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Running head: DEVELOPMENT OF SELF-CARE WORKSHOP FOR TRAINEES

Pepperdine University

Graduate School of Education and Psychology

THE DEVELOPMENT OF SELF-CARE WORKSHOP TO PREVENT VICARIOUS
TRAUMATIZATION IN TRAINING THERAPISTS WORKING WITH SEXUALLY
EXPLOITED CHILDREN

A clinical dissertation submitted in partial satisfaction

of the requirements for the degree of

Doctor of Psychology

by

Krystle K. Madrid

October, 2012

Anat Cohen, Ph.D. – Dissertation Chairperson

This clinical dissertation, written by

Krystle K. Madrid

under the guidance of a Faculty Committee and approved by its members, has been submitted to and accepted by the Graduate Faculty in partial fulfillment of the requirements for the degree of

DOCTOR OF PSYCHOLOGY

Doctoral Committee:

Anat Cohen, Ph.D., Chairperson

Barbara Ingram, Ph.D.

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VITA

EDUCATION

Pepperdine University 9/08-10/12

APA Accredited Doctoral Program
 Clinical Psychology Doctoral Student
 Anticipated Graduation Date, spring 2012
Clinical Competence Examination: passed 6/10
Preliminary Orals: passed with modifications, 2/2012
Final Defense Passed: 7/2012

Pepperdine University 9/06-12/07
 Master of Arts in Psychology

California State University, Northridge 9/01-12/05
 Bachelor of Arts degree in Psychology
 Bachelor of Arts degree in Women Studies
 Concentration: Social Work and Welfare

HONORS

- Psy.D. Contribution to Diversity Scholarship, Pepperdine University
 9/08-8/12
 Pepperdine Colleague's Grant, Pepperdine University
 9/08-8/12
- Dean's List for the School of Social and Behavioral
 Sciences, California State University, Northridge
 2003- 2005

SKILLS

Language: Fluent in Spanish
Specialized Training: Applied Behavioral Analysis, Picture Exchange
 Communication System, Trauma Focused CBT and Positive Parenting Program

CLINICAL EXPERIENCE

The Center for Multicultural Training in Psychology
Boston University School of Medicine Division of Psychiatry 9/11-8/12
APA Accredited Clinical Internship Program

- Intern in Psychology at Boston Medical Center and granted status as
 Psychology/Psychiatry Fellow in Psychiatry and Teaching Fellow at
 Boston University School of Medicine

Received training under the APA Mentored Practitioner-Scientist Model to provide
 evidence based treatment through a culturally competent lens

- Received training in cross-cultural and transcultural mental health, mental illness and recovery
- Participated in the three major training components: outpatient placements (Child and Adolescent Psychiatry), inpatient placements (Bridgewater State Hospital) and primary supervision/core seminars (Boston Medical School)

Bridgewater State Hospital, Bridgewater, MA

9/11-8/12

Forensic Psychology Intern

Supervisor: David Holtzen, Ph.D.

- Maximum Security Psychiatric Hospital for mentally ill males involved with the criminal justice system under the jurisdiction of Massachusetts Department of Corrections
- Provided psychological testing and complete multi-axial DSM-IV assessment and diagnosis under the supervision of designated forensic psychologists
- Conducted clinical assessment, develop and implement mental health treatment plans for patients under evaluation and/or committed to the hospital
- Co-facilitated Paranoia psychotherapy group to patients housed in the Minimum and Maximum Security Units
- Co-facilitated Dialectical Behavioral Therapy group to patients housed on the Maximum I Security Unit
- Provided case administration, complete treatment plans, assist in discharge planning and provide crisis intervention to patients housed on the Maximum II Security Unit
- Reviewed mental status and functioning of segregated inmates as needed
- Administered, scored and interpreted psychological instruments and provide feedback to patient and collaborate with treatment team in service of formulating treatment plans
- Monitored and regularly evaluate achievement of goals set in patient's treatment

Boston Medical Center, Child and Adolescent Psychiatry

8/11-8/12

Psychology Intern

Supervisor: Lauren Ashbaugh, Ph.D.

- Provided brief and long-term, individual child and adolescent psychotherapy to a inner-city, low income and racially/ethnically diverse populations in both English and Spanish
- Provided outpatient cognitive-behavioral, brief dynamic, and trauma focused CBT to patients suffering from mood and anxiety disorders, conduct disorder, oppositional defiant disorder, behavioral problems, personality disorders, and substance use disorders

- Co-facilitated Triple P parenting group to parents of children with behavioral and mood disorders
- Co-facilitated girls and boys social skills group to children age 9-12 with mood, anxiety and behavioral diagnosis.
- Conducted structured intake assessment interviews, determine diagnoses, and formulate appropriate treatment plans on a weekly basis
- Wrote integrative intake reports including five axes diagnoses and treatment plans
- Provided clinical presentations on cultural diversity and applied behavioral analysis to fellow interns and staff during clinical treatment team meetings
- Attended weekly multidisciplinary treatment team meetings

Children's Hospital, Los Angeles

7/10-7/11

Neuropsychological Assessment Extern, Clinical Trials Unit

Supervisor: Anita Hamilton, Ph.D.

- Conducted comprehensive neuropsychological evaluations in both English and Spanish to children and adolescents in the Clinical Trials Unit (age range: 7 months-18 years of age) diagnosed with brain tumors to determine functional status, including cognitive strengths and weaknesses
- Conducted neuropsychological evaluations for liver dysfunction, focal brain lesion, diffuse perinatal white matter disease and congenital heart failure research studies, including long term follow-up of adults treated for childhood cancer
- Conducted clinical interviews and developmental evaluations in English and Spanish for Division of Ophthalmology optic nerve hypoplasia outpatients
- Long term cognitive follow up for HIV young adults to adults (age range 18-24)
- Attended weekly behavioral sciences and neuropsychology didactic trainings and brain cutting
- Created and presented Fragile X and Autism Didactics
- Attended weekly Grand Rounds

Harbor-UCLA, Torrance CA

9/09-7/10

Adult Psychiatric Inpatient Assessment Extern

Supervisor: Carol Edwards, Ph.D.

- Conducted diagnostic interview in both English and Spanish to culturally diverse, economically disadvantaged patients suffering from Axis I and Axis II psychiatric disorders
- Administered (English and Spanish), scored and interpreted core battery of psychodiagnostic test instruments on inpatient psychiatric ward
- Administered psychodiagnostic and intelligence test instruments to outpatient population suffering from complex medical problems and Axis I and Axis II psychiatric disorders.
- Responsible for writing integrated assessment reports including five axes diagnosis
- Provided verbal feedback about assessment findings to both referring therapists and patients in service of diagnostic clarity and treatment planning
- Attended weekly individual and group supervision and provided formal case presentations
- Attended weekly Rorschach didactics targeting Exner scoring and interpretation
- Attended six week long MMPI-II didactic series targeting scoring and interpretation with Director of training, Dave Martin, Ph.D.

Pepperdine Community Counseling Center, Encino CA

9/08-8/11

Clinic Therapist

Supervisor: Anat Cohen, Ph.D.

- Provided brief and long-term, individual, couple and family psychotherapy to a diverse adult and adolescent population in both English and Spanish
- Provided outpatient cognitive-behavioral, brief dynamic, and long-term insight-oriented dynamic psychotherapy to a wide range of clients including adults and children suffering from mood and anxiety disorders, relational difficulties, behavioral problems, personality disorders, and substance use disorders
- Provided adjunctive brief and long-term psychotherapy to Children of the Night residents; children aged 11-17 rescued from prostitution
- Conducted structured intake assessment interviews, determined diagnoses, and formulated appropriate treatment plans
- Administered, scored, and interpreted psychodiagnostic measures to inform client conceptualization and change in client presentation across time

Responsible for the “on-call” clinic pager on a rotating basis and responded to crisis calls

- Wrote integrative intake reports including five axes diagnoses and treatment plans
- Presented clinical presentations in weekly individual and group supervision

McRory Pediatric Services, Encino, CA

9/08-9/09

Behavioral Intervention Therapist

Supervisor: Trisha McRea, M.A.

- Offered strategies and direct support to autistic spectrum children in accessing their curriculum
- Facilitated child's functioning within context of classroom without 1:1 support
- Provided behavior therapy to extinguish inappropriate behaviors and promote functional behaviors to aide in mainstreaming of children.
- Worked within interdisciplinary team

California Institute of Behavioral Analysis, Inc, Van Nuys, CA

2/07-7/08

Lead Behavioral Therapist

Supervisor: John Lubbers, Ph.D.

- Developed and implemented intervention treatment program for autistic spectrum children ages 2-11
- Facilitated clinical meetings and created individualized programming for children
- Trained behavioral therapists in applied behavioral analysis techniques
- Wrote monthly and quarterly reports to track program effectiveness
- Provided 1:1 therapy in home and clinical settings
- Implemented treatment programs
- Assisted in data collection for implemented programs
- Assisted in parent training

Center for Autism and Related Disorders, Inc, Tarzana, CA

12/05-2/07

Senior Behavioral Therapist

Supervisor: Doreen Granpeesheh, Ph.D.

