Vicarious traumatisation in practitioners who work with adult survivors of sexual violence and child sexual abuse: Literature review and directions for future research

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Abstract

Primary objective: The authors sought to summarise and evaluate evidence regarding vicarious traumatisation (VT) in practitioners working with adult survivors of sexual violence and/or child sexual abuse (CSA). Methods and selection criteria: Relevant publications were identified from systematic literature searches of PubMed and PsycINFO. Studies were selected for inclusion if they examined vicarious traumatisation resulting from sexual violence and/or CSA work and were published in English between January 1990 and June 2008. Critical analysis and results: Ten studies met the criteria of the present review. In summary, VT levels in the field of sexual violence/CSA are high with negative effects, but do not appear to exceed those reported by professionals working with non-sexual violence or with sexual offenders. Further investigation is needed into predisposing and mediating factors before clear conclusions can be drawn. Conclusions: Previous research has suffered a number of methodological limitations regarding definitions, sampling, comparison groups, support arrangements and measurement. These factors compromise not only the rigour and generalisability of findings but also our ability to define VT as a useful concept. These limitations are discussed and recommendations made for a future research agenda.

Keywords: Child sexual abuse, review, secondary trauma, sexual violence, vicarious traumatisation/trauma

Introduction

The term ‘vicarious traumatisation’ (VT) was introduced by McCann and Pearlman (1990) to describe how psychotherapeutic work with trauma victims can cause distress to practitioners. VT can be conceptualised as a normal reaction arising from hearing traumatic material while in a caring role. However, it has been proposed to have consequences for health workers (Pearlman & Saakvitne, 1995), similar to those experienced by Post-traumatic Stress Disorder (PTSD) sufferers themselves (Blair & Ramones, 1996). In fact, according to the DSM-IV criteria for PTSD, becoming aware of traumatic events experienced by someone close could lead to the development of PTSD symptomatology (American Psychiatric Association [APA], 1994).

In previous literature the term VT has sometimes been used interchangeably with other terminology, including ‘secondary traumatic stress’ and ‘burnout’ (Sabin-Farrell & Turpin, 2003). These distinct terms reflect the three main definitions of VT currently available: (i) ‘Secondary Traumatic Stress’ (Figley, 1995) (formerly called ‘compassion fatigue’) refers to Post-Traumatic Stress Disorder symptoms which are a direct consequence of the practitioner’s engagement with traumatised clients rather than a result of their own traumas. (ii) ‘Vicarious Trauma’ (McCann & Pearlman, 1990) refers to negative changes in therapists’ cognitive schemas regarding trust, safety, power, independence, esteem and intimacy resulting from contact with traumatised clients, and (iii) ‘Burnout’ is a more general term referring to the emotional exhaustion, disconnection and ineffectiveness caused by complex and emotionally demanding work (Bride et al., 2004; Jenkins & Baird, 2002; Kadambi & Ennis, 2004).

A number of theoretical explanations have been offered as to why psychotherapists might develop vicarious trauma following exposure to their clients’ traumatic narratives. Cognitive theories, for example, have suggested that key beliefs and assumptions about one’s self and the world could change as a result of exposure to clients’ traumas (Janoff-Bulman, 1985). McCann and Pearlman (1990) proposed that therapists who work with trauma clients are exposed to narratives about abuse of trust, powerlessness and lack of safety – experiences encountered at the time of primary traumatisation. VT may occur if these are
assimilated and incorporated into the therapists' personal schemas. Pearlman and Saakvitne (1995) later described vicarious trauma as a process which occurred 'through empathic engagement with clients’ trauma material' (p. 279).

While the concept of vicarious traumatisation appears to have been enthusiastically embraced by practitioners, the empirical research remains fragmented and inconsistent and does not yet represent a coherent body of work (Anway, 2001; Kadambi & Ennis, 2004; Sabin-Farrell & Turpin, 2003). There remains a scarcity of empirical research to endorse the validity of the concept (Dunkley & Whelan, 2006; Kadambi & Ennis, 2004; Sabin-Farrell & Turpin, 2003). Given the above, the aims of the present review are firstly to summarise and evaluate the available evidence base for vicarious trauma in practitioners who work with survivors of sexual violence and child sexual abuse (CSA) and secondly to propose a future research agenda for this area. We believe that such a review is timely considering the high prevalence of CSA history in both females (20%) and males (5–10%) in the general population (World Health Organisation [WHO], 2002) and the large number of professionals who engage with survivors of CSA and sexual violence.

