In recent years, numerous studies have investigated the effects of working with survivors (Brady, Guy, Poelstra, & Browkaw, 1999; Chrestman, 1999; Ghahramanlou & Brodbeck, 2000; Iliffe & Steed, 2000; Kassam-Adams, 1999; Pearlman & Mac Ian, 1995; Schauben & Frazier, 1995; Steed & Downing, 1998). Studies have also compared vicarious trauma effects in mental health clinicians and law enforcement personnel (Follette, Polusny, & Milbeck, 1994) and nurses and counselors (Lyon, 1993) who work with survivors of sexual assault. These studies provide preliminary information with regard to the effects of providing sexual abuse treatment. However, the differences in the study samples (e.g., profession, work setting), variables measured, and methodologies suggest the need for caution when interpreting the findings.

A growing number of studies have investigated the effects on clinicians who treat sexual offenders (Edmunds, 1997; Ellerby, 1997; Farrenkopf, 1992; Jackson, Holzman, & Barnard, 1997; Shelby, Stoddart, & Taylor, 2001; Steed & Bicknell, 2001) and clinicians who treat both survivors and offenders (Rich, 1997). Of these existing studies, much of what is reported is descriptive data. Many of the studies do not specify their methodology, and only Steed and Bicknell (2001) used standardized measures.

Clinicians who treat sexual offenders may need to manage strong emotional reactions (e.g., anxiety, anger, disgust) to hearing clients' traumatic material (e.g., stories of perpetration, deviant fantasies) and cognitive distortions (e.g., denial, minimization, projection; Ellerby, 1997; Kearns, 1995; Roundy & Horton, 1990), while striving to remain helpful, appropriately empathic, and professional (Bengis, 1997; Mitchell & Melikian, 1995). As a result, clinicians who treat offenders may experience different effects when compared to those who treat survivors and no offenders.

In separate studies, clinicians who treat survivors and those who treat offenders have been found to experience similar vicarious trauma effects. These trauma effects include disrupted cognitive schemas (Pearlman & Mac Ian, 1995; Rich, 1997), intrusive imagery (Kassam-Adams, 1999; Pearlman & Mac Ian, 1995; Rich, 1997; Steed & Bicknell, 2001; Steed & Downing, 1998), avoidance symptoms (Kassam-Adams, 1999; Steed & Bicknell, 2001), decreased sense of personal safety and safety of significant others (Jackson et al., 1997; Rich, 1997), hypervigilance around strangers (Jackson et al., 1997; Steed & Bicknell, 2001), difficulties with trust and intimate relationships (Pearlman & Mac Ian, 1995; Rich, 1997), self-esteem issues (Pearlman & Mac Ian, 1995), increased cynicism, depressed mood

and discouragement, disruptions in sexuality, and increased substance use (Rich, 1997). Although all therapists who provide sexual abuse treatment are thought to experience negative effects to some degree, not all develop vicarious trauma. This suggests that moderating and mediating variables may play a role in its development (Neumann & Gamble, 1995; Pearlman & Mac Ian, 1995; Pearlman & Saakvitne, 1995).

Variables that may moderate the development of vicarious trauma include gender (Kassam-Adams, 1999), age (Ghahramanlou & Brodbeck, 2000), amount of exposure to traumatized clients (Brady et al., 1999; Chrestman, 1999; Kassam-Adams, 1999; Schauben & Frazier, 1995), length of time providing sexual abuse treatment (Brady et al., 1999; Chrestman, 1999; Pearlman & Mac Ian, 1995; Rich, 1997; Steed & Bicknell, 2001), and clinicians' own maltreatment history (Follette et al., 1994; Ghahramanlou & Brodbeck, 2000; Kassam-Adams, 1999; Pearlman & Mac Ian, 1995). However, Schauben and Frazier (1995) reported that clinicians' own maltreatment history did not predict increased vicarious trauma. Variables that may mediate the development of vicarious trauma include access to clinical supervision and/or consultation (Farrenkopf, 1992; Follette et al., 1994; Jackson et al., 1997; Pearlman & Mac Ian, 1995; Rich, 1997), training for new and experienced clinicians (Chrestman, 1999; Follette et al., 1994; Pearlman & Mac Ian, 1995), self-care strategies, and social support (Chrestman, 1999; Follette et al., 1994; Jackson et al., 1997; Rich, 1997; Schauben & Frazier, 1995).

In summary, existing empirical literature provides an important foundation for understanding and intervening to reduce vicarious trauma in clinicians. Preliminary research has begun to identify variables associated with vicarious trauma; however, the extent to which these variables moderate or mediate the development of vicarious trauma is not known. These findings should be viewed as preliminary because there is a lack of consistent support for the contribution of these variables across studies and the studies themselves vary in significant ways (e.g., respondent profession, client population). To date, there have been no studies that compare vicarious trauma effects in clinicians who treat survivors and those who treat sexual offenders. As a result, it is not known whether these clinicians experience different effects.

THIS STUDY

This study builds on existing research by testing models of coping strategies that help minimize traumatic effects on therapists who treat survivors of

sexual abuse and sexual offenders. The study seeks to answer the following research questions: (a) What is the level of vicarious trauma in therapists working with survivors and with sexual offenders? (b) What demographic, personal history, and coping strategy variables are associated with vicarious trauma in clinicians who provide sexual abuse treatment? and (c) Do these variables differ for those working with different client populations?

It was hypothesized that (a) clinicians would report avoidance and intrusions trauma falling within the clinical range, (b) childhood maltreatment history and longer time providing sexual abuse treatment would be associated with higher levels of vicarious trauma, (c) greater use of positive personal and positive professional coping strategies would be associated with less vicarious trauma, (d) greater use of negative personal coping strategies would be associated with greater vicarious trauma, and (e) clinicians who treat offenders would report levels of avoidance and intrusions similar to those reported by clinicians who treat survivors.