- Implemented home and school based treatment programs for autistic spectrum children
- Worked within interdisciplinary team
- Provided initial and on-going training in applied behavioral techniques to therapists

Provided 1:1 therapy in home, school and clinical settings

- Acted as liaison between therapists and supervisors
- Assisted in design of individualized programs

ADDITIONAL CLINICAL EXPERIENCE

Pepperdine Community Counseling Center, Encino CA

09/10-8/11

Peer Supervisor

Supervisor: Anat Cohen, Ph.D.

- Provided peer supervision and mentorship to first and second-year doctoral students for their clinical training practicum at the community counseling center
- Assisted first and second-year doctoral students with client rapport building, intake summary development, treatment planning, compliance with legal/ethical standards, managing crisis issues, and professional development
- Assisted supervisee with articulating clear training goals for the year in terms of knowledge, skills, and competencies as a trainee therapist
- Developed and reviewed case conceptualizations for supervisee's clients based on various theoretical orientations, including psychodynamic and cognitive-behavioral therapy
- Audited peer supervisees' client files and assisted in proper documentation

Pepperdine Community Counseling Center, Encino CA

05/09-8/11

Graduate Assistant

Supervisor: Anat Cohen, Ph.D.

- Conduct telephone screenings and intake assessments with potential clients
- Screen and assign callers to clinic therapists
- Evaluated callers' needs in regards to current level of crisis, legal issues and severity of difficulties
- Provided quarterly clinical orientation and ongoing assistance to incoming doctoral and master level students on policies, procedures, documentation and client issues
- Trained therapists on administering, scoring and interpreting clinic psychodiagnostic measures

Conducted audit of therapist files ensuring accurate documentation, compliance with clinic procedures and quality control

- **RESEARCH EXPERIENCE**

Pepperdine University, West LA, CA

1/10- 8/11

Research Assistant, *Work-Life Balance Issues for Women*

Principal Investigator: Dean Margaret Weber

- Study aimed at exploring women's narratives on balancing work activities with the demands of marriage and motherhood
- Conducted interviews of influential women within leadership roles throughout the Los Angeles Area.

Pepperdine University, Encino, CA

8/07-8/08

Research Assistant, *Women's Voluntary Midlife Career Transitions*

Principal Investigator: Barbara Ingram, Ph.D.

- Study sought to explore subjective experience of women during voluntary career transition process in middle years of adulthood
- Assisted with literature review and data analysis
- Trained and aided in planning process of interview protocol

California Institute of Behavioral Analysis, Inc., Van Nuys, CA 9/07-11/07

Research Assistant, *Functional Assessment of Tantrum and Self-Stimulating Behavior*

Principal Investigator: Ly Caruz, Ph.D.

- Assessment of Behaviors within autistic spectrum children ages 3-7
- Helped in scoring of responses and inputting information
- Assisted with data analysis collection

Pepperdine University, West Los Angeles, CA

9/07-12/07

Research Assistant, *Childhood Bipolar Disorder Educational Resource for Mental Health Professionals*

Principal Investigator: Deborah Ellerbusch, M.A.

- Aided in planning process of information to be included in pamphlet
- Assisted in distribution of pamphlets to mental health professionals throughout Southern California in private and public facilities

Edited pamphlet and assisted with literature review

- **California State University, Northridge, CA** 9/05-12/05

Research Assistant, *Understanding Baseline Pattern Associated with Aging to Facilitate Differential Diagnosis of Dementia of Alzheimer's in the Early Stages of Disease.*

Principal Investigator: Maura Mitrushina, Ph.D

- Research explored neuropsychological and electrophysiological characteristic for normal aging
- Participated in assessment and case management of patients with traumatic head injuries
- Investigated functional status of long-term head-injury patients
- Administered WAIS-III and research specific questionnaires

California State University, Northridge, CA 12/04-5/05
Undergraduate Senior Thesis, *Sexual Assaults on Women in the US Military*
 Senior Thesis Chair: Breny Mendoza, Ph.D.

- Investigated sexual assaults against women in the military as well as the reasons used to support such acts
- Research findings suggested military culture perpetuates atmosphere for demeaning women with US military
- Findings suggested women were considered second-class status allowing for emergence of male power and thus inadequate belief that women were at males disposal within US military

PROFESSIONAL PRESENTATIONS

California State University, Northridge, CA 05/05
 1st Annual CSUN Women's Studies Student Conference

- Developed and presented information on research findings on undergraduate senior thesis "Sexual Assaults on Women in the US Military"
- Moderated second day senior thesis presentations

RELATED WORK EXPERIENCE

Clinical Management of Psychopathology 9/09-6/10
Teaching Assistant
 Professor: Anat Cohen, Ph.D., Pepperdine University

- Created PowerPoint slides for lectures based on intake/interviewing, DSM-IV-TR disorders, and other clinical management topics
- Provided answers to questions and guidance regarding coursework, reading assignments, and evaluative measures
- Proctored midterm, final exams and oral reports
- Graded exams and term papers

CONTINUING EDUCATION

Trauma Focused Cognitive-Behavioral Therapy, Certificate 10/09
Medical University of Southern Carolina

- On-line training course for Trauma-Focused Cognitive-Behavioral Therapy

PROFESSIONAL ORGANIZATIONS

- American Psychological Association
- Psi Chi Honor Society
- American Psychology Law Society

ABSTRACT

Trainees who treat sexually exploited children are helpless witnesses to long term psychological, social and physical effects of physical and sexual abuse trauma narratives. Trainees and those with limited training and self-care practices are at a greater risk for vicarious traumatization. Unfortunately little attention has been given to the experience of vicarious traumatization in trainees who treat sexually exploited children. In addition, there has been limited research on self-care training resources as a primary prevention tool against vicarious traumatization. The purpose of this study was to develop a self-care PowerPoint workshop to help prevent vicarious traumatization in trainees working with sexually exploited children. The validity of the workshop was evaluated by 5 experts in the field of vicarious traumatization, self-care, working with sexually exploited children and providing supervision to trainees. Evaluators completed a 9 item questionnaire. An abbreviated content analysis was conducted and evaluators agreed that the workshop was effective, practical, and helpful to trainees. Overall the evaluators felt that the workshop provided a foundational introduction to vicarious traumatization and the teaching of self-care techniques to prevent and ameliorate vicarious traumatization symptoms. Feedback on the limitations of the workshop will be integrated and can be used in future studies aimed at piloting the workshop and further assessing its usefulness.

Chapter I: Introduction

As a result of exposure to patients' narratives of traumatic experiences, mental health professionals may be at risk of experiencing their own traumatization. Because as many as one-fifth of Americans exposed to trauma will seek assistance from mental health professionals (Betts Adams, Matto, & Harrington, 2001), there is a very high probability that therapists will be exposed to trauma narratives.

Vicarious traumatization refers to the negative ramifications of therapists' exposure to a patient's trauma (Baird & Jenkins, 2003). Symptoms of vicarious traumatization include disruption of the therapist's ability to modulate their emotional reactions, think clearly and effectively, and maintain hope for their patients' healing. Vicarious traumatization is a cumulative process not linked to a specific patient. Working with a patient who has experienced trauma can be powerful. Shock, emotional intensity, suffering, pain, depression, and anxiety are all common reactions to traumatic narratives (Geller, Madsen, & Ohrenstein, 2004). Therapists and trainees working with trauma have to manage these symptoms and often times these reactions evolve into persistent symptoms and changes in thinking patterns and perceptions of others. Although the capacity to empathize with a patient is central to psychotherapy (McCann & Pearlman, 1990), the empathic engagement with a patient's trauma leaves the therapist vulnerable to the effects of vicarious traumatization (Geller et al., 2004). Symptoms can affect the therapist initially, over time, and can be long lasting (Adams & Riggs, 2008). McCann and Pearlman identified two disruptions: the therapist's loss of the belief that the world is safe and loss of the ability to maintain trust in humanity. Additionally, the

symptoms of intrusive thoughts and the emotional reactions of anger and anxiety have also been noted (Shauben & Frazier, 1995).

Psychotherapy with children exposed to sexual violence, trauma, and exploitation has been found to cause serious disruptions within therapists' personal and cognitive schemas (Hesse, 2002; Schauben & Frazier, 1995), a common sign of vicarious traumatization. Children who are sexually exploited are victims of multiple sources of trauma and are a particularly challenging population for therapists. These children share trauma narratives including forced sexual relationships with older adults, being indebted to a pimp or captor and memories of repeated gang rapes, sex trafficking, and physical assault. Additionally, the therapist must also work through the multiple exploitation ramifications.