Methods

The method followed the guidelines for systematic reviews by Droogan and Cullum (1998), adjusted to the purpose and scope of the present review paper. We have successfully followed these guidelines in previous reviews of the evidence in a number of areas, including cancer (Chouliara et al., 2004) and psychological trauma (Karatzias et al., 2007).

Studies of quantitative, qualitative and combined methodology were included if they fulfilled the following criteria:

- They were published in peer-reviewed journals after 1990.
- They were published in English.
- They examined vicarious trauma in relation to working with adult survivors of sexual violence and/or CSA, as stated in the title or abstract of the paper.

Studies were identified using a systematic search of electronic databases, including PubMed and PsycINFO (from 1990 to 2008). CINAHL was excluded due to its high overlap with PubMed. Keywords included: ‘vicarious trauma’, ‘vicarious traumatisation’, ‘vicarious traumatization’ and ‘secondary traumatic stress’. Additional search terms were: ‘sexual violence’, ‘sexual abuse’, ‘CSA’, ‘sexual assault’, ‘rape’ and ‘survivors’. Each key word was searched in combination with each of the additional search terms. Six further studies with a focus on survivors of sexual trauma/CSA were identified via a recent generic review on VT (Sabin-Farrell & Turpin, 2003). A total of 183 articles were initially retrieved. From these, 20 were initially selected because they were relevant to at least one combination between key words and additional search terms. Finally, 10 out of 20 were reviewed. Of those not reviewed, eight were unpublished dissertations and two were not primary data studies but personal narratives of the authors’ clinical experience. It was the original intention of the authors to include both primary research studies and any relevant reviews of the literature. However, no reviews or overviews were found. All papers included were therefore published primary research of varied design and methodology. Basic characteristics of the studies included are presented in Table I.

The retrieved studies were categorised by methodology and design, and the methodological strengths and limitations were identified based on previously established criteria for evaluating quantitative (Stroup et al., 2000) and qualitative (Mays & Pope, 2000) research. Seven of the ten reviewed studies employed a quantitative design (see Table I), two quantitative (Benatar, 2000; Steed & Downing, 1998) and one mixed quantitative-qualitative (Schauben & Frazier, 1995). Of the qualitative studies, one utilised a semi-structured interview for data collection (Steed & Downing, 1998) and the other an unstructured interview (Benatar, 2000). All quantitative studies were postal surveys and the majority utilised standardised scales in combination with self-devised questionnaires (mainly for demographics and work-related information), except Baird and Jenkins (2003) and Brady et al. (1999), who used standardised measures alone, and Knight (1997), who used a self-devised measure alone. The mixed methodology study (Schauben & Frazier, 1995) used standardised measures along with open-ended questions, which asked therapists to write about positive and negative aspects of working with survivors.

Results

A synthesis of findings from the reviewed studies is presented below.