METHOD

Respondents

Respondents in this study were 347 clinical members of two professional membership organizations, the Association for the Treatment of Sexual Abusers (ATSA) and the American Professional Society on the Abuse of Children (APSAC). The study includes respondents whose client population could be clearly categorized as “offenders” ($n = 252$) or “survivors” ($n = 95$) (see Table 1). The offender group includes clinicians who treat sexual offenders and those who treat sexual offenders and survivors. The survivor group includes clinicians who treat survivors, but no sexual offenders. The total sample is 40% male, with a mean age of 45.6 ($SD = 9.8$). Self-reported ethnicity is 94% Caucasian, with the remainder relatively evenly divided among African American, Latino, and other ethnicity. Of the total sample, 69% are 41 years or older. Educational background includes master’s degree (67%), doctoral degree (28%), and bachelor’s degree or less (5%).

The limited demographic data available for the two professional organizations indicate that the membership of ATSA is 59% male, and 73% are 41 years or older. The membership of APSAC is 88% Caucasian. Thus, the demographic data suggest that the study sample is broadly similar to the total membership of the two organizations.

TABLE 1: Demographic Characteristics

<i>Variable</i>	<i>Total Sample (N = 347)</i>	<i>Work With Survivors (n = 95; 27.4%)</i>	<i>Work With Offenders (n = 252; 72.6%)</i>	<i>p</i>
Gender				< .0001
Male	137 (39.48%)	10 (10.53%)	127 (50.40%)	
Female	210 (60.52%)	85 (89.47%)	125 (49.60%)	
Age ^a	45.53 (SD = 9.80)	44.44 (SD = 9.21)	45.94 (SD = 10.00)	.2033
Education				.0135
Bachelor's or less	18 (5.22%)	—	18 (7.20%)	
Master or specialist	233 (67.54%)	72 (75.79%)	161 (64.40%)	
Doctorate	94 (27.25%)	23 (24.21%)	71 (28.40%)	
Ethnicity ^b				.0715
Caucasian	326 (94.22%)	93 (97.89%)	233 (92.83%)	
African American	5 (1.45%)	—	5 (1.99%)	
Latino	5 (1.45%)	—	5 (1.99%)	
Other	10 (2.89%)	2 (2.10%)	8 (3.19%)	
Work setting ^c				.0002
Agency	104 (30.41%)	40 (42.55%)	64 (25.81%)	
Private practice	133 (38.89%)	37 (39.36%)	96 (38.71%)	
Residential/court/prison-based	56 (16.37%)	2 (2.13%)	53 (21.37%)	
Other	49 (14.33%)	14 (14.89%)	35 (14.11%)	
Length of time providing treatment				.2042
Less than 5 years	77 (22.19%)	27 (28.42%)	50 (19.84%)	
5 to 10 years	77 (22.19%)	21 (22.11%)	56 (22.22%)	
10 or more years	193 (55.62%)	47 (49.47%)	146 (57.94%)	
Maltreatment history ^{d,e}				
Any	263 (75.79%)	73 (76.85%)	190 (75.40%)	.7793
Multiple forms	186 (53.60%)	48 (50.53%)	138 (54.76%)	.4805
Sexual abuse	134 (38.62%)	42 (44.21%)	92 (36.51%)	.0051
Physical abuse	90 (25.94%)	30 (31.58%)	60 (23.81%)	.2525
Neglect	102 (29.39%)	21 (22.11%)	81 (32.14%)	.0987
Emotional abuse	180 (51.87%)	51 (53.68%)	129 (51.19%)	.9293
Emotional neglect	172 (49.57%)	46 (48.42%)	126 (50.00%)	.0616

a. Reported in years.

b. Data missing for one respondent.

c. Data missing for five respondents.

d. Totals may exceed 100% due to multiple maltreatment histories.

e. Yes = 1, no = 0.

Study Design and Method

The mailing lists from the two organizations were downloaded by computer and were visually screened using predetermined exclusion criteria

(e.g., non-U.S. member, attorney, police, criminal justice, medical setting, prevention program, child protection caseworker, administrative staff, minister) to obtain the population of clinical members. A computer macro was applied in Microsoft Excel to select a random sample of members from the resulting "clinical member" list for each organization, and these randomly selected lists were then combined. The final sample for this study was 57% APSAC members in accordance with its larger membership.

Written surveys were sent to 1,754 individuals, along with a postage-paid envelope and a cover letter that described the anonymous study. Return of the completed survey served as informed consent. Two weeks after the initial mailing, a postcard was sent to the entire mailing list to again invite voluntary participation. A total of 573 (33%) surveys was returned. This response rate is comparable to the rate reported in previous published studies of therapists, with rates ranging from 32% (Pearlman & Mac Ian, 1995) to 57% (Shelby et al., 2001). Excluding surveys that could not be delivered and those that were unusable, there were 409 surveys for an effective response rate of 23%. This study includes only the 347 respondents with complete data for the two dependent variables (intrusions and avoidance trauma).

The low response rate raised concerns about selection bias. It is not possible to know whether and how those who responded differ from those who did not respond. In an effort to assess this to a limited extent, analyses were conducted to compare the first 50 and the last 50 surveys received, to determine whether they differed on findings for major study variables. There were no statistically significant differences between groups for (a) age, (b) gender, (c) client population served, (d) educational background, (e) level of vicarious trauma, or (f) maltreatment history.

Measurement

Closed-ended survey questions developed for this study were used to collect data on demographic characteristics, client population served, and length of tenure providing sexual abuse treatment. Data from two standardized instruments were also analyzed for this study.