Children who are exploited generally exhibit a pattern of criminal behavior (Doezema, 1998). These children have less education than comparison groups and are more likely to be expelled from school. Lack of formal education places these children at a disadvantage in getting jobs when they grow up, making them more likely to stay with their pimp (Dane, 2000; Klueber, 2003). Additionally, involvement in prostitution makes children more likely to become associated with drug use as a means to dull their emotional pain and get through the act of having sexual relations with strangers (Schauer & Wheaton, 2006). Thus, sexually exploited children rarely present with a single traumatic event.

Trainees are first exposed to trauma work during practicum training in their graduate education. These therapists have been found to be more likely to experience symptoms due to their lack of formal trauma coursework, lack of adequate trauma

supervision, insufficient peer support and lack of self-care techniques (Adams & Riggs, 2008; Dutton & Rubenstein, 1995; Pearlman & Saakvitne, 1995). For the purposes of this study, psychology graduate training therapists will be referred to as trainees.

Trainees utilize empathy and compassion when working with patients exposed to sexual violence, trauma, and exploitation. This may be clinically and personally challenging for the therapists. Such a strain on a trainee's psyche requires the integration of self-care practices for personal and professional needs. The role of being a therapist requires the delicate balance of caring for the patient and themselves, this balance is crucial in preventing vicarious traumatization (Figley, 2002). Self-care practices aim at maintaining, restoring, and improving the health and well-being of trainees. Such practices are goal-centered and persons who can develop effective self-care practices draw from knowledge about their environments and themselves (Söderhamn, 2000). Therapists who are not balanced are not only putting themselves at risk, but also their patients. Therefore, it is important for trainees to develop and regularly use self-care practices.

Symptoms of vicarious traumatization have often been classified under other theoretical concepts. These concepts include burn out, countertransference, compassion fatigue, and post-traumatic stress. This study will elucidate that although symptoms have been classified under varying terms in previous literature (and literature from other fields of study, such as social work and nursing), vicarious traumatization is the most recent and for the purposes of this study, the most notably accepted and relevant theoretical concept used to describe a therapist's reaction to patients' trauma narratives.

Purpose of the Study

This author's interest in vicarious traumatization initially started as a first year doctoral student treating a 15-year-old sexually exploited adolescent who had been brutally and repeatedly raped by a family member since the age of six.

Sitting across from her, as she would talk about her trauma in vivid detail, I was acutely aware that I was having a visceral reaction to her narrative. In the moment, I was focused on providing empathic understanding and creating a warm and safe environment for her to express difficult emotions associated with her trauma. However, often after sessions, I felt a lack of competence and control as well as an increased concern about my emotional state. I also began to question the justness of the world. Throughout my tenure with this patient, I found myself forgetting to mention her during supervision, I would forget she was on my caseload and I would forget her name when it was brought to my attention. I soon came to realize that I was protecting myself from the emotional pain her narrative was evoking in me. This realization led me to seek out resources to help identify what I was experiencing and how to treat it. Fortunately, there were many resources on vicarious traumatization. However, few (if any) resources targeting graduate level trainees existed, highlighting the need for the current proposed workshop resource.

Research has suggested that trainees are more vulnerable to vicarious traumatization than experienced therapists (Adams & Riggs, 2008; Pearlman & Mac Ian, 1995). Trainees' overall vulnerability may stem from high levels of anxiety, high self-focus, limited awareness, and guilt when the patient re-experiences their trauma during the course of treatment (Dutton & Rubenstein, 1995). Trainees have also been found to

be reluctant to discuss their feelings and reactions to the traumatic material with supervisors and colleagues due to shame and a fear of appearing incompetent (Neumann & Gamble, 1995). The likelihood of experiencing symptoms is also heightened with high risk populations such as sexually exploited children.

However, despite the high risk and greater stress response associated with being a trainee (Rodolfa, Kraft, & Reiley, 1988), few studies have focused on trainees and this patient population. Research on vicarious traumatization has focused primarily on professionals rather than trainees. Professionals are defined as therapists who have had extensive training and experience working with trauma survivors (Betts Adams et al., 2001; Chrestman, 1999; Pearlman & Mac Ian, 1995). The goal of the current dissertation is to create a resource that will teach trainees about vicarious traumatization and help them maximize protective self-care techniques for preventing and managing vicarious traumatization when working with sexually exploited children.

Outcome Goals

The current study proposes to design a workshop focused on teaching trainee therapists to manage vicarious traumatization through the use of self-care practices. As a result of the workshop, trainees working with trauma narratives generated by sexually exploited children will:

1. Increase their knowledge about the onset and development of vicarious traumatization symptoms when working with trauma narratives.
2. Understand the vulnerability inherent in being a graduate trainee student and how this contributes to a higher risk of experiencing vicarious traumatization.
3. Identify and plan for the implementation of self-care techniques and appreciate the distinction between healthy and unhealthy self-care practices.

Summary

The primary focus of this dissertation is to develop a workshop to teach the self-care practices needed to prevent and manage vicarious traumatization in trainee therapists when working with sexually exploited children. Resources focusing on preventing vicarious traumatization are limited. Few (if any) resources have been developed to address the prevention of vicarious traumatization when working with sexually exploited children. The present study aims at developing a resource that utilizes well established self-care strategies and practices and applies them to a unique patient and therapist population.

Chapter II: Review of the Literature

The Study of Trauma

This review of the literature will provide a brief historical review of the study of trauma and conceptual clarity regarding *vicarious traumatization* by exploring the impact of reported trauma on therapists. The Psych Info and Scopus databases were utilized to review the literature on vicarious trauma among training therapists. Primary prevention through self-care techniques and identification of existing programs and materials were also researched. Key words included vicarious trauma, self-care, self-care techniques, and training therapists. The Psych Info database contains references from 1989 to present. The Scopus database contains references from 1990 to present. The search included, but was not limited to the following journals: *Training and Education in Professional Psychology*, *Journal of Child Sexual Abuse*, *Stress Medicine*, *Clinical Social Work Journal*, *Psychology of Women Quarterly*, *American Psychologist*, *Medical Teacher*, *Violence and Victims*, *British Journal of Guidance and Counseling*, *Psychotherapy in Practice*, , *Journal of Counseling and Development*, *Journal of Loss and Trauma*, *Families in Society*, *Journal of Traumatic Stress*, and *Professional Psychology: Research and Practice*. In particular, review explores how vicarious traumatization is applicable to trainee therapists working with sexually exploited children. Finally, the use of self-care techniques to cope with patient's trauma will be highlighted as a preventative measure against vicarious traumatization.

Trauma exposure is prevalent, may be pervasive, and can have potentially devastating effects on an individual. The first indications of the psychological impact of trauma came from reactions expressed by soldiers following active duty. During World

War I (WWI), various clinical syndromes expressed by soldiers became associated with combat duty. For example, increased air pressure from exploding shells on the battlefields led to documented physiological damage precipitating numerous symptoms that later were labeled as *shell shock* by the end of the war. Further study of symptoms came to be identified as *war neurosis* (The National Center for Post Traumatic Stress Disorder, 2012). By WWII, the number of men being discharged from service for psychiatric reasons exceeded the total number of men being newly drafted. During the Korean War, symptoms experienced by soldiers were classified as *combat stress*. During the Vietnam War, symptoms expressed by soldiers did not resemble the symptoms typically categorized as combat stress. These soldiers began to exhibit intense anxiety, depression, battle dreams, problems in interpersonal relationships, and explosive aggressive anger. Soldiers expressed these symptoms long after their combat role had ceased. With the end of American troop involvement in the Vietnam War in 1973, the number of veterans presenting with combat stress symptoms began to increase tremendously. However, what was more curious was that during this time period, non-veterans experiencing other traumatic situations such as plane crashes, natural disasters, and fires were exhibiting similar symptoms as combat veterans. Following research by veteran's task forces, the DSM-III was published with a new category: Post Traumatic Stress Disorder or PTSD (Everly & Lating, 1995; Figley, 1995).

Although PTSD is not the focus of the present study, it is the most researched response to trauma. The field of trauma has grown since the introduction of the PTSD diagnostic category in the Diagnostic and Statistical Manual of Mental Disorders, 3rd edition (DSM-III) (Everly & Lating, 1995; Figley, 1995). DSM-IV furthered this

diagnosis by indicating that the indirect knowledge of another person's traumatic experiences can also be traumatizing. Emotions expressed following a trauma exposure may reach clinical levels, causing PTSD. PTSD involves the exposure to a situation where an individual is confronted with an actual or threatened death or serious injury or a threat to self or others' physical well-being (American Psychiatric Association, 2000). The varying degree to which post traumatic responses are expressed depends on a multitude of vulnerability factors, which can lead to the development of psychological diagnosis. Biological make-up, demographic variables, previous trauma history, objective and subjective severity of trauma, dissociative experiences during the event and psychiatric history are risk factors that have been found to be associated with PTSD (Aker, Onen, & Karakilic, 2008).