The impact of VT on professionals working with survivors of sexual violence/CSA

There was a consensus in the reviewed studies about the negative effects of sexual violence/CSA work on a range of professionals. All studies reported some degree of psychological disruption, which in some cases exceeded the normal (expected) range for professionals (VanDeusen & Way, 2006; Way et al., 2004). A number of studies found high levels of PTSD symptomatology (Way et al., 2004), self-reported VT (Johnson & Hunter, 1997; Knight, 1997) and high levels of belief disruption (Schauben & Frazier, 1995; VanDeusen & Way, 2006). PTSD symptoms included avoidance and intrusion (Way et al., 2004), while disrupted beliefs included trust and intimacy (Johnson & Hunter, 1997; VanDeusen & Way, 2006), sense of
<p>| Authors/Country       | Design               | Variables                                                                                                                                                                                                 | Measures                                                                                      | Sample size (N) | Participants                                                                                                                                  | Findings                                                                                                                                                                                                 | Strengths                                                                                                                                                                                                 | Limitations                                                                                                                                                                                                 |
|----------------------|----------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|-----------------|-----------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. Schauben &amp; Frazier | Mixed quantitative &amp; qualitative | Couns. victimisation history and work experience, cognitive schemas, PTSD, negative affect, coping, post-traumatic stress, burnout, positive and negative experiences | TSI Belief Scale, BSI, MBI, PTSD checklist self-devised, COPE, open-ended questions          | 148 (42% response rate) | Female psychologists and counsellors working with sexual violence survivors (81.30% psychs and 70.39% couns. victimised under 18) | Percentage of survivors in caseload correlated positively with PTSD, Self-reported VT, and belief disruption | Mixed methodology, Personal history, client group CSA percentage | Small sample size, no power calculations reported, gender-biased sample, lack of standardised VT and PTSD measures, lack of sexual violence definition |
| 2. Johnson &amp; Hunter  | Quantitative         | Burnout, coping, beliefs and values (safety, trust, power, intimacy and esteem)                                                                 | 3MBI, WOC, self-devised beliefs and values                                                  | 41 and 32 in control group (37% and 42% response rates respectively) | Sexual violence counsellors from one service and counsellors from non sexual assault services | Higher scores on MBI Emotional Exhaustion subscale and escape-avoidance coping in sexual assault counsellors. Emotional exhaustion associated with power and intimacy beliefs. | Control group, sexual assault counsellors from one setting, | Small sample size, no data on couns. demographics and experience reported, no power calculations reported, no info on counsellor gender distribution, ill-described control group, lack of sexual assault definition, no data on types of assault included, VT measured by burnout scale, differences between groups in training, experience and working conditions |
| 3. Knight (1997)     | Quantitative         | Couns. Characteristics and history of sexual abuse, Affective reactions                                                                                                                                   | Self-devised questionnaire measuring personal reactions to clients (e.g. intimacy, mistrust, embarrassment) | 177 (46% response rate) | Mental health professionals working with survivors of CSA in statutory sector, agencies and private practice | Counsellors reported negative feelings, i.e. anger, sadness, horror and rescue fantasies. Reactions and CSA history not associated. Level of experience associated with stronger reactions | Focus on CSA, data on personal history and experiences, on info on counsellor gender distribution | Self-devised questionnaire – no info on psychometric properties, small sample size, no power calculations reported, no focus on VT |</p>
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<tr>
<th>Authors/Country</th>
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<td>4. Steed &amp; Downing (1998) (Australia)</td>
<td>Qualitative</td>
<td>VT experiences (experiences of traumatic material, cognitive schemata, coping strategies)</td>
<td>Semi-structured interview schedule, based on previous research</td>
<td>12 from various agencies</td>
<td>Female counsellors and psychologists working with sexual assault survivors</td>
<td>All therapists reported negative effects. Some positive effects were reported (e.g. in sense of identity, spirituality)</td>
<td>Focus on personal experience</td>
<td>Approach to data collection and analysis not explicitly stated, non homogeneous sample in experience and work variables, ill-defined sample, lack of info on therapist exposure to abuse, gender-biased sample, ill-defined client group</td>
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<td>5. Brady et al. (1999) (USA)</td>
<td>Quantitative</td>
<td>Basic demographics, work-related characteristics, involvement in personal therapy &amp; supervision, personal trauma history, VT, disruption in cognitive schemas, spirituality</td>
<td>4IES, 9TSI Belief Scale, Spiritual Well-Being Scale</td>
<td>446 (47% response rate)</td>
<td>female psychotherapists working with sexual abuse survivors</td>
<td>Higher levels of exposure associated with more VT symptoms, but not disruption of cognitive schemas. Higher exposure associated with higher spiritual well-being.</td>
<td>National random sampling, large sample, data on personal therapy, standardised scales, trauma-specific measure for VT (IES)</td>
<td>Gender-specific sample, No data on client group/no data on CSA rates, no info on allegiance</td>
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<td>6. Benatar (2000) (USA)</td>
<td>Qualitative</td>
<td>VT, positive self-transformation, therapist self-disclosure</td>
<td>Open-ended interview</td>
<td>12 (one group with and one group without CSA history)</td>
<td>Clinicians working with CSA survivor (psychologists and clinical social workers)</td>
<td>Key themes: world view, sense of safety, relationship to work, to self, and to others. No differences according to CSA history. Experienced therapists with CSA history no more vulnerable to VT than those without</td>
<td>In depth exploration, clear CSA focus data on supervision/personal therapy</td>
<td>Gender – bias, approach to data collection and analysis not explicitly stated, participants likely to have an interest in VT</td>
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<td>7. Baird &amp; Jenkins (2003) (USA)</td>
<td>Quantitative</td>
<td>Demographics and agency characteristics, secondary traumatisation/compassion fatigue, burnout, general psychological distress</td>
<td>2CFST, 9TSI Belief Scale (Revision L), 3MBI, 5SCL-90-R, questions on recent exposure to trauma clients</td>
<td>101 (35 sexual assault, 17 domestic violence counsellors)</td>
<td>Predominantly female sexual assault and domestic abuse counsellors (paid and volunteers)</td>
<td>No association between exposure to clients and STS, VT, burnout or general distress. Higher exposure associated with lower VT and belief disruption. Younger age and more trauma experience associated with emotional exhaustion</td>
<td>Measuring secondary traumatization along with burnout and general distress, use of VT specific measure</td>
<td>Small sample size—non exclusively focused on sexual assault counsellors, gender-biased, no power calculations reported, ill-defined client groups/no data on CSA rates.</td>
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<td>Way et al. (2004) (USA)</td>
<td>Quantitative</td>
<td>Demographics, work-related data, maltreatment history, response to traumatic event: intrusion and avoidance, self-reported childhood trauma/CSA, coping strategies</td>
<td>Self-devised questionnaire for demographics and coping, 1IES, 2CTQ</td>
<td>347 (95 with survivors, 252 with offenders (33% response rate))</td>
<td>Clinicians (60% female) from two prof. organisations working with sexual violence survivors and clinicians working with sex offenders</td>
<td>Levels of avoidance and intrusion in both groups were in clinical range. No significant differences between groups in IES scores. Greater VT levels associated with shorter length of time and use of positive coping strategies</td>
<td>Random sampling, trauma-specific measure for VT (IES)</td>
<td>Small sub-sample working with survivors, no power calculations, ill-defined client groups/no data on CSA rates, potential overlap (offenders can be survivors)</td>
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<td>Kadambi &amp; Truscott (2004) (Canada)</td>
<td>Quantitative</td>
<td>Demographics, work aspects, cognitive schemas disruption, reactions to stressful events, burnout</td>
<td>Self-devised Participant Questionnaire, TSI Revision M, 1IES, 1MBI</td>
<td>221 (sexual violence:86, cancer:64, GP:71) (35% overall response rate)</td>
<td>Predominantly female mental health professionals (84%) working with sexual violence, cancer and general practice</td>
<td>No significant differences between groups.</td>
<td>Random sampling, non-trauma comparison group, data on personal trauma history</td>
<td>Small sample size, gender-biases, high inter-correlations suggesting overlap, measuring VT by using burnout scale (MBI), ill-defined client groups/no data on CSA rates</td>
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<tr>
<td>VanDeusen &amp; Way (2006) (USA)</td>
<td>Quantitative</td>
<td>Demographics, work-related data, abuse history, coping strategies, trust and intimacy cognitions and childhood trauma/CSA</td>
<td>Self-devised questionnaire on coping, TABS, 2CTQ</td>
<td>383 (272 with survivors, 111 with offenders) (33% response rate)</td>
<td>Clinicians (61% female) working with sexual violence survivors and clinicians working with sex offenders</td>
<td>High rates of reported maltreatment. Belief disruption exceeded norms for health professionals. No association between history of CSA and VT. No differences between groups</td>
<td>Standardised measure for childhood trauma, male and female clinicians, larger sample size than other studies in the field</td>
<td>No measurement of traumatic symptomatology – just cognition, no power calculations, ill-defined client groups/no data on CSA rates, potential overlap (offenders can be survivors)</td>
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List of Table Abbreviations
1BSI = Brief Symptom Inventory
2CFST = Compassion Fatigue Self-Test for Psychotherapists
3CTQ = Childhood Trauma Questionnaire
4IES = Impact of Events Scale
5MBI = Maslach Burnout Inventory
6PTSD = Post-Traumatic Stress Disorder
7SCL-90-R = Symptom Checklist-90, Revisited
8TABS = Trauma Attachment Belief Scale
9TSI Belief Scale = Traumatic Stress Institute Belief Scale
10WOC = Ways of Coping Scale