The Impact of Event Scale (IES) (Horowitz, Wilner, & Alvarez, 1979) is a self-report measure of subjective distress related to an identified traumatic event. The scale has 15 questions rated on a 4-point Likert-type scale, ranging from 0 (*not at all*) to 3 (*often*). These questions assess vicarious trauma with two factors: Intrusion and Avoidance. The IES measures two effects believed to interfere with providing effective treatment (Pearlman & Saakvitne, 1995) and is the most commonly used instrument to measure vicarious trauma effects (e.g., Brady et al., 1999; Chrestman, 1999; Ghahramanlou & Brodbeck,

2000; Kassam-Adams, 1999; Pearlman & Mac Ian, 1995; Steed & Bicknell, 2001). Scores for the IES factors range from 0 to 21 (Intrusion) and 0 to 24 (Avoidance), with higher scores indicating greater vicarious trauma. The IES has adequate psychometric properties, with internal consistency of .78 for the Intrusion factor and .82 for the Avoidance factor (Horowitz et al., 1979). In this study, the standardized Cronbach's alpha was .86 for the Intrusion factor and .77 for the Avoidance factor.

The Childhood Trauma Questionnaire (CTQ) (Bernstein & Fink, 1998) measures self-reported history of childhood maltreatment (i.e., sexual abuse, physical abuse, physical neglect, emotional abuse, emotional neglect) and consists of 28 items. These items are scored on a 5-point Likert-type scale, ranging from 1 (*never true*) to 5 (*very often true*). This instrument was selected because it measures multiple forms of childhood maltreatment using a Likert-type scale, which provides detailed data. Scores for each scale range from 5 to 25, with higher scores indicating greater severity of childhood maltreatment. The psychometric properties of this instrument are adequate, with standardized Cronbach's alphas between .66 and .92 for the subscales, and demonstrated content, construct, and concurrent validity (Bernstein & Fink, 1998). All five subscales were used in this study. Standardized Cronbach's alphas in this study ranged between .70 and .90 for the maltreatment subscales.

One section of the survey measured the types of strategies respondents used to cope with providing sexual abuse treatment. Respondents were asked, "In the last 6 months, which of the following have you done to cope with the nature of your work? Circle all that apply." The survey listed 24 possible strategies, for example, "one-to-one supervision," "engaged in spiritual practices," "used alcohol to relax or get away from the day," plus an "other" category.

Analyses

Analyses were conducted using SAS 8.02 (The SAS System for Windows, 1999-2001). These analyses included (a) *t* tests and chi-square analyses to compare results for clinicians working with offenders and those working with survivors, and (b) sequential multiple regression (SMR) analysis was used to test the study hypotheses. A significance level of .05 was used in this study as the point for a statistical finding (i.e., $\alpha = .05$). It is acknowledged that this will result in an inflated experimentwise type I error rate. However, the decision to keep this rate was made so as not to make excessive

type II errors. Committing type II errors in the context of this exploratory study would unnecessarily mask potentially important factors influencing trauma effects in this type of sample.

RESULTS

Descriptive Findings

Respondent groups did not differ in age, ethnicity, or length of time providing sexual abuse treatment. The majority of the overall sample (56%) reported sexual abuse treatment tenure of 10 years or more. Clinicians treating offenders were more likely to be male, $\chi^2(1, N = 347) = 45.9, p < .0001$, and were more often employed in residential or prison settings, $\chi^2(4, N = 342) = 20.08, p = .0002$. The clinician groups did not differ in their self-reported childhood maltreatment history (as measured by the CTQ). Because females in this study reported a significantly higher rate of sexual abuse history than males, $\chi^2(1, N = 347) = 7.21, p = .0072$, the Cochran-Mantel-Haenszel statistic was used to analyze maltreatment history for the clinician groups while controlling for gender. This analysis was nonsignificant ($CMH = .1284, p = .1284$), indicating that the clinician groups do not differ in their sexual abuse history, even when controlling for gender.

After analyzing separate maltreatment subscales, scores on the CTQ were recategorized into two variables: “any maltreatment” and “multiple maltreatment” (i.e., two or more forms of maltreatment). Overall, 75.8% of the respondents reported having experienced at least one form of maltreatment as a child (i.e., sexual abuse, physical abuse, physical neglect, emotional abuse, emotional neglect), and 53.6% reported having experienced multiple forms of maltreatment.

Trauma Findings

Clinician groups did not differ significantly in their levels of vicarious trauma, as measured by the IES (see Table 2). For the total IES, the mean score was in the moderate range, and 52% of the sample scored in the clinical range. Although there are no norms available for clinicians, scores in this study are consistent with Kassam-Adams (1999) and Ghahramanlou and Brodbeck (2000) and higher than those found in other clinician samples (Pearlman & Mac Ian, 1995; Steed & Bicknell, 2001).

TABLE 2: Level of Vicarious Trauma^a

<i>Trauma Type</i>	<i>Total Sample (N = 347)</i>		<i>Work With Survivors (n = 95)</i>		<i>Work With Offenders (n = 252)</i>		<i>p</i>
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	
Avoidance	13.99	4.57	14.47	4.29	13.81	4.67	.3494
Intrusion	12.44	4.39	12.62	4.13	12.37	4.49	.2312
Total score	26.43	8.12	27.09	7.31	26.18	8.41	.6285

a. Means and standard deviations; measured by Impact of Event Scale.

Coping Strategy Findings

Respondents were asked to indicate the strategies they had used to cope with the nature of their work during the past 6 months (see Table 3). These items were combined into three groups, including negative strategies (i.e., use pornography, use alcohol, use illegal drugs), positive professional strategies (i.e., seek consultation, obtain supervision, seek support from coworkers, participate in group supervision, participate in clinical/professional support group), and positive personal strategies (i.e., physical exercise, spiritual practices, seek support from family/friends, seek own therapy). The two clinician groups differed in the extent to which they sought professional support, with clinicians who treat survivors being more likely to endorse these items, $t(347) = 2.70$, $df = 345$, $p = .0076$. These clinicians were also more likely to endorse use of positive personal coping strategies, $t(347) = 3.50$, $df = 345$, $p = .0005$.

