

AUSTRALIAN CENTRE FOR THE STUDY OF SEXUAL ASSAULT

'Feeling heavy': Vicarious trauma and other issues facing those who work in the sexual assault field

ZOË MORRISON

This paper is about vicarious trauma, a normal response to repeated exposure and empathetic engagement with traumatic material. It describes what vicarious trauma is, how it may be experienced, and what may predict it occurring. It also discusses how individuals and organisations may address vicarious trauma, and the broader social context this work takes place within. While addressing the challenges of this work, the paper also considers some of the uniquely rewarding aspects of working with the issue of trauma and sexual assault.

It's 3 o'clock. A full day already; I'm on board 'til nine. My energy level is zero and I'm listening to an all too familiar story that makes my heart ache. Literally ... Every abuse story, no matter how familiar, hurts my heart this way, recreating the same pattern ... Healing begins with awareness. Our agency brings awareness to abuse victims that they have choices. They don't have to live this way. We don't have to live this way either. (Reinbrecht, 2003, p. 8)

Introduction

'Vicarious trauma' is a psychological term used to refer to changes in a person that can occur when they are repeatedly exposed to traumatic material. In this paper, I outline what vicarious trauma is, the factors that make the experience of it more likely, and the ways it can be addressed. The paper addresses the issue of vicarious trauma, and other related issues, at three levels: the level of the individual, the level of the organisation, and the broader social context within which they exist. The aim of the paper is to provide a resource for those working with the issue of sexual assault; to understand, prevent and address



Australian Government

Australian Institute of Family Studies
Australian Centre for the Study of Sexual Assault

The Australian Centre for the Study of Sexual Assault aims to improve access to current information on sexual assault in order to assist policy makers, service providers, and others interested in this area to develop evidence-based strategies to prevent, respond to, and ultimately reduce the incidence of sexual assault.

The Australian Centre for the Study of Sexual Assault is funded by the Office for Women, Australian Government Department of Families, Community Services and Indigenous Affairs, through the Women's Safety Agenda. The Centre is hosted by the Australian Institute of Family Studies.

Contents

| | |
|--|----|
| Introduction | 1 |
| What is vicarious trauma? | 2 |
| Experience of vicarious trauma in the sexual assault field | 4 |
| Experience of vicarious trauma in other related professions | 4 |
| Does anything predict vicarious trauma? | 5 |
| Stigma and vicarious trauma | 6 |
| Can vicarious trauma be prevented? | 7 |
| Self-care strategies for the individual | 7 |
| Organisational support to prevent and address vicarious trauma | 8 |
| The sexual assault organisation in social context | 10 |
| Rewarding aspects of sexual assault work | 10 |
| Conclusion | 11 |
| References | 11 |
| Other resources | 12 |
| Acknowledgements | 12 |

The author

Dr Zoe Morrison is the Coordinator of the Australian Centre for the Study of Sexual Assault at the Australian Institute of Family Studies.

© Commonwealth of Australia 2007

This work is copyright. Apart from any use as permitted under the *Copyright Act 1968*, no part may be reproduced by any process without prior written permission from the Commonwealth. Requests and inquiries concerning reproduction and rights should be addressed to the Commonwealth Copyright Administration, Attorney General's Department, Robert Garran Offices, National Circuit, Barton ACT 2600 or posted at www.ag.gov.au/cca

The Australian Institute of Family Studies is committed to the creation and dissemination of research-based information on family functioning and wellbeing. Views expressed in its publications are those of individual authors and may not reflect Australian Government or Institute policy, or the opinions of the Editors or of the Director.

Australian Institute of Family Studies
Level 20, 485 La Trobe Street, Melbourne 3000 Australia
Phone: (03) 9214 7888 Fax: (03) 9214 7839
Internet: www.aifs.gov.au/acssa

ISSN 1833-1483 (Print)
ISSN 1834-0148 (Online)

Edited and typeset by Woven Words
Printed by Impact Printing

vicarious trauma; and to indicate future directions for research and advocacy efforts.

The paper is written for people who work in the sexual assault field, and for people working with the issue of sexual assault in other professions (for example, lawyers, judges, police, nurses, doctors, other health workers, educators, researchers, community workers, church workers, and so on). The paper is also relevant to those who work in overlapping and related violence and trauma fields, such as domestic violence and child protection.

What is vicarious trauma?

Vicarious trauma is described as a transformation in a therapist (or other worker) as a result of working with clients' traumatic experiences. The full definition, developed by Pearlman and Saakvitne (1995), is as follows:

The inner transformation that occurs in the inner experience of the therapist [or other professional] that comes about as a result of empathic engagement with clients' trauma material.' (p. 31).

It is related to concepts such as 'emotional exhaustion', 'burnout', 'compassion fatigue', 'secondary traumatisation' and 'counter-transference', but some key differences exist between some of these concepts (see Dunkley and Whelan, 2006). It can also be expressed as 'feeling heavy', or when the work (or an aspect of the work) 'gets inside you'.

A very short history of the concept

Effects of trauma exposure on professionals were first observed formally in the late 1970s in emergency and rescue workers who displayed symptoms similar to the trauma victims they were helping. This prompted investigation of other people working with victims in various capacities, such as disaster relief workers, nurses, and crisis and hotline workers (Mouldern & Firestone, 2007). In 1995, Stamm stated that the issue was not whether such a phenomenon existed, but what it should be called. 'Vicarious trauma' was coined by McCann and Pearlman in 1990, and is the term perhaps most widely referred to in much of the literature on this topic, with some even arguing it is the most appropriate term (Dunkley & Whelan, 2006).