Research has found that emotional responses to trauma events may play a role in "trauma related psychopathology" (Amstadter & Vernon, 2008, p. 392). Traumatic events include natural disasters such as tornadoes, hurricanes, earthquakes, floods and man-made trauma such as war, concentration camp experience, torture, and physical and sexual abuse. Each of these situations may engender similar or different emotions that could be defined as a traumatic response; therefore, the understanding of emotions expressed and the prevalence rate of emotional pathology by varying types of traumatic events is particularly important. Sexual assault, for example, is associated with a high prevalence rate of emotional pathology with sexual assault victims frequently reporting high levels of emotions post trauma followed by physical assault and injury groups.

It seems reasonable to postulate that different types of traumatic events typically lead to different patterns of emotion following the event. Amstadter and Vernon (2008)

predicted that emotional responses during trauma exposure are likely related to concerns of survival; whereas, Frijda and Lazarus, as cited in Amstadter and Vernon, stated that post traumatic responses allow the individual to make appraisals and moral judgments of the event.

Trauma work is often slow and overwhelming. Many therapists working with these patients face varying emotional reactions, initial failures and frustrations as they work toward success and transformation (Saakvitne & Pearlman, 1996). Although shame and guilt are often used interchangeably, so for the purposes of this dissertation, the definitions of Amstadter and Vernon (2008) will be used: “[shame refers to the] self-conscious moral emotion resulting from a negative appraisal of one’s self, whereas guilt is thought to result from a negative appraisal of one’s behavior” (p. 393). Shame and guilt are commonly expressed emotions post trauma especially with sexual assault victims. Post trauma, sexual assault victims begin to make appraisals of their actions, style of dress, and decision making. These appraisals may allow the victim to feel guilty about their perceived role in the assault and the victim may begin to question how she could not stop the assault. Concurrently, shame is experienced because the assault has taken away the victim’s perceived sense of dignity and self-worth. Overwhelmingly, shame comes from the notion that victims are forever changed.

Therapists are also vulnerable to experiencing shame. However, this experience is based on different aspects. Therapists may begin to feel ashamed that they have let a patient’s trauma narrative impact them. Additionally, therapists may also experience guilt for leading the patient to re-experiencing the trauma; they may feel guilt for not feeling

empathy for the patient or for feeling too much empathy. Hence, therapists like victims, experience these emotions based on negative appraisals of their respective behavior.

Anger is another commonly expressed trauma reaction. High levels of anger have also been reported to occur during trauma. Anger responses usually are in response to an individual feeling defeated by a purposeful and powerful outside source (Amstadter & Vernon, 2008). Strong post trauma anger has been reported among combat veterans and sexual assault victims. Anger within sexual assault victims can be linked to an insatiable loss of control, overwhelming feelings of vulnerability, and lack of safety and trust in the future and within intimate partnerships.

Anger expressed in therapists can be geared toward the patient for allowing themselves to be victimized; it may be directed at the situation or trauma event that has led the patient to experience the pain. It could be directed toward the patients' support system that is not being supportive and ultimately it can be directed at the therapist's lack of professional training and skills to help the patient get through their trauma processing.

Sadness expressed during trauma exposure is typically associated with an appraisal of loss (Amstadter & Vernon, 2008). The concept of trauma is interlinked with the concept of loss, which is a hallmark of trauma (Pearlman & Saakvtine, 1995). Loss includes but is not limited to the loss of innocence (as with child sexual abuse), loss of dignity and safety (as with sexual exploitation), loss of a loved one (as with death or abandonment) and loss of control (as with not knowing why the trauma happened).

Working with trauma and the inherent loss, therapists are forced to confront the realities of loss; beliefs about safety, control, and attachment (Pearlman & Saakvtine, 1995). Overall, sadness in sexual assault victims can be attributed to feelings of loss of

innocence, a permanent change in the individual's sense of self, and an inability to feel empowered interpersonally and with others. Although sadness is the hallmark of depression, and high levels of depression have been linked to trauma exposure (Amstadter & Vernon, 2008), sadness is rarely studied.

Finally fear has also been seen as the central emotion following a traumatic experience. Fear arises during a traumatic event as it is needed to assess possible harm. Amstadler and Vernon (2008) postulated that fear will be the most elevated emotion during a traumatic event during the immediate threat of harm and then lowered in the time period following trauma exposure.

Fear response encourages the biological systems of an individual in threat of harm to survive. Although fear is highest during the trauma, fear can still be expressed in trauma survivors particularly in situations that are reminiscent of the initial trauma scene. Emotions that are experienced post traumas are typically negative. Although a variety of emotional responses are elicited during and after a traumatic exposure, few comparisons of emotional responses among varying trauma events have been conducted (Amstadter & Vernon, 2008).

As sexual assault victims present with the highest amount of emotional reactions post trauma, it is reasonable to expect these narratives to correlate to eliciting emotional reactions from therapists. Empathic engagement with the patient makes the therapist vulnerable to intense overwhelming feelings, which can lead to a disruption in their psyche. Reactions to these narratives can vary tremendously; however, the five most researched traumatic eliciting emotions (i.e., shame, guilt anger, sadness, fear) appear to

be universal in all helping professionals. It is expected that emotional responding will vary based on trauma type.

The recent surge of *evidence supported treatment* requires patients to re-live their trauma by disclosing their trauma repeatedly with their therapist. Evidence supported treatment refers to clearly specified psychological treatments shown to be efficacious in controlled research with a delineated population. Evidence based practices are considered the standard of care when treating traumatized patients. Unfortunately, these proposed therapies almost inevitably require the patient to relive the trauma and process the trauma and affect surrounding the situation so the patient can begin to move and grow beyond it. This constant re-experiencing places the patient in a vulnerable position in relation to their emotional reactions.

Concurrently, providing psychotherapy is personally and professionally challenging and can have a negative impact on professionals in the field (Kadambi & Ennis, 2004; Norcross, 2000). Research has suggested therapists who work with traumatized patients are at a higher level of risk for developing vicarious traumatization symptoms. The therapist must remain as a stable force and not react to the trauma material. Throughout this process, the therapist must provide a warm, safe, and empathic environment for the patient while disregarding their own affect. This process can further be impacted by shocking accounts of rape, childhood abuse, and torture (Figley, 1995; Herman, 1997; Neumann & Gamble, 1995; Pearlman & Saakvine, 1995), which has been found to affect and elicit change in the therapist's worldview; this will be discussed in subsequent sections.

Being subject to an individual's intimate details of their trauma vulnerability can have a particularly impactful affect on a trainee who enters the treatment relationship with uncertainty and lack of training. Despite abundance of literature on the impact of patient trauma on the therapist and the therapy, the experience of vicarious traumatization for trainees as a specific subgroup of therapists has not been examined exclusively. Although DSM-IV furthered the PTSD diagnosis by including the indirect knowledge of another person's traumatic experiences, this still does not fully capture what therapists experience when working with trauma narratives. PTSD differs from vicarious traumatization through the clinical levels of symptoms experienced by therapists. PTSD develops following exposure to an extreme traumatic stress involving direct personal experience of an event involving threatened death, actual or threatened serious injury, threat to one's physical integrity, or witnessing such events to the physical integrity of another person, or learning about unexpected or violent death (American Psychiatric Association, 2000). Although, the two concepts of PTSD and vicarious traumatization are similar, there are significant differences. Whereas vicarious traumatization can result from a single patient's traumatic narrative or a combination of multiple patients' trauma narrative, the PTSD diagnosis does not differentiate single episode trauma from chronic trauma (Herman, 1997). Additionally, vicarious traumatization results from having an emotional and often physical reaction to a patient's trauma narrative. PTSD varies from this description and as such does not account for such effects and it not suitable for describing these emotional experiences.

Treatment Options

During the Korean War, the approach to combat stress became pragmatic; individual breakdown in combat effectiveness was dealt with in a very situational manner. Clinicians provided immediate on-site treatment to the affected individual, always with the expectation of returning to combat (The National Center for Post Traumatic Stress Disorder, 2012). Although trauma treatment grew out of a need to have soldiers return to combat, the evolution of trauma symptoms following a traumatic experience has required the field of psychology to develop appropriate treatment protocols for all individuals experiencing trauma reactions so that they may also return to their functional baseline. Varying treatment modalities such as cognitive behavioral and psychodynamic therapy have been utilized to treat trauma; however, for purposes of this study, only evidence-based treatment will be discussed.

The importance of understanding and implementing evidence based treatment is taught early on in training programs. The American Psychological Association (APA) has developed competency benchmarks to measure trainee progress and assess readiness for independent practice. An integral part of these benchmarks is the measurement of trainees' foundational knowledge of evidence based treatment. These benchmarks also stress the implementation of evidence-based treatment that takes into account empirical support, clinical judgment and clinical diversity (Fouad et al., 2009). Although the mastery of these techniques is celebrated, evidenced-based treatment of trauma requires special training and education, which most trainees do not receive.