Bivariate Findings

Bivariate analyses were also carried out between demographic characteristics (age, gender, length of time providing sexual abuse treatment), personal and professional coping strategies, and maltreatment history, and the two dependent variables to determine if these variables were associated with avoidance and intrusions trauma. Maltreatment history (as measured by the CTQ) was not associated with either type of trauma effects for either clinician group. For those working with survivors, the shorter the tenure in providing sexual abuse treatment, $F(2, 95) = 4.01$, $p = .0214$, the higher the intrusions trauma. Bivariate analyses between these variables and avoidance trauma showed that no variables were significant.

For those working with offenders, the younger the clinicians ($r = -.13, p = .0360$) and the greater the use of positive ($r = .30, p < .0001$) and negative personal coping strategies ($r = .28, p < .0001$), the higher the avoidance trauma. Bivariate analyses between these variables and intrusions trauma showed that the younger the clinicians ($r = -.15, p = .0190$) and the greater the use of positive ($r = .28, p < .0001$) and negative personal coping strategies ($r = .17, p = .0087$), the higher the intrusions trauma.

Sequential Regression Findings

Analyses for Total Sample

SMR was first employed with the total sample to determine if the addition of information concerning coping strategies makes a unique contribution to models predicting avoidance and intrusions after differences in demographic characteristics are statistically controlled. In the first step, age, gender, maltreatment history, and length of time providing sexual abuse treatment were entered. In the second step, a variable for client population was entered. In the third step, a variable for negative personal coping strategies was entered. The fourth step included positive personal coping strategies, and the fifth step included positive professional strategies. This order was selected to determine whether professional coping strategies significantly contributed to models predicting vicarious trauma after controlling for personal coping strategies.

Initial SMR analysis reveals that 1% of the observed variability in avoidance trauma was explained by clinicians' age, gender, maltreatment history, and length of time providing sexual abuse treatment. Adding client population increased this percentage to 2%. In the final step, following the addition of negative personal coping strategies, positive personal coping strategies, and positive professional coping strategies, the explained variance in avoidance trauma increased to 10%. In a similar manner, 2% of the observed variability in intrusions trauma effects was explained by demographic variables. Adding client population served increased the statistical prediction to 2.6%. In the final step, after adding personal and professional coping strategies, the statistical prediction increased to 8.5%. Overall, there was a low level of variance accounted for in avoidance and intrusions trauma effects. To provide a clearer picture of the contribution of the predictor variables on the dependent variables, the models were examined separately for clinicians who work with survivors and those who work with offenders.

TABLE 3: Strategies Used to Cope With Effects of Providing Sexual Abuse Treatment^a

Trauma Type	Total Sample (N = 347)		Work With Survivors (n = 95)		Work With Offenders (n = 252)		p
	M	SD	M	SD	M	SD	
Negative personal strategies ^b	.23	.49	.19	.42	.25	.51	.2933
Positive personal strategies ^c	1.76	1.07	2.08	1.02	1.64	1.06	.0005
Positive professional strategies	1.95	1.22	2.23	1.12	1.84	1.24	.0076

a. Means and standard deviations; a higher score indicates greater endorsement of coping strategies.

b. i.e., use substances, pornography.

c. i.e., exercise, seek support.

Analyses for Clinician Subgroups

The total sample was split according to client population served (i.e., survivors, offenders) and the SMR models were reanalyzed without the group covariate but in the same sequential process (see Tables 4-7). This split will result in a loss of statistical power; however, it is expected that greater homogeneity will ultimately be more interpretable.

Avoidance in clinicians who treat survivors. Table 4 reveals that 1% of the observed variability in avoidance trauma effects was explained by demographic characteristics (clinicians' age, gender, maltreatment history, and length of time providing sexual abuse treatment). In the second and third steps, the addition of negative and positive personal coping strategies respectively did not increase the explained variance. In the fourth step, the addition of positive professional coping strategies increased the explained variance to 3.5%. In this model, no variables contributed significantly to the variance in avoidance trauma effects.

This study hypothesized a sequential benefit of demographic, maltreatment history, and coping strategy variables toward explaining vicarious trauma. The direct examination of these hypotheses is presented in Table 4. The addition of subsequent steps in the model resulted in a statistically nonsignificant improvement in the R^2 .

Intrusions in clinicians who treat survivors. Table 5 reveals that 8% of the observed variability in intrusions trauma in clinicians who work with survivors was explained by demographic variables and maltreatment history. In the second step, the addition of negative personal coping strategies increased

TABLE 4: Multiple Regression Analyses for Variables Predicting Avoidance in Clinicians Who Treat Survivors (N = 95)

Variable	B	SE B	β	p	R ²	ΔR^2	p
Step 1					.0109		
Age	.02	.06	.000001	.6826			
Gender ^a	-.91	1.47	.004	.5347			
Any maltreatment ^b	-.59	1.07	.003	.5795			
Tenure providing treatment ^c	-.21	.34	.004	.5407			
Step 2					.0132	.0023	ns
Age	.02	.06	.000001	.7716			
Gender ^a	-.72	1.54	.004	.6418			
Any maltreatment ^b	-.54	.08	.003	.6175			
Tenure providing treatment ^c	-.19	.34	.004	.5817			
Negative personal strategies	-.52	1.15	.002	.6503			
Step 3					.0132	.0000	ns
Age	.02	.06	.000001	.7733			
Gender ^a	-.72	1.56	.004	.6438			
Any maltreatment ^b	-.53	1.16	.003	.6489			
Tenure providing treatment ^c	-.19	.35	.004	.5835			
Negative personal strategies	-.52	.17	.002	.6597			
Positive personal strategies	-.01	.49	.000008	.9791			
Step 4					.0348	.0216	ns
Age	.01	.06	.000001	.8477			
Gender ^a	-.10	1.61	.004	.9526			
Any maltreatment ^b	-.56	1.15	.003	.6290			
Tenure providing treatment ^c	-.11	.35	.004	.7542			
Negative personal strategies	-.60	1.17	.002	.6112			
Positive personal strategies	-.05	.49	.000008	.9171			
Positive professional strategies	.60	.43	.02	.1670			

a. Male = 1, female = 0.