What does vicarious trauma involve?

Vicarious trauma is a cumulative effect of working with trauma, which can affect many aspects of a person's life. It may consist of short-term reactions, or longer-term effects that continue long after the work has finished. Some have even argued its effects are

potentially permanent (Mouldern & Firestone, 2007, p. 68).

As mentioned above, some effects of vicarious traumatisation parallel those experienced by the primary victim/survivor. For example, vicarious traumatisation can lead to a person experiencing the symptoms of post-traumatic stress disorder (PTSD).

While the symptoms of trauma need to be recognised as culturally diverse and specific (Wasco, 2003), trauma reactions are generally divided into three categories:

- *intrusive reactions*: dreams/nightmares, flashbacks, obsessive thoughts, physiological reactions and other persistent re-experiencing of the traumatic event;
- *avoidant reactions*: general numbing in responsiveness and avoidance (particularly of things related to the traumatic material); and
- *hyper-arousal reactions*: hyper-vigilance and difficulty concentrating.

Workers may also experience the following:

- anxiety;
- depression;
- de-personalisation;
- feeling overwhelmed by emotions such as anger and fear, grief, despair, shame, guilt;
- increased irritability;
- feeling of reduced personal accomplishment;
- procrastination;
- low self-esteem;
- having no time or energy for self or others;
- increased feelings of cynicism, sadness or seriousness;
- an increased sensitivity to violence and other forms of abuse, for example when watching television or a film;
- avoiding situations perceived as potentially dangerous;
- feeling profoundly distrustful of other people and the world in general;
- disruptions in interpersonal relationships;
- sleeping problems; and
- substance abuse.

Connected to these experiences, vicarious traumatisation may also involve a change in a person's beliefs about themselves, the world, and other people within it. This is known in the psychological field as changes in their 'cognitive schema', and may involve:

- feeling that the world is no longer a 'safe place' (for themselves and/or others);
- feeling helpless in regard to taking care of themselves or others;
- feeling their personal freedom is limited; and
- feelings of alienation (that their work within the field of sexual assault sets them apart from others).

However, it also needs to be recognised that for many people, particularly those who have already experienced or been exposed to trauma, these beliefs may already be apparent. Also, while some psychological literature classifies the above beliefs as 'disrupted' or 'distorted', others argue that they are in fact accurate reflections of the lived reality of many (Wasco, 2003).

Overall, it is useful to state that vicarious trauma is just one way of conceptualising people's reactions to working in the field of sexual assault. It can be a useful way of conceptualising these reactions, because it can give legitimacy to what people are experiencing (it is a known psychological concept), it recognises that many other people experience it (it's not just you), and it taps into a field of useful psychological research and enquiry. However, it is important not to 'pathologise' these reactions (view them as medically or psychologically abnormal) through using the concept of vicarious trauma. In fact, all research on this subject points out that these reactions are normal human reactions to repeated exposure to distressing events.

Impact of vicarious trauma on organisations

Organisations overall can also feel the impact of vicarious traumatisation and related issues. There may be a 're-enactment of client issues'; for example, betrayal, secrecy, mistrust, rage, or boundary violations (McAllister, 2003, p. 6). There may be a high worker turnover; there may be ongoing conflict within and between organisations; and there may be poor productivity and/or, by contrast, over-conscientiousness.

Other issues facing those working in the sexual assault field

While vicarious traumatisation deals with a 'transformation' in the therapist's 'inner experience', other research points out that, connected to this, working in fields such as sexual assault can involve a change in a workers' 'psycho-social relationships'—their relationships with friends and family, and their 'public relationship' (Hindle & Morgan, 2006).

In regard to relationships with family and friends, research on vicarious trauma has pointed out that interpersonal relationships may be affected. Other research has pointed out the ways the emotional

While vicarious traumatisation deals with a 'transformation' in the therapist's 'inner experience', other research points out that, connected to this, working in fields such as sexual assault can involve a change in a workers' 'psycho-social relationships'.

impact of this work can affect overall home or 'family life'. For example:

Quite often you take home your work in your head ... it owns you I suppose ... yeah it takes over your life and that's it. ('Petra' in Hindle & Morgan, 2006, p. 37)

Negative comments or perceptions about their work by those in their social circle may lead workers to feel hurt, unappreciated, misunderstood and disconnected from others in their social world, prompting changes in their social relationships. For example:

Since I've worked [in the field] I've let quite a few friends go because ... I've got nothing in common with them anymore. Yeah, my whole circle of friends apart from a few very close friends has changed quite considerably. ('Leslie' in Hindle & Moran, 2006, p. 39)

In relation to the public relationship, or the relationship with the wider world, workers can encounter negative and inaccurate stereotypes about the work that they do, which can have an emotional toll on workers, causing hurt, frustration, feelings of alienation and personal questioning (Hindle & Morgan, 2006). Workers may also experience bullying or harassment because of their work in this field. These negative experiences can be compounded when dealing with a lack of funding, or temporary and/or insecure funding. Finally, factors such as adverse political responses and media coverage to sexual assault (such as media that support rape myths or are misogynous) can also adversely impact workers.