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safety, worldview and relationship to work, to self and to others (Benatar, 2000). However, belief disruption, did not predict VT and was more strongly predicted by the clinician’s personal trauma history (VanDeusen & Way, 2006). The emotional effects on professionals included negative feelings (i.e. anger, sadness, horror) and rescue fantasies in relation to their work (Knight, 1997). Although Knight (1997) specifically measured reactions to client material, as opposed to responses to clinician’s own trauma, the study utilised a self-devised scale and did not report on the psychometric properties of this scale. High levels of burnout were reported in one paper (Johnson & Hunter, 1997), but this study did not control for work-related factors, which could contribute to burnout. A high proportion of professionals working with survivors of sexual violence/CSA reported that they had experienced maltreatment, victimisation, sexual violence and/or CSA themselves (Knight, 1997; Schauben & Frazier, 1995; VanDeusen & Way, 2006; Way et al., 2004). However not all reviewed studies collected data on personal history of sexual violence/CSA and only one study assessed this history using a standardised measure (i.e. Way et al., 2004: Childhood Trauma Questionnaire). Positive aspects of working with survivors (e.g. in sense of identity, sense of purpose and spirituality) were less often reported (Benatar, 2000; Steed & Downing, 1998), but this could be due to the wide use of standardised questionnaires and the subsequent lack of qualitative designs, which could explore clinicians’ experiences in more depth.