b. Yes = 1, no = 0.

c. Sexual abuse treatment.

the explained variance to 8.5%. In the third step, the addition of positive personal coping strategies did not increase the explained variance. In the fourth step, the addition of positive professional coping strategies increased the explained variance to 10%.

In the first step in the model, length of time providing sexual abuse treatment contributed significantly to the model ($p = .0102$). This variable also made a significant contribution to the model in the second ($p = .0096$), third ($p = .0107$), and fourth steps ($p = .0191$).

This study hypothesized a sequential benefit of demographic, maltreatment history, and coping strategy variables toward explaining vicarious trauma. The direct examination of these hypotheses is presented in Table 5.

TABLE 5: Multiple Regression Analyses for Variables Predicting Intrusions in Clinicians Who Treat Survivors (N = 95)

Variable	B	SE B	β	p	R ²	ΔR^2	p
Step 1					.0833		
Age	.07	.06	.0004	.1890			
Gender ^a	1.07	1.36	.007	.4331			
Any maltreatment ^b	-.91	.99	.006	.3568			
Tenure providing treatment ^c	-.83	.32	.07	.0102			
Step 2					.0852	.0019	ns
Age	.08	.06	.0004	.1708			
Gender ^a	.90	1.42	.007	.5293			
Any maltreatment ^b	-.96	1.00	.006	.3383			
Tenure providing treatment ^c	.84	.32	.07	.0096			
Negative personal strategies	.45	1.06	.002	.6812			
Step 3					.0860	.0008	ns
Age	.08	.06	.0004	.1717			
Gender ^a	.95	1.44	.007	.5121			
Any maltreatment ^b	-1.07	1.07	.006	.3206			
Tenure providing treatment ^c	.84	.32	.07	.0107			
Negative personal strategies	.40	1.08	.002	.7122			
Positive personal strategies	.13	.45	.001	.7717			
Step 4					.0992	.0132	ns
Age	.07	.06	.0004	.1977			
Gender ^a	1.42	1.50	.007	.3460			
Any maltreatment ^b	-1.09	1.07	.006	.3101			
Tenure providing treatment ^c	.78	.33	.07	.0191			
Negative personal strategies	.34	1.08	.002	.7525			
Positive personal strategies	.10	.45	.001	.8202			
Positive professional strategies	.45	.40	.01	.2623			

a. Male = 1, female = 0.

b. Yes = 1, no = 0.

c. Sexual abuse treatment.

The addition of subsequent steps in the model resulted in a statistically nonsignificant improvement in the R^2 .

Avoidance in clinicians who treat offenders. Table 6 reveals that 2.7% of the observed variability in avoidance trauma was explained by clinicians' age, gender, maltreatment history, and length of time providing sexual abuse treatment. In the second step, the addition of negative personal coping strategies increased the explained variance in avoidance trauma to 9%. In the third step, the addition of positive personal coping strategies increased the explained variance to 18%. In the fourth step, the addition of positive professional coping strategies did not increase the explained variance.

TABLE 6: Multiple Regression Analyses for Variables Predicting Avoidance in Clinicians Who Treat Offenders (N = 252)

Variable	B	SE B	β^2	p	R ²	ΔR^2	p
Step 1					.0266		
Age	-.08	.03	.02	.0255			
Gender ^a	.77	.60	.007	.2026			
Any maltreatment ^b	.44	.68	.002	.5155			
Tenure providing treatment ^c	.12	.25	.001	.6272			
Step 2					.0901	.0635	.01
Age	-.06	.03	.02	.0935			
Gender ^a	.43	.59	.007	.4670			
Any maltreatment ^b	.47	.66	.002	.4801			
Tenure providing treatment ^c	.11	.24	.001	.6434			
Negative personal strategies	2.36	.57	.07	< .0001			
Step 3					.1777	.0876	.01
Age	-.04	.03	.02	.1828			
Gender ^a	.55	.56	.007	.3261			
Any maltreatment ^b	-.47	.63	.002	.4550			
Tenure providing treatment ^c	.04	.23	.001	.8455			
Negative personal strategies	2.35	.54	.07	< .0001			
Positive personal strategies	1.31	.26	.10	< .0001			
Step 4					.1787	.001	ns
Age	-.05	.03	.02	.1668			
Gender ^a	.47	.58	.007	.4247			
Any maltreatment ^b	-.45	.63	.002	.4746			
Tenure providing treatment ^c	.04	.23	.001	.8632			
Negative personal strategies	2.38	.55	.07	< .0001			
Positive personal strategies	.35	.27	.10	< .0001			
Positive professional strategies	-.13	.24	.001	.5921			

a. Male = 1, female = 0.

b. Yes = 1, no = 0.

c. Sexual abuse treatment.

In the first step in the model, respondent age contributed significantly to the model ($p = .0255$). This variable moved out of significance in subsequent steps. Negative personal coping strategies made a significant contribution to the model in the second, third, and fourth steps ($p < .0001$), whereas positive personal coping strategies made a significant contribution to the model in the third and fourth steps ($p < .0001$).