Research has found that working with traumatised clients is especially demanding, and can be distinguished from working with other 'difficult populations', because of the exposure of workers to emotionally shocking images of horror and suffering (Cunningham, 2003, p. 452). Counsellors working with sexual assault survivors, in particular, have been found to experience the 'symptoms' detailed in the section above (Johnson & Hunter, 1997; Pearlmann & MacLean, 1995; Schauben & Frazier, 1995). Therapists working with sexual offenders have also been found to experience vicarious traumatisation (Mouldern & Firestone, 2007). Indeed, research has found that working in the sexual assault field can be particularly distressing when compared with other forms of trauma work such as counselling clients with cancer (Cunningham, 2003) and a range of other therapy areas (Johnson & Hunter, 1997). Working with victims of interpersonal violence has been found to result in the highest 'traumatic stress' scores. Within the field of interpersonal violence, working with victims of rape has been found to be associated with greater disrupted beliefs (Bober & Regher, 2006). However, another study found that while a greater percentage of survivors in caseloads contributed significantly to therapists' PTSD-like symptoms, it did not contribute to disrupted cognitive schemas (Brady, Guy, Poelstra, & Brokaw, 1999). This study also found that therapist's trauma symptoms were relatively mild; that is, although therapists who treated more sexual assault survivors were likely to exhibit more trauma symptoms than their colleagues, the level of intensity of these symptoms was not severe.

Experience of vicarious trauma in other related professions

While recognition of the experience of vicarious traumatisation has grown in the last decade, this has mostly been in fields such as trauma counselling. Indeed, most of the research on this topic has been applied to professional counsellors (Wasco & Campbell, 2002), with only limited attention given to the issue outside the counselling professions. Despite this, there is growing recognition that anyone who has extended contact with trauma victims or traumatic material is at risk of vicarious traumatisation (Wasco & Campbell, 2002). This includes legal professionals, health professionals, researchers and educators. Research shows that when the possibility of vicarious trauma is not recognised or acknowledged, people may be more detrimentally affected because there are few if any efforts to prevent or reduce this harm. This has led some experts to recently call for a widening of the recognition of vicarious traumatisation to

Research has found that working with traumatised clients is especially demanding, and can be distinguished from working with other 'difficult populations', because of the exposure of workers to emotionally shocking images of horror and suffering .

Research on this topic that focuses on this broader social level (rather than at the level of the individual or organisation) is still limited. However, it can be said that the relationship between the sexual assault professional and the wider world is likely to affect the wellbeing of the professional and her/his ability to continue working in the field.

Experience of vicarious trauma in the sexual assault field

Those of us who work with victims have seen or heard some of the worst that human beings do to other human beings. We have lost the luxury of innocence. (Arms, 2003, p. 5)

other professionals exposed to traumatic material, as discussed below (Dunkley & Whelan, 2006).

Lawyers

Research has found that lawyers can experience high levels of vicarious traumatisation. A survey of lawyers working with domestic violence and criminal defendants found that lawyers demonstrated significantly higher levels of secondary traumatic stress and burnout compared to two control groups, which consisted of mental health providers and social services workers (Levin & Greisberg, 2003). The researchers suggested these symptoms related to lawyers with higher caseloads and having a lack of supervision around trauma and its effects.

Police

In the 25 years of doing my job, this is the first time I've ever heard someone mention the words 'self-care'.

Comment by policeman at workshop on secondary traumatisation run by a sexual assault service provider.

Similarly, police officers have been found to have significantly higher symptoms of psychological distress (including anxiety, depression, dissociation and sleep problems) and PTSD symptoms than mental health professionals (Follette, Polusney, & Milbeck, 1994). No research has been found that explores how experiencing vicarious traumatisation affects the ways lawyers or police (or other professionals) deal with victim/survivors and perpetrators of sexual assault in the course of their work.

Researchers

Research has found that researchers who work in the field of sexual assault may be affected. For example, one study found that people researching rape (who worked only with archival data and had no personal contact with victims or offenders) experienced somatic complaints, sleep disorders, increased cautiousness, increased need for social support and emotional responses such as anger, anxiety, fear and sadness (Alexander et al., 1989, cited in Wasco & Campbell, 2002). As Campbell (2002) pointed out, the norms of research do not typically provide for such effects.

Does anything predict vicarious trauma?

As already stated, vicarious traumatisation is a normal response to repeated exposure to traumatic material. As McAllister (2003) stated:

It is the nature of the trauma that causes [vicarious traumatisation], not some

weakness or failure within the provider or organisation. (p. 1)

Thus, plainly put, exposure to trauma is the clearest predictor of vicarious traumatisation. Related to this, 'caseloads', or the extent of trauma exposure, have been found to be predictive factors of vicarious traumatisation.

Extent of trauma exposure and caseloads

Time spent counselling trauma victims is the best predictor of trauma scores among counsellors (Bober & Regehr, 2006). Research has also found that counsellors with a higher percentage of sexual assault survivors in their caseload reported more disrupted beliefs, more PTSD symptoms, and more self-reported vicarious trauma (Schauben & Frazier, 1995). This has implications for preventing or addressing vicarious traumatisation, which we discuss below.

The role of empathy is important here. Empathy is a major resource for trauma workers, who use it to assess survivors' problems and work out a treatment approach (Campbell, 2002). Empathising with survivors of rape helps workers understand their experience of being traumatised, although in the process, the professionals may be traumatised as well (Figley, 1885, cited in Campbell, 2002).

Time spent counselling trauma victims is the best predictor of trauma scores among counsellors. Research has also found that counsellors with a higher percentage of sexual assault survivors in their caseload reported more disrupted beliefs, more PTSD symptoms, and more self-reported vicarious trauma.