Comparison between professionals working with survivors of sexual violence/CSA and those who work with other client groups

A number of the studies included in this review provided comparisons between groups of professionals for measures of VT. Some of these studies compared professionals who work solely in the area of sexual violence/CSA with professionals working in a wide range of non-sexual assault services, such as generic mental health, marital counselling, adolescent, palliative care, drug/alcohol, disability or child and family services (Johnson & Hunter, 1997). Kadambi and Truscott (2004) compared sexual violence workers with two non-trauma groups: psycho-oncology and primary care professionals. Others compared a group of professionals who worked with survivors of sexual violence with a group who worked with sex offenders (VanDeusen & Way, 2006; Way et al., 2004). Most studies failed to find statistically significant differences between sexual violence/CSA professionals and any of the comparison groups in relation to VT and belief disruption, coping, or burnout (Kadambi & Truscott, 2004; VanDeusen & Way, 2006; Way et al., 2004). Only one study (Johnson & Hunter, 1997) reported higher levels of emotional exhaustion and of escape-avoidance coping in the sexual assault professionals, as opposed to the non-sexual assault group.

VT correlates in sexual violence/CSA work

The reviewed studies investigated a number of variables as potential factors in the development of VT. These included: demographics (e.g. Baird & Jenkins, 2003; Brady et al., 1999), level of exposure to sexual trauma work (e.g. Baird & Jenkins, 2003; Way et al., 2004), professional experience (Brady et al., 1999; Kadambi & Truscott, 2004; Knight, 1997; Schauben & Frazier, 1995; VanDeusen & Way, 2006; Way et al., 2004), personal history of sexual violence, CSA or trauma history (Knight, 1997; VanDeusen & Way, 2006; Way et al., 2004), disruption of cognitive schemata (Johnson & Hunter, 1997; Kadambi & Truscott, 2004; Steed & Downing, 1998) and general levels of distress and coping (e.g. Baird & Jenkins, 2003; Johnson & Hunter, 1997; Schauben & Frazier, 1995; VanDeusen & Way, 2006).

Demographics (e.g. age and gender) were not associated with VT in most studies, with one exception, Baird and Jenkins (2003), who found younger workers reporting greater emotional exhaustion. According to some studies, higher levels of VT were associated with increased exposure to sexual trauma work (Brady et al., 1999; Johnson & Hunter, 1997; Schauben & Frazier, 1995). However Baird and Jenkins (2003), in contrast, found that trauma counsellors working with higher numbers of clients reported lower VT and belief disruption, something which might be attributed to the ability of more experienced professionals to develop self-protective mechanisms. Increased levels of VT were associated with less professional experience whether general experience (Knight, 1997) or specific experience working with sexual trauma (Way et al., 2004). Way et al. (2004) found greater levels of VT were associated with shorter length of time working with survivors and with use of positive coping strategies. The former finding was proposed to be because professionals who cope better might tend to stay longer in the field and may be less affected by this type of work. The latter could be attributed to under-reporting of negative coping by participants, perhaps associated with social desirability effects. Because Way et al. (2004) did not control for work-related variables, the effect of work setting on coping mechanisms is not known. A worker’s personal history of sexual violence or CSA was not associated with higher symptomatology in any of the studies reviewed here (Knight, 1997; Schauben & Frazier, 1995; VanDeusen & Way, 2006; Way et al., 2004). According to Benatar (2000), for example, experienced therapists with a CSA history were no more vulnerable to VT than those without, suggesting the potential mediating role of professional experience between VT and a history trauma. However, VanDeusen and Way (2006) found that a history of maltreatment, although it did not predict VT symptomatology, did predict disrupted cognitions. Due to the lack of longitudinal studies in this review, it is unclear whether disruptions of certain schemas could act in a
cumulative manner over time as a predisposing factor to the development of future VT symptomatology.