This study hypothesized a sequential benefit of demographic, maltreatment history, and coping strategy variables toward explaining vicarious trauma. The direct examination of these hypotheses is presented in Table 6. The addition of variables in steps 2 and 3 represented a statistically significant improvement in the R^2 .

TABLE 7: Multiple Regression Analyses for Variables Predicting Intrusions in Clinicians Who Treat Offenders (N = 252)

Variable	B	SE B	β^2	p	R ²	ΔR^2	p
Step 1					.0334		
Age	-.07	.03	.02	.0264			
Gender ^a	.76	.57	.007	.1886			
Any maltreatment ^b	.72	.65	.005	.2716			
Tenure providing treatment ^c	-.01	.24	.00002	.9497			
Step 2					.0517	.0183	.05
Age	-.06	.03	.02	.0581			
Gender ^a	.58	.57	.007	.3218			
Any maltreatment ^b	.70	.65	.005	.2761			
Tenure providing treatment ^c	-.02	.23	.00002	.9332			
Negative personal strategies	1.22	.56	.02	.0300			
Step 3					.1255	.0738	.01
Age	-.05	.03	.02	.1123			
Gender ^a	.69	.55	.007	.2140			
Any maltreatment ^b	.70	.62	.005	.2599			
Tenure providing treatment ^c	-.08	.22	.00002	.7298			
Negative personal strategies	1.21	.54	.02	.0252			
Positive personal strategies	1.16	.25	.08	< .0001			
Step 4					.1267	.0012	ns
Age	-.05	.03	.02	.1313			
Gender ^a	.78	.58	.007	.1764			
Any maltreatment ^b	-.68	.62	.005	.2753			
Tenure providing treatment ^c	.07	.23	.00002	.7485			
Negative personal strategies	1.19	.54	.02	.0292			
Positive personal strategies	.12	.26	.08	< .0001			
Positive professional strategies	.14	.24	.001	.5605			

a. Male = 1, female = 0.

b. Yes = 1, no = 0.

c. Sexual abuse treatment.

Intrusions in clinicians who treat offenders. Table 7 reveals that 3% of the observed variability in avoidance trauma effects was explained by clinicians' age, gender, maltreatment history, and length of time providing sexual abuse treatment. In the second step, the addition of negative personal coping strategies increased the explained variance to 5%. In the third step, the addition of positive personal coping strategies increased the explained variance to 13%. In the fourth step, the addition of positive professional coping strategies did not increase the explained variance.

In the first step in the model, respondent age contributed significantly to the model ($p = .0264$). This variable moved out of significance in subsequent steps. Negative personal coping strategies made significant contributions to

the model in the second ($p = .0300$), third ($p = .0252$), and fourth steps ($p = .0292$). Positive personal coping strategies made a significant contribution to the model in the third step ($p < .0001$).

This study hypothesized a sequential benefit of demographic, maltreatment history, and coping strategy variables toward explaining vicarious trauma. The direct examination of these hypotheses is presented in Table 7. The addition of variables in steps 2 and 3 represented a statistically significant improvement in the R^2 .

In summary, the models analyzed in this study appear to have more explanatory power for clinicians who treat offenders than for those who work with survivors. It may be that there are other, unmeasured variables that may better account for the variance in models predicting vicarious trauma for clinicians who treat survivors.

DISCUSSION

This study used a large random sample of male and female therapists who are members of two professional organizations. This is the first study to compare levels of vicarious trauma in clinicians who treat survivors and those who treat sexual offenders. The study also examined variables associated with vicarious trauma and personal and professional coping strategies.

The clinician groups were similar in age, maltreatment history, and length of time providing treatment. Although females in this study reported a higher rate of prior sexual abuse history, there was no difference in sexual abuse history between clinician groups, even when controlling for gender. Clinicians treating survivors were found to use more positive personal and professional strategies. Because these analyses did not control for work setting, it is not known to what extent work setting influenced use of coping strategies. Clinicians who treat offenders were more likely to be male, have a bachelor's degree or less, and practice in a residential or prison-based program.

The first hypothesis was supported. The level of vicarious trauma for the majority of the sample fell within the clinical range. This was consistent with previous studies (Kassam-Adams, 1999; Ghahramanlou & Brodbeck, 2000).

The second hypothesis was not supported. In this study, shorter length of time providing sexual abuse treatment was a predictor of greater intrusions trauma for those treating survivors. It may be that clinicians most affected by vicarious trauma left the field prematurely and therefore were not represented in this study. Length of time providing treatment has been reported by others to be significantly correlated with vicarious trauma (Brady et al.,

1999; Chrestman, 1999; Pearlman & Mac Ian, 1995; Rich, 1997; Steed & Bicknell, 2001).

Although therapists may be particularly susceptible to vicarious trauma based on their individual characteristics (Pearlman & Mac Ian, 1995), bivariate analyses found that maltreatment history in and of itself was not significantly associated with vicarious trauma in this study. This is consistent with Schauben and Frazier (1995) and in contrast to other studies (Follette et al., 1994; Ghahramanlou & Brodbeck, 2000; Kassam-Adams, 1999; Pearlman & Mac Ian, 1995). This cross-sectional study does not allow us to determine whether clinicians with greater maltreatment histories have left the field. It may also be that other, unmeasured characteristics more effectively predict vicarious trauma (e.g., level of empathy, personality style).

The third hypothesis was not supported. Greater trauma effects were positively associated with greater use of positive personal strategies. Because the study is cross-sectional, it is impossible to know whether greater trauma effects preceded or succeeded use of individual coping strategies. It is possible that clinicians with greater vicarious trauma also engaged in more coping strategies in an effort to counter the effects of their work. Greater use of professional supports was not associated with lower trauma effects. It may be that crucial variables were not measured in this study.

The fourth hypothesis was supported. Greater trauma effects were positively associated with greater use of negative personal strategies. Again, this study's cross-sectional methodology does not allow a test of cause and effect.