Counselors must personally endure repeated exposure to distress and use their own feelings of sorrow as tools for therapy. As such, it is impossible to escape this kind of work without personal consequences. (Campbell, 2002, p. 101)

Level of experience in the field

Level of experience may also be relevant in predicting vicarious trauma, but existing research on this is contradictory. Providing sexual abuse treatment to survivors over a shorter length of time has been found to predict greater 'intrusive' symptoms in clinicians, but it is also suggested that clinicians most affected by trauma may leave the field prematurely and therefore they may not have been represented in this study (Way, VanDeusen, Martin, Applegate, & Jandle, 2004). On the other hand, number of years' experience working in the field was found to be associated with more

disruptive beliefs regarding intimacy with others (Bober & Regehr, 2006). These researchers suggest degree of exposure has an impact on intrusion and avoidance symptoms, but that altered beliefs do not appear to occur in the short term. Finally, some researchers suggest that symptoms may also be recognised to a lesser extent over time, becoming 'normalised', and so less noticed (Iliffe & Steed, 2000).

What about a worker's own abuse history?

Given the prevalence of sexual assault, many workers in the field will also be primary victim/survivors, although it is worth noting that, while inconclusive, research does not suggest a higher proportion of abuse survivors among those in the 'helping' professions (Stevens & Higgins, 2002). Some research suggests an association between personal history of abuse and experiencing vicarious traumatisation; in one study of trauma therapists, counsellors with a personal trauma history showed greater disruptions (in, for example, their beliefs about themselves and the world) than those without such a history (Pearlman & Maclan, 1995).

However, other research has not found a personal history of abuse to be a relevant factor in predicting vicarious traumatisation. For example, Schauben & Frazier (1995) found that vicarious traumatisation 'symptomology' was not related to personal trauma history, including experience of sexual assault. Another study found that personal histories of abuse were not associated with vicarious trauma, except in individuals who had sought treatment, which suggests that those who were distressed or unresolved about their personal histories were likely to seek appropriate assistance (Bober & Regher, 2006). Stevens & Higgins (2002) found that a personal history of maltreatment

predicted current trauma symptoms, but not burnout. Thus, while personal experience of abuse may sometimes be salient to the experience of vicarious trauma, and sometimes not, research also has found that it is traumatising within itself to be exposed to traumatic material.

... After the presentation, after the supper and drinks had begun, people started talking about how their work affected them. Maybe it's a difficult topic to discuss.

Comment by a researcher after presenting a paper on vicarious trauma at a meeting of sexual assault counsellor advocates.

While recognition of vicarious traumatisation and other associated issues has increased, it can still be difficult to acknowledge, disclose and address. This has been found in the research. For example, in a study of domestic violence counsellors, while counsellors were proficient in talking about domestic violence issues and had the language to do so, less thought and discussion had been given to the impact of this work on the self (Iliffe & Steed, 2000). This is not perhaps surprising given the social context within which work on sexual assault takes place, and given the ways experiences of vicarious trauma have traditionally been understood. Much research on vicarious trauma in the past was focused at the level of the individual worker, and particularly their so-called 'coping strategies'. This approach has now been criticised, because it individualise[s] the problem (Bober & Regher, 2006), potentially leaving individuals feeling that the experience of vicarious trauma is somehow 'their fault'. Furthermore, the experience of vicarious trauma may differ for different people, again making it seem as if it is a personal issue, rather than a normal and expected reaction to repeated exposure to traumatic material.

As would be expected, attaching stigma to vicarious trauma has been found to negatively affect a person's ability to access necessary assistance to recover (Brescher, 2004). Because of this, it is important to detach stigma from the experience of vicarious trauma. One way of doing this may be to locate the 'cause' of vicarious trauma with trauma itself, and its social causes, rather than with the individual workers and organisations who must deal with these issues. Addressing vicarious trauma appropriately, without stigma, means that workers are able to continue to support victim/survivors, and enjoy their important role.

In the following sections, strategies professionals can take to address their own experience of vicarious trauma are discussed. It is demonstrated that the success of these strategies, and a professional's ability to engage in them, will be influenced by the level of support received by workers within the organisation they work in. It is also suggested that people's and organisations' ability to deal with vicarious trauma will be influenced by the broader social context within which sexual assault work takes place.

In a study of domestic violence counsellors, while counsellors were proficient in talking about domestic violence issues and had the language to do so, less thought and discussion had been given to the impact of this work on the self.

Stigma and vicarious trauma

When the topic of vicarious trauma came up in our presentation, the audience grew still

Can vicarious trauma be prevented?

A variety of strategies are recommended in the literature to both prevent and deal with vicarious traumatisation. However, if vicarious traumatisation is a common response to repeated exposure to trauma, to what extent are these strategies effective? In fact, despite all the advice, little research has been done to assess various strategies' effectiveness (Bober & Regehr, 2006). Of the research that has been done on strategies undertaken by individuals, use of coping strategies was associated in one study with lower levels of PTSD symptoms in rape counsellors (Schauben & Frazier, 1995). However, other research has found no association between time devoted to coping strategies and traumatic stress levels (Bober & Regher, 2006). Also, use of particular coping strategies is not associated with lower levels of trauma or symptoms of burnout (Stevens & Higgins, 2002). Another study also found that even if therapists believed recommended coping strategies worked (such as leisure activities, self-care and supervision), this did not translate into spending time on these activities (Bober & Regher, 2006). Bober and Regher concluded that 'there is no evidence that using recommended coping strategies is protective against symptoms of acute distress' (2006, p. 7).