**Methodological limitations of reviewed studies**

The quality of the information provided by the publications reviewed here is limited by the small number of studies, as well as by significant methodological weaknesses and confounding factors. These include:

**Small numbers of studies examining specific forms of sexual violence.** We originally intended this literature review to focus on studies of work with adult survivors of CSA but we were unable to identify enough primary data peer-reviewed for our purposes. Only two studies focused exclusively on practitioners working with CSA survivors (Benatar, 2000; Knight, 1997). Consequently we had to expand the scope and focus of the present review to include sexual violence against adults. These studies might or might not include CSA survivors amongst their client population. When CSA was included amongst other types of sexual abuse, CSA rates in client groups were rarely reported separately (Schauben & Frazier, 1995).

Most studies failed to provide a clear definition of CSA and/or sexual violence – only one study defined CSA as ‘sexual contact between a child and an individual in position of authority’ (Knight, 1997). In this study it was made explicit that CSA ‘encompasses the full range of sexual activities’ and not only penetrative sex. One other study provided an operational definition of sexual abuse which included ‘rape/attempted rape’, ‘incest/sexual abuse’, ‘sexual harassment’ and ‘other sexual assault’ (Schauben & Frazier, 1995).

**CSA Caseload.** Client groups with whom practitioners worked were ill-defined and poorly described (e.g. VanDeusen & Way, 2006; Way et al., 2004). A breakdown of type, duration and severity of sexual abuse was rarely provided, with a few exceptions (Knight, 1997). As a result the exact percentage of CSA survivors and CSA severity in participants’ caseload is unknown. This could be due to client confidentiality and ethical challenges in terms of obtaining client information.

**Definitions of VT.** There was no agreed operational definition of VT used across the studies. Some authors viewed VT as a separate and distinct concept (e.g. Steed & Downing, 1998), others as synonymous to secondary trauma (e.g. Baird & Jenkins, 2003) or burnout (e.g. Johnson & Hunter, 1997).

**Samples.** Samples of practitioners were diverse and/or poorly defined. They included a large range of practitioners of different backgrounds, training and experience, practicing in a variety of clinical settings. Detailed information was not always provided on participant demographics, personal history of sexual abuse/CSA and work characteristics (Johnson & Hunter, 1997; Steed & Downing, 1998; VanDeusen & Way, 2006; Way et al., 2004). Samples were often skewed or homogeneous, failing to account for the range of beliefs and experiences in practitioners. Most studies had predominantly or exclusively female samples (e.g. Baird & Jenkins, 2003; Schauben & Frazier, 1995), but this gender bias could be attributed to the gender proportions in the helping professions themselves.

**Sampling and response rates.** Sampling was often random (e.g. Kadambi & Truscott, 2004; Way et al., 2004) but sample sizes tended to be small (even for qualitative studies) and no power calculations were provided. Although total samples often appear large, they included only small sub-samples of sexual violence practitioners (e.g. VanDeusen & Way, 2006). Small samples were also due to response rates being generally rather low in the majority of studies. Response rates varied greatly across studies (33–50%) and across sub-samples within the same study (50–100%; Baird & Jenkins, 2003). Low response rates raise questions about selection bias and could be attributed to the high sensitivity of the topic, to the gate-keeping role of practice managers and to confidentiality issues (Way et al., 2004). Sensitivities around practitioner and client confidentiality could contribute to managers declining participation for their staff as well as reluctance of individual practitioners to take part in research on VT and CSA (Knight, 1997).

**Comparison groups.** Non-trauma or generic (non-sexual) trauma comparison groups were rarely utilised, and no robust theoretical rationale was provided for choice of comparison groups. Only one study provided a non-sexual violence control group (Johnson & Hunter, 1997). One study utilised non-trauma comparison groups, but these were not guaranteed to exclude sexual violence/CSA survivors (i.e. psycho-oncology and primary care; Kadambi & Truscott, 2004). A number of studies utilised samples of professionals working with sex offenders (VanDeusen & Way, 2006; Way et al., 2004), many of whom are survivors of CSA themselves (Simons et al., 2008).