The fifth hypothesis was supported. Clinician groups did not differ in levels of vicarious trauma symptoms. The similarity between groups is consistent with Brady et al. (1999), who found that clinicians working with adult and child survivors did not differ in their vicarious trauma. This is not to suggest that there is no relationship between vicarious trauma and client population. It is possible that the clinician groups in this study were too similar. That is, the traumatic material that the clinician groups were exposed to over time may have been too similar in content or may have shared overlapping features. For example, sexual offenders may also share details of their experience of sexual abuse victimization as a child.

Implications for Practice

In this study, clinicians with shorter time providing sexual abuse treatment reported higher levels of vicarious trauma. It may be that those who are new to the field require more specialized training on the potential risks of doing trauma work and self-care. This may be an initial step toward increasing self-

awareness, early recognition, and amelioration of vicarious trauma (Freeman-Longo, 1997). Such education should emphasize that vicarious trauma is a normal response to working with traumatized people and is not a result of deficiencies in clinicians (Pearlman, 1999; Pearlman & Mac Ian, 1995; Pearlman & Saakvitne, 1995). Ongoing staff training should also include information on vicarious trauma and self-care strategies. It is recommended that organizations institutionalize case consultation (Catherall, 1999; Fontes, 1995), sharing difficult cases, ongoing professional education, and personal days.

Study Limitations

The findings in this cross-sectional study are based on retrospective self-report. Therefore, the results may be influenced by response biases such as minimization, lack of self-awareness, or inaccuracy in memory. The response rate was low (33%). Several factors may have contributed to this. The surveys were mailed during the holiday season, there was no explicit request made to return the survey if the respondent did not meet the study criteria, and the survey was not remailed. It may also be that individual factors played a role. For example, some respondents may have self-selected out of the study based on the sensitive nature of the survey, the length of the survey, or because of personal/professional circumstances. Although early and late responders did not differ on critical study variables, it cannot be determined whether and how responders differed from nonresponders. The study sample lacked heterogeneity in ethnicity and there was no comparison group of therapists who provide no sexual abuse treatment. The study used the IES as a single measure of vicarious trauma effects, without a second measure. The study did not measure the amount of exposure to clients with sexual abuse issues and did not measure the contribution of burnout or other occupational stress. This study measured coping strategies with questions developed for the survey. The decision was made not to use a standardized coping measure to target specific coping strategies of interest. Because this study is cross-sectional, it is not possible to determine whether the use of coping strategies preceded or succeeded development of avoidance trauma.

Implications for Research

Future research should include prospective studies that help understand the temporal relationship between coping strategies and trauma effects. More research is needed on specific coping strategies that may help reduce vicarious trauma. Little is known about the role of professional strategies in reduc-

ing vicarious trauma effects. It may be that professional supports are not available in particular settings, or are made available but perceived lack of confidentiality serves as a barrier to making use of these strategies. Qualitative data could help determine what aspects of doing trauma work are most distressing to clinicians (e.g., client factors, organizational factors, or larger system factors). Spouses, partners, or significant others should be interviewed to provide collateral data. Future research could also focus on the contribution of possible moderating variables such as clinician empathy.

This study, similar to previous studies, is cross-sectional, making it impossible to determine cause and effect relationships. Additional research with improved methodologies, including prospective studies, is needed to isolate variables that may affect development and amelioration of vicarious trauma.

It is recommended that future research explore the relative contribution of client population to vicarious trauma, for example, sexual offenders only versus sexual abuse survivors only, versus nontraumatized clients. Amount of exposure to traumatized clients should also be measured because it has been found to be associated with vicarious trauma (Brady et al., 1999; Chrestman, 1999; Kassam-Adams, 1999; Schauben & Frazier, 1995). Another variable that should be explored is the contribution of treatment modality (e.g., group, individual, cotherapy). Last, a critical area for further research is with resilient clinicians who repeatedly hear traumatic stories and continue to do quality work with the goal of making a difference in their clients' lives.

REFERENCES

- Bengis, S. M. (1997). Personal and interpersonal issues for staff working with sexually abusive youth. In S. B. Edmunds (Ed.), *Impact: Working with sexual abusers* (pp. 31-50). Brandon, VT: Safer Society Press.
- Bernstein, D. P., & Fink, L. (1998). *Childhood Trauma Questionnaire: A retrospective self-report*. San Antonio, TX: The Psychological Corporation.
- Brady, J. L., Guy, J. D., Poelstra, P. L., & Browkaw, B. (1999). Vicarious traumatization, spirituality, and the treatment of sexual abuse survivors: A national survey of women psychotherapists. *Professional Psychology: Research and Practice*, 30(4), 386-393.
- Catherall, D. R. (1999). Coping with secondary traumatic stress: The importance of the therapist's professional peer group. In B. H. Stamm (Ed.), *Secondary traumatic stress: Self-care issues for clinicians, researchers and educators* (pp. 80-92). Lutherville, MD: Sidran Press.
- Chrestman, K. R. (1999). Secondary exposure to trauma and self reported distress among therapists. In B. H. Stamm (Ed.), *Secondary traumatic stress: Self care issues for clinicians, researchers and educators* (2nd ed., pp. 37-47). Lutherville, MD: Sidran Press.
- Edmunds, S. B. (1997). The personal impact of working with sex offenders. In S. B. Edmunds (Ed.), *Impact: Working with sexual abusers* (pp. 11-29). Brandon, VT: Safer Society Press.