As mentioned above, results regarding the lack of success in suggested individual coping strategies has recently led some researchers to question these recommended intervention strategies, and particularly coping strategies focused at the level of the individual (Bober & Regher, 2006).

Indeed, emphasising individual coping strategies or 'resilience' could be a form of 'victim-blaming', and misunderstanding of the causes of vicarious trauma, which has implications for how vicarious trauma should ultimately be addressed:

As mental health professionals dedicated to the fair and compassionate treatment of victims in society, we have been strong in vocalizing concerns that those who are abused and battered not be blamed for their victimization and their subsequent traumatic response. Yet when addressing the distress of colleagues, we have focused on the use of individual coping strategies, implying that those who feel traumatized may not be balancing life and work adequately and may not be making effective use of leisure, self-care, or supervision ... In light of findings that the primary predictor of trauma scores is hours per week spent working with traumatized people, the solution seems more structural than individual. (Bober & Regehr, 2006, p. 8)

Bober and Regehr (2006) argued that attention needs to shift from education to advocacy for improved and safer working conditions.

The significance of the organisational environment

[Counsellor advocates] described the organizational support that they received as instrumental in their ability to continue providing supportive services to sexual assault survivors. (Wasco, Campbell, & Clark (2002), p. 749)

Ecological theorists argue that the self-care routines of workers when dealing with vicarious traumatisation can best be understood as interactions between individuals and their environments. Wasco et al. (2002) stated that, because vicarious traumatisation occurs in the work place, this environment is highlighted as particularly important. Their research found links between the organisational setting and counsellor advocates' ability and propensity to engage in self-care activities. They found that:

- specific organisational procedures or cultures facilitate or bar opportunities for certain self-care routines; and
- organisational cultures or policies create situations that necessitate or eliminate the use of particular types of self-care activities or routines.

Research has also found that, no matter what organisation a counsellor worked within, all counsellors needed to regulate the amount of rape-related pain in their lives through cathartic self-care routines. However, those counsellors who worked in organisations with higher levels of support tended to employ more 'integrative self-care strategies' (see below) than those working in organisational settings with less support.

Given these findings, let us look firstly at workers' own proactive self-care strategies to assist with dealing with vicarious traumatisation, and then turn to looking at aspects of a supportive organization.

'Self-care' refers to proactive strategies or routines that professionals use to offset the negative aspects of working with trauma victims and to promote their own wellbeing.

Self-care strategies for the individual

Research has documented the activities and routines in which professionals in the field engage to offset the negative aspects of working with trauma victim/survivors. 'Self-care' refers to proactive strategies or routines that professionals use to offset the negative aspects of working with trauma victims and to promote

their own wellbeing. Self-care is distinguished from 'coping', which is said to refer to reactions that may or may not be chosen consciously: 'the notion of self care is predicated on the assumption that working with trauma victims can be emotionally strenuous for service providers' (Wasco & Campbell, 2002, p. 734).

One research study (Wasco & Campbell, 2002) found that counsellor advocates used five types of self-care resources in dealing with their work:

- changing how they think about things (cognitive);
- using body and senses (physical);
- relying on their religious beliefs or spirituality (spiritual);
- using friends, family or creative recreational activities as outlets (social/recreational); and
- putting into words the painful details and intense feelings that they experience (verbal).

It was found that when counsellor advocates practise proactive self-care strategies, two functions are served:

- regulating the amount of work-related or rape-related stress that rape victim counsellor advocates experience (cathartic strategies); and
- developing skills, strengths and support to compensate for the daily exposure to traumatic experiences (integrative strategies).

Examples of specific self-care strategies cited in various other literature are:

- socio-political involvement—working to address the broader social causes of sexual assault, which has been found to enable people to positively channel their knowledge and feelings of 'anger and powerlessness' regarding violence against women and inadequate systems responses (Iliffe & Steed, 2000);
- having and maintaining interests completely separate from work; for example, during interviews in one study on vicarious traumatisation, many workers were as passionate about their outside interests as their paid work, which was seen as allowing them to separate themselves from the work and the stresses they encountered there (Brescher, 2004);
- taking breaks at work, and from work, when needed;
- taking up opportunities for debriefing and other therapeutic support;
- maintaining professional connections;
- maintaining connections with others outside the field;
- accepting support and positive feedback when it is offered;
- giving support and positive feedback to others;
- treating themselves particularly well, consciously focusing on their own self-care;

- physical activity and other bodily self-care (for example, seeking treatment for any illness);
- spiritual engagement;
- humour; and
- identifying successes, reminding themselves of successes.

Organisational support to prevent and address vicarious trauma

Organisational support can be key to helping employees vent, process, or debrief about traumatic material (Wasco & Campbell, 2002). Conversely, unsupportive administration, low salaries and difficulties encountered in providing services are all predictive of higher burnout rates (Bell, Kulkarni, & Dalton, 2003). So what are ways in which organisations can create a supportive environment for professionals working in the sexual assault field?

Ensuring appropriate and diverse caseloads

Given that the level of exposure to trauma is a predictor of vicarious traumatisation levels, the number of cases workers see within a given time period needs to be appropriate. It is also important that workers do not feel pressure to see more than this because of 'waiting lists' (if waiting lists are a problem, more workers need to be funded). In relation to professions where caseloads are not applicable, exposure to traumatic material or traumatised clients/participants needs to be recognised as difficult and challenging work, with appropriate supports put in place.