Trauma Focused-Cognitive Behavioral Therapy (TF-CBT). TF-CBT is a component-based treatment model incorporating trauma-sensitive interventions with

cognitive behavioral, family, and humanistic principles and techniques. It is a conjoint child and parent psychotherapy approach for children and adolescents who are experiencing emotional and behavioral difficulties related to traumatic life events (Cohen, Mannarino, Berliner, & Deblinger, 2000). With this model, children and their parents learn new skills to process thoughts and feelings related to these events. Additionally, the therapist enhances safety, growth, parenting skills and family communication. An important step to this treatment is the teaching of affective expression regulation within the patient and teaching the identification of varying levels of emotional intensity and strategies for expressing these emotions appropriately.

The goal with this treatment is that the patient will be able to identify unhelpful cognitions about the traumatic events and reduce the feelings associated with the trauma exposure. A therapist facilitates this goal achievement by encouraging the patient to describe in details the trauma, the thoughts, and feelings associated to the trauma. In exploring traumatic experiences, children often become visibly upset and uncomfortable. This is a challenging process. The therapist must help control intrusive and upsetting trauma-related imagery for the patient as well as maintaining their own composure. This leaves the therapist unable to shield themselves from the patients' trauma which itself is traumatic.

Eye Movement Desensitization and Reprocessing (EMDR). EMDR is an integrative psychotherapeutic approach that emphasizes the role of the brain's information processing system. The foundational theoretical belief is that the information processing system of an individual helps to ameliorate the somatic and psychological consequences of distressing events. Non organic emotional problems are conceptualized

as the result of inappropriately processed memories of disturbing or traumatic experiences. EMDR is an eight-phase treatment, focusing on the memories underlying current problems. EMDR includes the use of bilateral physical stimulation, such as side-to-side eye movements, alternating hand taps, or alternating auditory tones while the person undergoing treatment is mentally focusing on aspects of various life experiences (Shapiro & Solomon, 2008). EMDR therapy involves accessing disturbing memories that are relevant to present psychological problems. As with TF-CBT, EMDR requires that the patient access dysfunctional stored experiences related to the trauma(s). This exposure, although reparative to the patient, may become dysfunctional to the therapist. This dysfunction leads to vicarious traumatization reactions. These reactions are common for therapists treating trauma survivors. However, trauma literature most commonly focuses on trauma survivors (i.e. those who are directly impacted) and not on those who treat trauma.

The Evolution of Vicarious Traumatization

The emotional, cognitive, and physical consequences of providing professional services to trauma survivors have been addressed in the literature over the past decade. Various conceptual views have been developed to explain the experience of symptoms incurred when treating trauma. Burnout was the first conceptual understanding of emotions elicited from work experiences. Figley (1995) coined the term *compassion fatigue* and secondary trauma, while Herman (1997) referred to the response as traumatic countertransference. Research has now more accurately conceptualized this symptomatology as vicarious traumatization.

Burnout. Burnout was the first conceptual understanding of the impairment a profession can have on an individual level. Burnout was coined by Freudenberger (1975), a German-born American psychologist, but the major development grew out of the work of Maslach (Maslach, Schaufeli, & Leiter, 2001). The dictionary defines burnout as “to fail, wear out or become exhausted by making excessive demands on energy, strength or resources” (Maslach et al., 2001, p. 397). It is a prolonged response to “chronic and emotional interpersonal stressors on the job” (p. 397). Burnout is composed of three dimensions: exhaustion, cynicism, and inefficacy. Exhaustion consists of emotional, physical, and psychological components, including depletion, wearing out, loss of energy, fatigue and debilitation. Someone suffering from exhaustion may find themselves too tired to engage in extra work at home, loss of desire to attend social events, and physical ailments. Psychological exhaustion includes the loss of interest, loss of spirit, and loss of trust. This emotional exhaustion includes letting the dynamics within the professional world affect the individual personally. Such as individuals experiencing burnout may become visibly upset at their boss and coworkers and negative evaluations of job performance may cause the individual to sit in their office crying or not attending to work responsibilities.

The second dimension of burnout involves cynicism. This refers to the internal psychological experience involving feelings, attitudes, motives and expectations. The individual begins to experience a negative shift when interacting with others. This can include loss of idealism and realism. Aspects of the employment start to cause a strain on the individual’s view of job satisfaction. The individual suffering from burnout may

begin to feel negatively toward co-workers and upper management and individuals may become cynical about the companies mission statement.

The final dimension involves inefficiency including a negative response toward oneself and personal accomplishments. This can be encompassed by the physical and emotional state of depression, an inability to cope, reduced capability, withdrawal and low morale. Additionally, feelings of low self-esteem and feelings of being a failure are also expressed. Overall burnout becomes a negative experience for the individual in that it concerns daily distress and discomfort for the individual (Maslach et al., 2001).

The literature on burnout has not reached a consensus regarding the direct causes and results; however, there are some major themes. Burnout usually focuses on contact with others and factors that make contact emotionally stressful. Burnout can occur “in all occupations, for anyone at any level” (Maslach et al., 2001, p. 397). However, burnout is not appropriate for accounting for all the hallmark symptoms experienced by professionals treating trauma populations. Vicarious traumatization differs from burnout in that it specifically involves exposure to emotionally trying images and descriptions of suffering (McCann & Pearlman, 1999). Additionally, although burnout has the implication of not being remedied once it has occurred, positive aspects about the job may ameliorate the symptoms of burnout (Fahy, 2007). On the contrary, positive aspects about the job in a person suffering from vicarious traumatization will have very little impact in changing their symptoms. Thus burnout can be seen as simply job stress, rather than trauma to a trainees psyche.

Despite these contrasts, similarities exist within these two concepts; burnout and vicarious traumatization both result in physical, emotional and behavioral symptoms,

which can cause interpersonal and work related difficulties. Of note, work related difficulties in trainees can lead to a decline in patient care due to a decrease in concern and esteem for the patient (Raquelpaw & Miller, 1989). The main tenant regarding how burnout varies from vicarious traumatization lies in the manifestation of symptoms. Burnout is the result of general psychological stress of working with difficult patients or within difficult situations (Figley, 1995) versus vicarious traumatization, which is the traumatic reaction to specific patient-presented information. Thus it is not due to working with difficult populations, but rather it is working with traumatic history from a traumatic population.

Additionally and more importantly, vicarious traumatization typically occurs when working with trauma survivors; whereas, burnout can occur within any profession. Burnout also does not lead the individual to make lasting changes in the domains of trust, intimacy, safety concerns, feelings of control, and esteem needs (Trippany, Kress, & Wilcoxon, 2004), which will be elaborate upon in subsequent sections. Chrestman (1999) also identified the experience of intrusive imagery as foundational to vicarious traumatization which is absent from burnout.

Burnout was the first conceptual understanding of reactions experienced by individuals due to work hazards and this has informed the construction of all other conceptual theories. Individuals in helper roles were beginning to experience deeper emotional reactions that could not possibly be simply attributed to burnout. To account for this gap that burnout permitted, traumatic countertransference was developed to understand and the depth in pain that therapists were experiencing when treating patients.

Thus, the literature identified traumatic counter transference as a more thorough explanation.

Traumatic countertransference. The relationship between a therapist's psychic connection and emotional pull toward the patient within the therapeutic relationship has been identified in the literature as countertransference. Countertransference is linked to psychoanalytic thought and it refers to the emotions displayed, behaviors exhibited, and information expressed by the therapist (Neumann & Gamble, 1995). It refers to the evoked responses by the therapist in regard to information provided by the patient. For example, consider a therapist is currently dealing with the significant loss of their father passing away. As a result they may unconsciously place feelings of love and loss onto their elderly patient who triggers for the therapist the memory of their father. This can stem from behaviors and emotions inadvertently displayed by the patient. Thus these evoked emotions are referred to as countertransference. Although attributing therapist reactions to traumatic counter transference was the first step in addressing the emotions expressed by an individual in a helper role, it did not fully grasp the full extent of what therapists treating trauma narratives were experiencing. More specifically, countertransference taps into something similar or related that is occurring in the therapist's private life (Figley, 1995), of which the patient would be unaware. Symptoms being expressed by therapists were not exclusively due to factors relative to the therapist and as such could not be attributed to traumatic countertransference.

Vicarious traumatization is the cumulative effect of hearing about another person's trauma, which does not need to be linked to anything specific to the therapist's personal life (Kanter, 2007). However, the differences between both concepts are not as

distinct. Sometimes the reactions a trainee experiences can have an element of their personal life intertwined, such as the trainee being a trauma survivor. Figley (1995) nevertheless made the distinction that vicarious traumatization does not necessarily equate to the experience of countertransference. But the related disruptions in cognitive systems inherent with vicarious traumatization can become a part of the trainee's unconscious material, which may then become available to countertransference reactions (Saakvitne & Pearlman, 1996). Another important distinction is that countertransference typically involves the trainee's experiences regarding the therapeutic work. Vicarious traumatization, on the other hand, can transcend the therapeutic session interjecting in every aspect of the trainee's life (Trippany et al., 2004). Because traumatic countertransference is limited to the reactions experienced by the patient within the therapeutic setting and does not permeate the therapist's private life, it fell short of capturing the reactions experienced by therapists. Thus secondary traumatic stress was the next concept developed not only to understand the reactions experienced by therapists, but more specifically, it helped elucidate the changes in world view therapists were encountering.