**Measurement of VT and confounding factors**

Due to the differences in definitions of VT and the lack of a VT-specific measure, approaches to measurement varied across the studies reviewed. A few studies utilised standardised measures of post-traumatic symptomatology (i.e. PTSD checklist, Impact of Events Scale) as measures of VT (Kadambi & Truscott, 2004; Schauben & Frazier, 1995; Way et al., 2004). As a result these studies might have failed to distinguish between therapists’ responses to their clients’ traumatic material and their own personal traumas. Most studies (e.g. Baird & Jenkins, 2003) utilised measures of belief disruption (e.g. Trauma
Symptom Inventory), compassionate fatigue (e.g. Compassion Fatigue Self-Test) or burnout (e.g. Maslach Burnout Inventory). These were not validated for VT and CSA, and information on their psychometric performance was not provided. Some studies utilised self-devised questionnaires and again failed to provide information on psychometric properties (Knight, 1997). A high overlap has been suggested between VT and burnout in particular (Kadambi & Truscott, 2004), although other researchers have claimed divergent validity (Schauben & Frazier, 1995). Discriminant validity of the most commonly used scales will be required before conclusions can be drawn.

**Design**

All quantitative studies reviewed were cross-sectional postal surveys. The reliance on postal questionnaires could be explained by the sensitivity of the topic and an attempt to boost recruitment. There is a distinct dearth of qualitative studies exploring the experience of VT in practitioners working with survivors of sexual violence. The qualitative studies presented ill-defined samples and procedures. The theoretical approach to data collection and analysis was not explicitly stated in qualitative studies (Benatar, 2000; Steed & Downing, 1998).

**Supervision, training, personal therapy and allegiance**

It is worth noting that the majority of the studies (7 out of 10) were conducted in the USA, two in Australia and one in Canada (See Table I). There was distinct absence of UK-based studies. This is a significant point, as training and supervision requirements for professional practice vary greatly across countries, making findings hardly comparable and greatly inhibiting generalisability. The supervisory arrangements of practitioners and their use of personal therapy were rarely described in the reviewed studies. Only one provided data on both (Benatar, 2000) with one other examining engagement in personal therapy (Brady et al., 1999). None of the studies provided information on practitioners’ theoretical allegiance.

**Discussion – The construction of a future research agenda**

In summary, VT is a common experience amongst professionals working in the field of sexual violence and/or CSA, according to the studies reviewed. The effects of working with this population can be negative, with very few studies reporting positive effects (Brady et al., 1999; Steed & Downing, 1998). Although high levels of VT have been reported by most studies of professionals working with sexual abuse survivors, these are not significantly higher than those reported by professionals working with sex offenders or non-sexual violence cases (Kadambi & Truscott, 2004; Way et al., 2004). A number of factors of VT have been investigated (i.e. exposure, experience and personal trauma history). According to most of the reviewed studies, higher levels of VT were associated with higher levels of exposure and lower levels of experience in working with survivors of sexual violence. However, these findings are not conclusive due to the limited number of studies and significant methodological limitations.

Many issues remain unanswered. Our knowledge about predictors of VT, including predisposing, protective and mediating factors, is rather limited in relation to this specific line of work. There is also a limited understanding of the positive as well as negative psycho-emotional changes resulting from this work. A few studies have discovered some unexpected benefits reported by practitioners as a consequence of engaging with sexually traumatised clients (Benatar, 2000; Brady et al., 1999; Steed & Downing, 1998). An in-depth exploration of the experience of working with survivors of sexual violence/CSA is required, with a view to identifying a range of pathways and suggesting effective strategies for professional practice.

Previous research on VT in sexual violence workers clearly suffers from several methodological problems, including a lack of agreed operational definitions, poor response rates, inadequate control for confounding factors, and lack of comparison groups. To a certain extent these echo the limitations of generic research on VT (Kadambi & Ennis, 2004; Pearlman & Mac Ian, 1995; Sabin-Farrell & Turpin, 2003; Way et al., 2004). These methodological issues will need to be addressed if vicarious traumatisation/secondary traumatic stress is to be empirically verified as a useful and relevant theoretical concept for psychological practitioners who work with survivors of sexual violence and CSA.

Considering the findings of the present review, we suggest that future research in this field should address the following.