More diverse caseloads are associated with decreased vicarious traumatisation (Crestman, 1995, cited in Bell et al., 2003, p. 463). Diverse caseloads can be achieved for some workers through ensuring they see a diversity of clients rather than only traumatised clients. For those working in a specialist field (for example, sexual assault counsellor advocates), more diverse caseloads can be achieved through seeing a diversity of client types: children as well as adults (if the service sees both children and adults), adult survivors of child abuse as well as adults recently abused, and both female and male survivors. Another strategy for diversifying caseloads is for a sexual assault specialist to work at multiple levels in sexual assault recovery and prevention (e.g., engaging in individual counselling, group work, training, research, communication, advocacy and community education/social change work).

Providing effective supervision for all

Effective supervision is said to be an essential component of the prevention and healing of vicarious

traumatisation (Bell et al., 2003). Responsible supervision creates a relationship in which a worker feels safe to express their fears, concerns and feelings of inadequacy. Sometimes staff supervision will be combined with ensuring organisational accountability and staff evaluation. This can create a tension: a worker's concern about the evaluation of their work may make her or him reluctant to bring up something relevant to vicarious traumatisation. Because of this, some recommend supervision and evaluation remain separate functions (Bell et al., 2003). In agencies where this is not possible, the use of external clinicians for trauma-specific supervision is recommended. Certainly, all supervisory relationships need to be characterised by trust and transparency, set by a supportive workplace culture (discussed below). It is also worth noting that supervisors themselves need to be able to access effective supervisory support.

Access to debriefing

Debriefing and peer support were identified in a study of domestic violence counsellors as the most important strategy for dealing with the after-effects of a difficult counselling session (Iliffe & Steed, 2000). Workers dealing with trauma need to have access to regular debriefing. 'Critical incident debriefing' is a formalised method for processing specific traumatic events, and is an important component of organisational support. However, it is different from managing repetitive or chronic traumatic material, and ongoing support for this also needs to be available.

Indeed, it has been suggested that talking in a semi-structured setting may be an integral part of dealing with rape crisis work. Rape victim advocates may be bound to silence outside of the work setting, either by legal confidentiality mandates or social pressures not to bring up the topic of rape. Therefore, a key way in which organisations can support workers is by providing opportunities to verbalise 'rape-related pain' and be in the company of supportive listeners, which may be difficult for them to arrange in other areas of their lives. This also relates to staff and peer support (see below).

Staff and peer support

The literature on both vicarious traumatisation and burnout emphasises the importance of social support within the organisation. As Bell et al. (2003) state, staff opportunities to debrief informally and process traumatic material with supervisors and peers are helpful. Group support can be formal or informal, take a variety of forms, and can be peer or professionally led. It may involve case conferences, clinical seminars or even reading groups. Time for

social interaction between co-workers (for example, celebrating birthdays and specific achievements, team-building activities, staff retreats) can increase workers' feelings of support. Staff support also relates to workplace culture (see below).

Organisational support can be key to helping employees vent, process, or debrief about traumatic material. Conversely, unsupportive administration, low salaries and difficulties encountered in providing services are all predictive of higher burnout rates.

Safety and comfort in the work environment

Some work places are so dangerous that workers experience primary trauma, including physical and sexual violence, abuse, stalking and threats of violence, rather than only vicarious trauma. They may also experience bullying and harassment. Research has found that being threatened by a client or other person at work is strongly correlated with compassion fatigue. Obviously, protecting workers' physical and psychological safety must be of primary concern when creating a supportive work environment. Workplace measures must exist that clearly and urgently prioritise a sexual assault professional's physical and psychological safety. Such measures must prevent the occurrence of any direct physical and psychological harm, and respond swiftly and effectively to any safety violations that occur.

As well as safety issues, workers' comfort is also important. Research has suggested workers need to have personally meaningful items in their workplace (Pearlman & Saakvitne, 1995), and 'inspiring posters or pictures' can 'model the importance of the personal in the professional' (Bell et al., 2004, p. 467). A comfortable break room (separate from clients, if relevant) is also important, perhaps with provisions for comfort (hot drinks, music, etc.).

Workplace culture

The values and culture of an organisation set the expectations about the work. When the work includes contact with trauma, they also set the expectations about how workers will experience trauma and deal with it, both professionally and personally. (Bell et al., 2003, p. 466)

I feel very supported doing the work that I'm doing. (Rape victim advocate and research respondent, Wasco & Campbell, 2002)

An organisational culture that normalises the effects of working with trauma can be a start to providing a supportive environment for workers to address

An organisational culture that normalises the effects of working with trauma can be a start to providing a supportive environment for workers to address those effects in their work and wider lives.

start at the beginning of a professional's career and will be ongoing.

Apart from the above points, additional aspects of a supportive organisation might include:

- allowing for holidays, flexible working hours, taking time off for illness and participating in continuing education, and not explicitly or implicitly expecting or encouraging staff to work overtime. Ideally, people working in this field would have additional leave to deal with vicarious trauma issues or to simply take a break when necessary;
- creating opportunities for varying caseload and work activities;
- making staff care and self-care part of a mission statement;
- making time, resources and funds available for workers' self-care activities. Ideally, staff salaries would be commensurate with the difficult nature of this work, like other work that places professionals in 'danger';
- addressing self-care issues in staff meetings;
- being understanding and supportive of sexual assault issues, and effectively dealing with rape supportive beliefs in the organisation;
- accepting that workers will sometimes make mistakes and creating an environment free from shaming behaviours;
- actively soliciting staff views on what would create a more supportive organisation;
- actively soliciting staff views on decisions affecting staff and the organisation;
- warning applicants of the potential 'risks' of trauma work (Pearlman & Saakvitne, 1995), while balancing this with a discussion of the positives (see below); and
- discussing the positive aspects of sexual assault work, including emphasising and celebrating good news and achievements.