Secondary traumatic stress/compassion fatigue. Secondary traumatic stress (STS) was coined by Figley (1995) to account for the limitations of the traumatic countertransference concept. STS address the natural behaviors and emotions resulting from knowing about a traumatizing event. It develops in the person close to the victim through hearing about the trauma. STS is not directly linked to helper professionals but to anyone privy to hearing about the situation. Therapists who have a greater capacity for feeling and expressing emotions seem to be at a greater risk for STS. Figley viewed STS

as a disorder (i.e., STSD) similar to that of PTSD. STSD develops when STS is left untreated.

Cerney (1995) identified symptoms of STS to mirror those of PTSD. These include: re-experiencing the patient's traumatic event through increased hyperarousal, difficulties with sleep and concentration, agitation, irritability, avoidance, intrusive thoughts and images, and physiological reactivity to patient material (Figley, 1995). Although similar to PTSD, the main distinction between the two is the person who is immediately and overtly exposed to the traumatic material first hand (i.e., witnessing) versus who hears about the traumatic material or witnesses the internal struggle and external reactions from the individual (i.e., the therapist, close friend, family member). STS differs from vicarious traumatization in that it is open to any significant relationship that is a system of support (Cerney, 1995); vicarious traumatization is restricted to the helping professional.

For instance, a patient in treatment working through a history of sexual abuse puts the helping professional, through the inherent act of conducting therapy, in a vulnerable position. Through the effect of listening to this trauma, vicarious traumatization can result. The helping professional in turn returns to their internal support system to gain support. The significant other is vulnerable to experience STS, hence the "same contagion effect can be transmuted to the support system" (Figley, 1993, p. 1). As a direct result from STS, the helping professional may demonstrate an inability to relate within their personal life causing them to withdraw emotionally and become physically unavailable (Cerney, 1995, p. 140). Dutton and Rubinstein (1995) stated the distancing amongst the helping professional within their private life may manifest from the

inaccurate belief that no one could understand nor believe the intense distress their patient material is causing within them. Figley (1993) initially named these reactions as STS. He later renamed it compassion fatigue.

Figley (1993) introduced the concept compassion fatigue, which he defined as the stress that is connected with exposure to the sufferer. This was later expanded to include the stress an individual experiences as a direct result of patients suffering. Compassion fatigue results from a combination of a therapist's compassion and altruism. For example, a therapist working with a suffering patient may feel a moral obligation to provide help to the patient despite the emotional reactions this may elicit in the therapist. Compassion fatigue can be further aggravated by a lack of support at work and within the individual's home. Radey and Figley (2007) identified four major factors contributing to compassion fatigue. They included poor self-care, inability or refusal to control work stressors, lack of satisfaction from the work, and previous unresolved trauma. These factors can shed light as to why some therapists affected by compassion fatigue can overcome it while others succumb to it. Compassion fatigue has also been seen to encompass stressors that devalue the helping professional as a whole (Bride & Figley, 2007; Fahy, 2007).

Pearlman and Mac Ian (1995) have defined vicarious traumatization as the *cumulative* effects on a therapist working with trauma victims whereas Conrad and Perry (2000) identified the possibility of experiencing STS from a single traumatic experience. STS and more recently compassion fatigue built upon burnout and traumatic countertransference literature to address the gap regarding emotional reactions experienced by the therapist. Although these concepts were instrumental in highlighting

the therapist as a vulnerable entity within the therapeutic relationship, it also made the distinction that anyone privy to traumatic material can be affected. The inclusion of a therapist's support system as being vulnerable assumes that the therapist experiencing these emotional reactions is utilizing the support system and sharing their emotional experiences which are not always the case. Vicarious traumatization identifies emotional reactions as specific to traumatic material presented by the patient and can only be experienced by the therapist treating the patient.

Vicarious traumatization as a construct provides more conceptual clarity and provides a more sophisticated and complex explanation of therapist's reactions to patient's trauma (Trippany et al., 2004). More importantly, the concept of vicarious traumatization has implications for preventing it in trainees. Thus for purposes of this dissertation, vicarious traumatization is seen as the more current and accurate understanding of any distress and impairment that results from working in a helping role with trauma victims. Because vicarious traumatization is grounded in trauma theory and the more complete conceptual understanding of reactions expressed in therapists, it will be discussed at length in the following section.

Vicarious Traumatization

The term vicarious traumatization was coined by McCann and Pearlman in 1990 to describe the negative changes in clinicians who work with survivors, including disturbances in their sense of self, spiritual worldview, interpersonal relationships, and behavior (Chrestman, 1999; Freeman-Longo, 1997; Kassam-Adams, 1995). Vicarious traumatization developed from and clearly is grounded in trauma theory. It refers to a

process not just an event. It includes strong reactions that are pervasive and cumulative across patients, time, and in response to patient's life experience.

Generally the effects of vicarious traumatization are not viewed as pathological but a common effect of working with trauma narratives (Chrestman, 1999; McCann & Colletti, 1994; Pearlman & Mac Ian, 1995; Pearlman & Saakvitne, 1995). The symptoms of vicarious traumatization result from exposure from patients' traumatic experiences and can include the loss or disruptions in safety, trust, esteem, intimacy, and control regarding both self and others (Trippany et al., 2004). These symptoms occur as a result of listening empathically over time and can have a cumulative pervasive and negative effect on the therapist's identity, world view, psychological needs, beliefs and memory system (Baird & Jenkins, 2003; Figley 1995; McCann & Pearlman, 1990; Pearlman & Mac Ian, 1995; Sexton, 1999). As a result of this exposure, therapists are changed. The patients' vivid and often graphic descriptions of past victimization can precipitate vicarious traumatization.

Effects include intrusive imagery (e.g., flashbacks, visual and sensory images), avoidance, emotional numbing, hypervigilance, decreased self esteem, and decreased trust in their own competence (VanDeusen & Way, 2006). Some symptoms like intrusive imagery tend to occur earlier in the therapists interaction with the traumatized patient (Pearlman & Saakvitne, 1995). Other effects include disruptive cognitive schemas such as experiencing decreased trust and viewing the world as unsafe (Steed & Downing, 1998). McCann and Pearlman (1990) hypothesized that traumatic experience can cause serious disruptions of certain aspects of a person's schema. Disrupted cognitions about the self tend to occur later on in treatment. These disruptions refer to the clinician's

inability to trust their instincts. Working with traumatized patients may leave the therapist susceptible to exhibiting a diminished sense of self-competency and self-worth (Cerney, 1995; Way, VanDeusen, & Cottrell, 2007).

Empathic pain coupled with slow transformation results in vicarious traumatization; however, the very nature of the psychotherapist's role is such that it puts therapists at a particular emotional risk (Canfield, 2005). Therapists' vulnerability to vicarious traumatization is unavoidable when the therapists' work involves empathic engagement with the patients' traumatic material (Adams & Riggs, 2008). McCann and Pearlman (1990) proposed that a therapist's cognitive world can be altered by verbal exposure to the patient's traumatic material. For instance, as the patient is discussing instances of rape and assault by family members, the therapist must come to terms with the reality that being a part of a family does not automatically provide protection. The realization of this reality can alter the way the therapist may now perceive how other families relate to each other. Thus, the construct is forever altered, yet therapists do not assign blame to the patient for the experience of traumatization. Rather, vicarious traumatization is viewed as an occupational hazard, an inevitable effect of trauma work. Most therapists experiencing such effects may mistakenly classify these symptoms as burnout. They may consider it as an inescapable effect of trauma work. Rather it is "a human consequence of knowing, caring, and facing the reality of trauma" (Saakvitne & Pearlman, 1996, p. 17).

While it is crucial and often essential for the patient to share and explore details surrounding the trauma, the therapist is adversely affected. Therapists carry these images with them, integrating them into their own psyche. Thus, what is enacted in the room is

the therapists' inability to shield themselves from such brutal images and an inability to protect the patient from the events they have already experienced. This leaves the therapist as a "helpless witness to trauma," which itself is traumatic (Vissing, Straus, Gelles, & Harrop, 1991, p. 151).

Baird and Jenkins (2003) suggested that being exposed to traumatic material can produce trauma reactions in the therapist, yet both qualitative and quantitative studies found that the symptoms exhibited by the therapists did not meet diagnostic classification; therefore, further research into vicarious traumatization is warranted. Current research, however, is limited. Evidence for the concept of vicarious traumatization is difficult to establish, but qualitative studies have provided results supporting the existence and effects of vicarious traumatization (Sabin-Farrell & Turpin, 2003).