**Definitions**

We endorse the view by Pearlman and Mac Ian (1995), that future research should focus on the ‘development of clear operational definitions of constructs that can be used by all researchers’. This is particularly important in sexual abuse/CSA, where client material can be diverse and often vary in traumatic content.

**Populations**

Attention also needs to be paid to the practitioner population under investigation as previous research has included samples from psychologists (Schauben & Frazier, 1995), female psychotherapists (Brady et al., 1999) and social workers (Bride, 2007), with some practitioners in general practice and others in specific trauma settings, some in paid and others in voluntary
capacities. In the UK a wide range of professionals engage with survivors in a variety of settings in the statutory and the voluntary sector. Setting-related factors might contribute to VT levels and research on such factors has, so far, been limited. In addition, the relative contribution of client population has been suggested as an important issue (Way et al., 2004). Future research should describe in detail the client groups with whom these practitioners work, especially in relation to type, duration and severity of sexual violence.

Improved control for primary traumatisation

Control for primary traumatisation is imperative for future research (e.g. in therapists working in emergency settings). In addition, the relationship between general work stress, personal distress unrelated to work and distress or symptomatology directly related to work with traumatised clients, needs to be further investigated.

Supervision and consultative support

The importance of supervision for supporting practitioners working with survivors of CSA is emphasised in previous literature (Etherington, 2000). However, to date, the relative contribution of supervision, teamwork and consultative support to mediating VT in this professional group has not been investigated. Many of the reviewed studies have been carried out with practitioners based in the US, who do not have the same professional requirement to participate in ongoing supervision as do practitioners in the UK. The generalisability of much previous research to UK practitioners may be significantly impaired as a result (Dunkley & Whelan, 2006; Pearlman & Mac Ian, 1995). The impact of supervision, training, teamwork and consultative support needs to be investigated.

Investigate mediating factors for risk and resilience

A significant proportion of practitioners in previous studies have reported personal experiences of trauma, including sexual traumas and/or childhood sexual abuse (Brady et al., 1999; Jenkins & Baird, 2002; Schauben & Frazier, 1995; Way et al., 2004). However, only a few studies investigated the association between personal history of sexual violence and VT. Therefore, the relationship between personal trauma history and vicarious trauma has yet to be established by future research. Factors such as the nature, duration and severity of the trauma (Follette et al., 1994) as well as use of positive coping mechanisms (personal therapy, supervision etc) will need to be examined as potential mediators between the risk of vicarious traumatisation and personal history of trauma. Inexperienced practitioners (e.g. trainee therapists and those new to trauma counselling) may be at particular risk of developing traumatic symptoms (Way et al., 2004). As suggested by Way et al. (2004), longitudinal studies would help clarify whether such findings are due to period effects (i.e. decreased vicarious traumatisation as a result of increased therapeutic experience) or other factors, such as disturbed and traumatised practitioners withdrawing from the sexual trauma field. Previous research has inadvertently been skewed towards inexperienced practitioners, as seasoned professionals may not be as easy to recruit (Benatar, 2000).

Positive self-transformation of the therapist

While vicarious trauma refers specifically to the negative impact of engaging with traumatised clients (Steed & Downing 1998), ‘Positive Self-Transformation’ (PST) refers to positive growth as a consequence of professional contact with this population (Benatar, 2000). A few studies have reported unexpected benefits amongst trauma practitioners which require further investigation (Benatar 2000; Brady et al., 1999; IIiffe & Steed, 2000; Steed & Downing, 1998), including increased spiritual or existential well-being (Brady et al., 1999). These preliminary findings expand on the recent academic interest in post-traumatic growth following primary trauma (Calhoun & Tedeschi, 1999; Joseph & Linley, 2006; Linley & Joseph, 2004) and will require further attention if our understanding of the impact on the practitioner of trauma work, and sexual trauma work in particular, is to be adequately balanced.

The above considerations would increase rigour and ability to generalise in research on VT in professionals working with survivors of sexual abuse/CSA, resulting in a better understanding of such experiences. Such an understanding could have direct implications for evidence-based practice and for more effective training, management and support of practitioners working with these client groups.

Conclusion

As demonstrated in this review, previous literature suggests that to hear clients’ experiences of sexual trauma can be challenging. However, the idea that working with these clients can be actively damaging to the mental health and wellbeing of practitioners clearly requires further investigation before definite conclusions can be drawn (Kadambi & Ennis, 2004).

Biographical notes

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