The sexual assault organisation in social context

There has been a shift in the literature on vicarious traumatisation, from a focus on the individual level

those effects in their work and wider lives. It may also give 'permission' or encouragement for workers to take care of themselves. Part of acknowledging the impact of vicarious traumatisation will include providing education about vicarious traumatisation. Ideally, this education will

to the organisational level, with the most recent research on the topic emphasising the importance of organisational support. Researchers and theorists have noted that, because vicarious traumatisation occurs in the workplace, the nature of this environment is particularly important (Wasco et al., 2002). But individual workers and sexual assault organisations also exist within a broader social environment, which will also influence the need, ability and propensity of both individual and organisational strategies to deal with vicarious trauma. Workplace policies, legislation and funding will enable, constrain and shape the supports an organisation is able to put in place. Broader social attitudes about rape will inevitably influence individuals and organisations in the ways they carry out their work, and the impact it has on them. Perhaps this broader social level is the next field of exploration in vicarious trauma research and prevention.

Rewarding aspects of sexual assault work

This paper has necessarily discussed potentially negative and challenging aspects of working in the sexual assault field. However, researchers and practitioners alike also mention rewarding aspects of working in the field (Pearlman & Saakvitne, 1995; Schauben & Frazier, 1995). Some have even suggested that these positives outweigh the negatives, particularly if symptoms of vicarious trauma are mild (Brady et al., 1999). Paradoxically, these rewards are integrally linked with some of the challenges of this work.

A national survey of 1000 female psychotherapists in the United States found that therapists with a greater exposure to sexual trauma clients ranked high on levels of 'spiritual wellbeing'. It was found that the more the respondents were exposed to trauma material, the higher was their spiritual wellbeing. Practitioners who treated more abuse survivors reported a more existentially and spiritually satisfying life than those with less exposure to trauma clients (Brady et al., 1999).

As Herman (1992) writes:

Therapists who work with survivors report appreciating life more fully, taking life more seriously, having a greater scope of understanding of others and themselves, forming new friendships and deeper intimate relationships, and feeling inspired by the daily examples of their patients' courage, determination and hope. This is particularly true of those who, as a result of their work with patients, become involved in social action. These therapists report a sense of higher purpose in life and a sense of camaraderie that allows them to maintain

a kind of cheerfulness in the face of horror. By constantly fostering the capacity for integration, in themselves and their patients, engaged therapists deepen their own integrity. (p. 153)

Many people who work with the issue of sexual assault are given the opportunity to witness and even play a pivotal role in the healing of people who have been harmed. Engaging with the broader social and even spiritual issues prompted by bearing witness to human trauma may provide the opportunity for interesting and rich personal development. Being prompted by this work to engage in proactive self-care may be an opportunity for a person to explore aspects of nurturing the self that might not otherwise have been considered. Finally, working in this field can mean making a positive and lasting impact on an issue of profound social and political importance.

Conclusion

Key aspects of the topic of vicarious traumatisation are summarised below.

- Vicarious traumatisation is a normal response to repeated exposure and empathetic engagement with distressing traumatic material.
- It involves physiological symptoms, changes in a person's views about themselves in the world, and potentially other adverse effects. Symptoms may be similar to the primary trauma survivors with whom the professional is working.
- Connected to the experience of vicarious trauma, professionals working in the sexual assault field may also experience changes in their social relationships and 'public relationship'.
- Working in the sexual assault field has been found to be particularly distressing when compared to other forms of trauma work, although the overall experience of trauma symptoms by those working with sexual assault survivors may still be relatively mild.
- The experience of vicarious traumatisation is not limited to counsellors—other professionals who deal with traumatic material (both directly and indirectly) are also affected. However, vicarious trauma is still seldom recognised in these fields.
- Vicarious traumatisation is predicted by extent of exposure to trauma. It may also be influenced by level of experience. Personal abuse history may be related to the experience of vicarious traumatisation, but vicarious traumatisation also relates to a separate trauma of its own.
- Stigma is still attached to vicarious traumatisation, and this can make it more difficult to acknowledge and address.
- Self-care for the individual includes cognitive, physical, spiritual, social and recreational, and verbal strategies.
- Self-care strategies can regulate the amount of stress professionals experience and involve the development of skills, strengths and support to compensate for daily exposure to trauma.
- Prevention or intervention strategies should not, however, unduly individualise the problem by only focusing on individual coping strategies.
- The extent of support for professionals in their work environment is an important determinate of professionals' ability and propensity to engage in self-care activities.
- The ways in which organisations can create a supportive environment for workers include ensuring appropriate and diverse caseloads, providing effective supervision, providing debriefing opportunities, providing staff and peer support, ensuring safety and comfort in the work environment, and overall creating a workplace culture that normalises the effects of working with trauma and puts necessary supports in place.
- The organisational environment also needs to be seen within the broader social context that exists. This may create constraints and opportunities in relation to the supports it is able to provide.
- Working in the sexual assault field can be a uniquely positive and rewarding experience. It may provide opportunities for developing personal strengths, witnessing the positive healing process of people who have been harmed, and playing a part in making a lasting positive contribution to society. For many, these positive aspects of working in the field will outweigh the negative aspects.