One of the most referenced studies in the literature on vicarious traumatization is Pearlman and Mac Ian (1995). Their research focused on the assessment of cognitive schemas and general distress in relation to trauma work, avoidant and intrusive symptoms. Results of this study found that therapists with personal trauma histories and less-supervised therapists are more likely to have disturbed views of the world, which may impact the way new information is incorporated into understanding and viewing future events.

Having a personal abuse history has been found to be a risk factor for vicarious traumatization (Schauben & Frazier, 1995; VanDeusen & Way, 2006). Other risk factors linked to experiencing vicarious traumatization symptoms include negative coping strategies (Way, VanDeusen, Martin, Applegate, & Jandle, 2004), higher percentage of

trauma patients in the caseload (Schauben & Frazier, 1995), and being a novice to the field of trauma (VanDeusen & Way, 2006; Way et al., 2004). However, research has also suggested that vicarious traumatization can be experienced when working with any type of population not necessarily only trauma survivors (Kadambi & Truscott, 2004).

Bride (2004) argued that novice therapists are not equipped with the same adequate coping strategies as more seasoned therapists and that they reported more symptomatology. Baird and Jenkins (2003) research also suggested that more educated therapists experience less vicarious traumatization due to more opportunity for training experiences. Novice therapists presumably have less experience and training; yet, the study found that if more seasoned therapists did not utilize appropriate coping strategies, then their rates could also be higher. As a seasoned professional within this field, the therapist is more inclined to carry a higher amount of traumatized patients on their caseload, which increases their risk of becoming vicariously traumatized.

Chrestman (1999) conducted a qualitative study that identified the situation where case loads with less trauma cases created a mediating factor against the experience of vicarious traumatization symptoms. Similarly, Brady, Guy, Poelstra, and Brokaw (1999) found that higher exposure to sexual abuse history was a predictive factor to the experience of vicarious traumatization symptoms. Norcross and Guy (2007) also found higher exposure to traumatic narratives were a predictive factor in vicarious traumatization symptomatology. In this study, therapists' caseloads were half endorsed child sexual abuse and rape and endorsed experiencing intrusive and avoidant symptoms.

Themes found in qualitative studies focus on the theoretical factors contributing to vicarious traumatization. This includes previously stated aspects of the patient, the

therapist, and the trauma narrative. The most commonly mentioned factor is the exposure to the traumatic narrative itself.

Vicarious Traumatization Narratives

Therapists working with traumatized patients can have a personal reaction to the traumatic narrative (Iliffe & Steed, 2000; Schauben & Frazier, 1995; Steed & Downing, 1998). This gives therapists an opportunity to experience horrors of the world that they may never have had the opportunity to know; however, this exposure can alter therapists' sense of safety (Pearlman & Saakvitne, 1995). The following scenarios, based on anecdotal information and altered to protect the identities of the therapists and clients, demonstrate this phenomenon:

A trainee who, by her own admission, led a "sheltered life," struggled to reconcile her childhood experience of financial privilege and physical safety with that of her patient's early childhood sexual trauma and exploitation. The trainee is embarrassed to share her own background with other trainees and with the supervisor for fear of being perceived as naïve and incompetent. Thus, she proceeded to treat the patient and harbors feelings of shame and guilt associated with the profound differences between herself and her patient.

A sexually exploited child unexpectedly shares in detail her recent rape by a group of men. The trainee is able to listen supportively and attend to the patient. The next day, the trainee is notified that the minor left her current residence and returned to prostitution. The trainee expresses feelings of hopelessness and helplessness, accompanied by self-blame, wondering if there was more that could have been done to help the patient.

A trainee requests to meet with her supervisor immediately after her first session with a sexually exploited child. The trainee is tearful and visibly upset. She expresses that she does not wish to continue to work with this patient population. She explains that hearing about the patient's misfortunes is immensely difficult because it makes the trainee "question everything she knows about the world."

After working with several sexually exploited children, a trainee expresses a desire to adopt one of the children she is working with. Upon further exploration in supervision, the trainee recognizes that listening to repeated stories of sexual

exploitation and violence toward children has induced feelings of anger about social injustice and a desire to take drastic steps to mend a disturbing situation by rescuing one particular child from sexual exploitation.

Iliffe and Steed (2000) noted that the symptoms therapists experience may often be overlooked. Rasmussen (2005) suggested that trauma work can elicit affect in the therapist that can be confusing and may hinder the therapeutic work. Empathic engagement leaves the therapist vulnerable to symptom development as does the lack of support and training for treating trauma patients (Pearlman & Saakvitne, 1995).

Theoretical Models of Vicarious Traumatization

Establishing a conceptual understanding of how vicarious traumatization arises is crucial for the development of preventative measures. Although not initially created to understand vicarious traumatization, the Constructivist Self Developmental Theory (CSDT) has contributed to an appreciation of it (Pearlman, 1997). The following section will provide an overview of several theories regarding the etiology of vicarious traumatization symptoms.

CSDT view of vicarious traumatization. CSDT is a theoretical framework combining psychoanalytic theory with theories of social cognition (Pearlmann & Saakvitne, 1995). It focuses on the interaction between the person and the situation, emphasizing the self in development (McCann & Pearlman, 1990). According to McCann and Pearlman, CSDT forms the foundation for clinical work with survivors and can be used to describe how trauma effects develop. CSDT assumes symptoms are strategies that have been adopted in order to manage one's reactions to trauma (Pearlmann & Saakvitne, 1995). Through this lens, symptoms are never viewed as pathological. In the event of trauma, CSDT states the five main aspects of a person's self

are disturbed regardless of whether a trauma occurs once (i.e., car accident) or multiple times (i.e., sexual abuse). These five aspects include (a) frame of reference, (b) self capacities, (c) ego resources, (d) psychological needs, (e) related cognitive schemas, and (f) the memory system.

Frame of reference refers to an “individual’s world view, identity, and spirituality” (Pearlmann & Saakvitne, 1995, p. 61) and is integral when perceiving and interpreting life experiences. This includes understanding oneself and interpreting an experience, the world around the individual, and her or his personal relationships. A world view includes a person’s broadest belief about the world, which includes moral principles and life philosophy. Amstadter and Vernon (2008) described the world view as including the “injustice or justice of life’s occurrences, randomness or predictability of life events, and overarching beliefs about the benevolence or malevolence of the world” (p. 10).

Essentially the frame of reference refers to the skills, meanings, and thoughts that the individual has developed over time and uses to help navigate through daily life occurrences. Experiences are constantly adding to the individuals frame of reference construct. For therapists, hearing a patient describe chronic physical and sexual abuse may result in alterations to their frame of reference. The therapist may change her worldview from a just and safe world to a dangerous and unfair world. For trainees this can result in similar disruptions, including changing how the trainee views their work impacting the patient. A change in world view may cause the trainee to see the therapeutic work as fruitless since the patient is living in an unjust world and will inevitably be harmed again. This can lead the trainee to have diminished hope and

optimism for the treatment outcome hindering the therapeutic process and the patient's progress.

Identity refers to an individual's sense of self across varying cognitive, physical, and emotional states. This means that the individual has a constant internal sense of self that has been developed over time much like the frame of reference. However, the difference lies in that an individual's identity dictates how that person will react in any given situation. It incorporates a person's inner experience of self and the varying characteristic feeling states of themselves and the world (Pearlman & Saakvitne, 1995). Identity forms a self narrative incorporating a perception of oneself and in relation to other people. A change in how therapists view themselves can cause them to experience inner turmoil and question their role as a helping professional.

For a trainee, this may have additional ramifications. A trainee affected by the patient's trauma narrative will integrate the pain and emotional instability displayed by the patient into their own psyche. What results is an instable trainee trying to survive in a particularly competitive graduate school environment. The functional stability of the trainee will inevitably be challenged causing more stress and more disruption in the trainee's personal and professional life. For example, the instability experienced by the trainee could result in abandoning of relationships and isolation from their family ultimately demolishing their support system which is crucial in providing a buffer for additional professional stress.

The final tenet of worldview that is affected is spirituality. Spirituality is the deepest values and meanings by which people live. Utilizing spirituality, a therapist is able to hold meaning in life and is able to create a connection between an orientation to

the future and a relation to nonmaterial aspects of existence (Pearlmann & Saakvitne, 1995). For example, when a trainee is treating a sexually exploited child, the trainee is forced to sit with acts of violence and dehumanization. The child's innocence is forever lost and the trainee must make sense of this reality. Having faith in the idea that *good things happen to good people* is forever altered when a therapist must come to terms with a sexually violated and exploited child. Spirituality enables a person to discover the essence of his/her being. A constant barrage of trauma narratives can cause therapists to question their sense of spirituality especially in the face of such cruel and dehumanizing violation of others. An altered frame of reference results in diminishing self capacities adding increased stress levels and disorientation for the therapist (Pearlman, 1997; Pearlman & Saakvitne, 1995).