- Ellerby, L. (1997). Impact on clinicians: Stressors and providers of sex-offender treatment. In S. B. Edmunds (Ed.), *Impact: Working with sexual abusers* (pp. 51-60). Brandon, VT: Safer Society Press.
- Farrenkopf, T. (1992). What happens to therapists who work with sex offenders? *Journal of Offender Rehabilitation, 18*(3/4), 217-223.
- Figley, C. R. (1995). Compassion fatigue as secondary traumatic stress disorder: An overview. In *Coping with secondary traumatic stress disorders in those who treat the traumatized* (pp. 1-20). New York: Brunner/Mazel Publishers.
- Figley, C. R. (1999). Compassion fatigue: Toward a new understanding of the cost of caring. In B. H. Stamm (Ed.), *Secondary traumatic stress: Self care issues for clinicians, researchers and educators* (2nd ed., pp. 3-28). Lutherville, MD: Sidran Press.
- Follette, V. M., Polusny, M. M., & Milbeck, K. (1994). Mental health and law enforcement professionals: Trauma history, psychological symptoms, and impact of providing services to child sexual abuse survivors. *Professional Psychology: Research and Practice, 25*(3), 275-282.
- Fontes, L. A. (1995). Sharevision: Collaborative supervision and self-care strategies for working with trauma. *The Family Journal: Counseling and Therapy for Couples and Families, 3*, 249-254.
- Freeman-Longo, R. E. (1997). Introduction: A personal and professional perspective on burnout. In S. B. Edmunds (Ed.), *Impact: Working with sexual abusers* (pp. 51-60). Brandon, VT: Safer Society Press.
- Ghahramanlou, M., & Brodbeck, C. (2000). Predictors of secondary trauma in sexual assault trauma counselors. *International Journal of Emergency Mental Health, 2*(4), 229-240.
- Horowitz, M., Wilner, N., & Alvarez, W. (1979). Impact of Event Scale: A measure of subjective stress. *Psychosomatic Medicine, 41*, 209-218.
- Iliffe, G., & Steed, L. G. (2000). Exploring the counselor's experience of working with perpetrators and survivors of domestic violence. *Journal of Interpersonal Violence, 15*, 393-412.
- Jackson, K. E., Holzman, C., & Barnard, B. (1997). Working with sex offenders: The impact on practitioners. In S. B. Edmunds (Ed.), *Impact: Working with sexual abusers* (pp. 51-60). Brandon, VT: Safer Society Press.
- Kassam-Adams, N. (1999). The risks of treating sexual trauma: Stress and secondary trauma in psychotherapists. In B. H. Stamm (Ed.), *Secondary traumatic stress: Self care issues for clinicians, researchers and educators* (2nd ed., pp. 37-47). Lutherville, MD: Sidran Press.
- Kearns, B. (1995). Self-reflection in work with sex offenders: A process not just for therapists. *Journal of Child Sexual Abuse, 4*, 107-110.
- Lyon, E. (1993). Hospital staff reactions to accounts by survivors of childhood abuse. *American Journal of Orthopsychiatry, 63*, 410-416.
- 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.
- Mitchell, C., & Melikian, K. (1995). The treatment of male sexual offenders: Countertransference reactions. *Journal of Child Sexual Abuse, 4*, 87-93.
- Neumann, D. A., & Gamble, S. J. (1995). Issues in the professional development of psychotherapists: Countertransference and vicarious traumatization in the new trauma therapist. *Psychotherapy, 32*, 341-347.
- Pearlman, L. A. (1999). Self-care for trauma therapists: Ameliorating vicarious traumatization. In B. H. Stamm (Ed.), *Secondary traumatic stress: Self care issues for clinicians, researchers and educators* (2nd ed., pp. 51-64). Lutherville, MD: Sidran Press.

- 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, 558-565.
- Pearlman, L. A., & Saakvitne, K. W. (1995). *Trauma and the therapist: Countertransference and vicarious traumatization in psychotherapy with incest survivors*. New York: W. W. Norton.
- Rich, K. D. (1997). Vicarious traumatization: A preliminary study. In S. B. Edmunds (Ed.), *Impact: Working with sexual abusers* (pp. 75-88). Brandon, VT: Safer Society Press.
- Roundy, L. M., & Horton, A. L. (1990). Professional and treatment issues for clinicians who intervene with incest perpetrators. In A. L. Horton, B. L. Johnson, L. M. Roundy, & D. Williams (Eds.), *The incest perpetrator: A family member no one wants to treat* (pp. 165-187). Thousand Oaks, CA: Sage.
- The SAS System for Windows (Version 8.02) [Computer software]. (1999-2001). Cary, NC: The SAS Institute.
- Schauben, L. J., & Frazier, P. A. (1995). The effects on female counselors of working with sexual violence survivors. *Psychology of Women Quarterly*, 19, 49-64.
- Sexton, L. (1999). Vicarious traumatization of counselors and effects on their workplaces. *British Journal of Guidance & Counselling*, 27, 393-403.
- Shelby, R. A., Stoddart, R. M., & Taylor, K. L. (2001). Factors contributing to levels of burnout among sex offender treatment providers. *Journal of Interpersonal Violence*, 16, 1205-1217.
- Steed, L., & Bicknell, J. (2001). Trauma and the therapist: The experience of therapists working with the perpetrators of sexual abuse. *Australasian Journal of Disaster and Trauma Studies* [Online]. Available: <http://www.massey.ac.nz/%7Etrauma/issues/2001-1/steed.htm>
- Steed, L. G., & Downing, R. (1998). A phenomenological study of vicarious traumatization amongst psychologists and professional counsellors working in the field of sexual abuse/assault. *Australasian Journal of Disaster and Trauma Studies* [Online]. Available: <http://www.massey.ac.nz/%7Etrauma/issues/1998-2/steed.htm>
- Wilson, J. P., & Lindy, J. D. (1994). Empathic strain and countertransference. In J. P. Wilson & J. D. Lindy (Eds.), *Countertransference in the treatment of PTSD* (pp. 5-30). New York: Guilford Press.

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