There has been a shift in the literature on vicarious traumatisation, from a focus on the individual level to the organisational level, with the most recent research on the topic emphasising the importance of organisational support.

References

Arms, M. (2003). Nurturing weary souls. *The CCASA Connection, Winter*, 5.

Bell, H., Kulkarni, S., & Dalton, L. (2003). Organisational prevention of vicarious trauma. *Families in Society: The Journal of Contemporary Services*, 84(4), 463–470.

Bober, T., & Regehr, C. (2006). Strategies for reducing secondary or vicarious trauma: Do they work? *Brief Treatment and Crisis Intervention*, 6(1), 1–9.

Brady, J., Guy, J., Poelstra, P., & Brokaw, B. (1999). Vicarious traumatisation, spirituality, and the treatment of sexual abuse survivors: A national survey of women

psychotherapists. *Professional Psychology: Research and Practice*, 30(4), 386–393.

Brescher, H. (2004). Burnout and vicarious traumatisation: What are refuge workers facing? *Domestic Violence & Incest Resource Centre Newsletter*, 2, 9–14.

Campbell, R. (2002). *Emotionally involved: The impact of researching rape*. London: Routledge.

Cunningham, M. (2003). Impact of trauma work on social work clinicians: Empirical findings. *Social Work*, 48(4), 451–59.

Dunkley, J., & Whelan, T. (2006). Vicarious traumatisation: Current status and future directions. *British Journal of Guidance and Counselling*, 34(1), 107–116.

Follette, V. M., Polusney, 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, 275–82.

Herman, J. L. (1992). *Trauma and recovery*. London: Pandora.

Hindle, S., & Morgan, M. (2006). On being a refuge worker: Psycho-social impacts of advocacy. *Women's Studies Journal*, 20, 32–47.

Iliffe, G., & Steed, L. G. (2000). *Children and domestic violence*. Devon, UK: Research in Practice.

Johnson, C., & Hunter, M. (1997) Vicarious traumatisation in counsellors working in the New South Wales Sexual Assault Service: An exploratory study. *Work & Stress*, 11(4), 319–28.

Levin, A. P. & Greisberg, S. (2003). Vicarious trauma in attorneys. *Pace Law Review*, 24(1), pp. 245–252. Retrieved 24 July 2007, from: <http://www.giftfromwithin.org/html/vtrauma.html>

McAllister, J. (2003). The art of transformation: Overcoming vicarious trauma. *The CCASA Connection*, Winter, 1–7.

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

Mouldern, H. M., & Firestone, P. (2007). Vicarious traumatization: The impact on therapists who work with sexual offenders. *Trauma, Violence & Abuse: A Review Journal*, 8(1), 67–83.

Pearlman, L., & MacLean, P. (1995). Vicarious traumatizations: An empirical study of the effects of trauma work on trauma therapists. *Professional Psychology: Research and Practice*, 26, 558–65.

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

Reinbrecht, J., (2003). Body & soul: Supporting our bodies to support our lives. *The CCASA Connection*, Winter, 8.

Schauben, L. J., & Frazier, P. A. (1995). Vicarious trauma: The effects on female counsellors of working with sexual violence survivors. *Psychology of Women Quarterly*, 19, 43–49.

Stamm, B. H. (Ed.). (1995). *Secondary traumatic stress: Self-care issues for clinicians, researchers, and educators*. Baltimore: The Sidran Press.

Stevens, M., & Higgins, D. (2002). The influence of risk and protection factors on burnout experienced by those who work with maltreated children. *Child Abuse Review*, 11, 313–331.

Wasco, S. M. (2003). Conceptualizing the harm done by rape: Applications of trauma theory to experiences of sexual assault. *Violence, Trauma & Abuse*, 4, 309–322.

Wasco, S. M., & Campbell, R. (2002). Emotional reactions of rape victim advocates: A multiple case study of anger and fear. *Psychology of Women Quarterly*, 26(2), 120–30.

Wasco, S. M., Campbell, R., & Clark, M. (2002). A multiple case study of rape victim advocates' self-care routines: The influence of organizational context. *American Journal of Community Psychology*, 30(5), 731–60.

Way, I., VanDeusen, K. M., Martin, G., Applegate, B., & Jandle, D. (2004). Vicarious trauma: A comparison of clinicians who treat survivors of sexual abuse and sexual offenders. *Journal of Interpersonal Violence*, 19(1), 49–71.

Other resources

Green, R., Gregory, R., & Mason, R. (2003). It's no picnic: Personal and family safety for rural social workers. *Australian Social Work*, 56(2), 94–106.

Women's Health Statewide. (2002). *Vicarious traumatisation: Occupational health and safety draft policy*. Adelaide: Author. Retrieved 24 July 2007, from: http://www.whs.sa.gov.au/pub/draft_VT_polic_1.pdf

Staff-meeting, workshop or reading group idea: have everyone read the paper and then discuss their thoughts on the issue.

Supervision idea: supervisors could ask staff members to read the paper and ask how they think they could be better supported.

As always, please contact ACSSA if you would like more information or resources on this topic.

Acknowledgements

Many thanks to Sarah Crookes, Jackie Burke, Cameron Boyd and Daryl Higgins for their very helpful comments and suggestions on the topic of this paper. Many thanks also to other people and groups around Australia who greatly assisted our thinking on this issue, but who prefer to remain anonymous, including the person who educated me about 'feeling heavy'.