Self capacities are developed through early relationships with caregivers. It refers to the "inner abilities that allow an individual to maintain a consistent, cohesive, sense of self" (Pearlman, 1997, p. 9). There are three self capacity types; the first involves the ability to experience, tolerate, and integrate strong affect. This means that the individual has developed the skills necessary to experience strong emotions personally or those emotions of others without their daily functioning being impaired. The second includes the ability to maintain a sense of connection with others, meaning that the individual can maintain meaningful interpersonal relationships with relative ease. The final type includes the ability to maintain a sense of self as "viable, benign, and positive" (p. 12). This means that the individual is able to see themselves as a productive person in the world with many talents and skills that can be of service to others.

For example, as a result of vicarious traumatization, the complexity of listening and integrating the trauma narrative can adversely affect a therapist's self capacities. This may cause the therapist to begin to have difficulties with affect toleration during sessions. It can cause difficulties in differentiating their emotions from their patients. This unhealthy joining with the patient can negatively affect the therapeutic relationship. For a trainee, the complexity of listening and integrating the trauma narrative can adversely affect the trainee's ability to regulate their emotions. As a result a trainee may shut down and withdraw into him/herself, fueling a disconnection the sense of self and the world around them. If self capacities are compromised, the therapist may then begin to experience difficulties within their ego resources.

Ego resources are individual inner resources used whenever an individual needs to relate to others and respond to their own psychological needs. These resources are crucial for helping an individual navigate through their daily life. For instance, therapists use ego resources to establish personal boundaries, recognize psychological needs, exercise judgment, and partake in perspective taking (Pearlmann & Saakvitne, 1995). Intact ego resources allow the therapist to maintain a professional life apart from their personal needs. A disturbance in ego resources can ravage the psychological well being of a therapist. The therapist may begin to exhibit difficulty with patient relationship and may lack the ability to recognize when their actions are inadvertently blurring boundaries and negatively affecting the therapeutic relationship. For a trainee, disruptions in ego resources may lead the trainee to engage in poor decision making. For example, a trainee experiencing these disruptions may become interlinked with the patient causing them to give their patient their private home line or email, be available to the patient 24 hours a

day, give the patient more time during session, or disclose personal information. This lack of boundaries leaves the trainee susceptible to further vicarious traumatization. As a result a trainee's psychological needs can also be impacted.

Psychological needs are comprised of five specific categories: safety, trust, esteem, intimacy, and control. Safety refers to a sense of security; a trainee experiencing vicarious traumatization can exhibit higher levels of vulnerability and fearfulness (Trippany et al., 2004) due to a feeling of being unable to protect herself from real or imagined threats (Pearlman, 1997). This fearfulness can be evidenced by taking self-defense classes, walking in pairs, or by installing an alarm system. Trust refers to the firm belief in the reliability, truth, ability, or strength of someone or something. Ruptures in their trust systems may leave a therapist vulnerable to disruptions with trusting her own perceptions and beliefs and an inability to regulate emotional, physical, and psychological needs. For a trainee, this lack of trust can affect personal relationships. For example the trainee may refuse to share emotional disturbances with a significant other. The trainee, as a result of disruptions, may lack the trust in a significant other to help regulate these needs for them (Trippany et al., 2004). Accepting the assistance of another to regulate needs is not seen as pathological. Rather being able to allow someone else, like a significant other, to help regulate your emotions has been identified in the literature as having a "healthy dependence" (Pearlman & Saakvtine, 1995, p. 71). Esteem needs are characterized as value for the self and others (Pearlman, 1997). For a therapist, this means the ability to maintain respect for one's level of training and experience. Additionally, this allows the therapist to remain faithful in the role of a helping professional and to view these skills in high regard. This will allow the therapist

to have a firm foundation in their work with patients. As a result, the therapist is less likely to let patients' negative view and reaction to the therapeutic work affect their confidence in their position.

According to CSDT everyone has a natural need to trust themselves and others. This intrinsic need is pivotal in leaving a therapist vulnerable to vicarious traumatization. Once this foundation has been shaken, the therapist is susceptible to self-doubt and doubts surrounding their judgment and skill as a clinician. Therapists experiencing difficulties within this domain may begin to question their efficacy as a clinician. The same is true for trainees; for example, a trainee may feel despair and hopelessness, blaming their work for the patient's continued pain and will avoid addressing these cognitive distortions in supervision. This questioning coupled with typical anxieties central to being a novice leaves the trainee susceptible to maintaining the symptoms of vicarious traumatization.

Intimacy needs are defined as the desire and want to feel a connection with another (Pearlman & Saakvitne, 1995; Trippany et al., 2004). Any disruption within this domain results in isolation and avoidance from others. This can also manifest in an intense loneliness when alone and an intense desire to fill this time up. Therapists afflicted within this need may either retreat away from others or become increasingly dependent on others (Pearlman, 1997). For a trainee, this can manifest in consistently seeking approval and time with a supervisor or peers. Contrarily, the trainee can also be seen dismissing peer consultation and utilizing supervision with non-essential issues to the therapeutic work such as discussing their reactions to trauma narratives.

Pearlman and Saakvtine (1995) described control needs as the ability for the therapist to self-manage, including their ability to direct future plans, express feelings, and navigate themselves in the world. This may manifest in the trainee's inability to establish treatment goals and self training goals. The development of a trainee's cognitive schemas about themselves and the world is constructed by the manner in which the trainee processes information related to these basic psychological needs. Thus as a trainee begins to experience vicarious traumatization, their psychological needs are being disrupted and as such the development of their cognitive schema will inevitably change in order to incorporate their new belief systems, which may or may not be consciously apparent to the trainee.

Cognitive systems are integral to processing psychological needs and memory systems. Cognitive schemas refer to a mental framework of knowledge, beliefs, and expectations concerning a particular topic or aspect of the world. Cognitive schemas help organize and interpret vast amounts of information in a condensed and synthesized manner. For a therapist, this allows them the ability to absorb all the information presented by the patient and use it throughout the course of treatment to obtain treatment goals. Memory systems include interpersonal memory, bodily memory, verbal memory, imagery and affects (Pearlman & Saakvtine, 1995). When a patient experiences a traumatic experience, each memory system will be affected by containing a fragment of the trauma.

For example, in a therapeutic situation that involves a patient describing sexual abuse, that patient can construct an interpersonal memory of how the perpetrator interacted with her before the assault; the victim may remember the perpetrator's cologne

(bodily memory), the names the perpetrator expressed (verbal memory), flashbacks of clothes being ripped (imagery), and the shame and guilt (affect) associated with the trauma. Similarly, when a therapist is subjected to the memories of their patient's trauma history, these memories can become integrated into their own memory systems. For example, hearing about the trauma can cause the trainee to develop an interpersonal memory of the trust the child had in the trainee to share their narrative of an adult violating them. The trainee may remember the smell of their coffee (bodily memory) or the labels the child uses to describe himself (verbal memory). Imagery of the child being balled up in the couch sobbing may occur and feelings of sadness, helplessness, and disgust associated with hearing and processing the trauma narrative is expected (affects).

These memory systems can then manifest as intrusive thoughts and dreams where the therapist is identifying with the victimization. For a trainee, such traumatic material may turn to denial, avoidance, and numbing to protect them against the memory system incorporation (Astin, 1997; Trippany et al., 2004). However this negative coping mechanism has a temporary effect and has greater implications for the quality of empathy and care the trainee provides to patients. Empathic engagement, which is central to the therapeutic relationship and essential for facilitating growth and assimilation of trauma into a patient's memory, becomes threatened by vicarious traumatization. As an individual is faced with trauma, he or she establishes a construction of the traumatic material and attempts to make meaning out of the trauma. These constructions are based on a multitude of experiences unique to the individual. Thus the same event occurring to two people will produce varying trauma constructions. Hence a seasoned therapist will not establish the same construction as a trainee. Likewise, no two trainees working with

sexually exploited children will produce the same construction. A trainee will create their reality based not only on the vicarious traumatization but also on the integration of the symptoms. Unfortunately a trainee may mistakenly view these symptoms as a common side effect of trauma work and may not know to seek out supervision.

Valent and vicarious traumatization. Valent (1995) proposed another theory for the development of vicarious traumatization. He drew from biological, psychological, and social perspectives to construct eight survival strategies to provide a more extensive framework for diagnosing trauma symptoms. He suggested that humans utilize one or a combination of these survival strategies to cope with unexpected events. The adaptive or maladaptive use of these strategies by the individual in conjunction with biological, psychological, and social components contribute to the wide variety of trauma responses in the therapist. The eight survival strategies are Rescuing (Caretaking), Attaching, Asserting, (Goal Achievement), Adapting (Goal Surrender), Fighting, Fleeing, Competing, and Cooperating. Based on this framework, a patient seeks therapy when their survival strategies are inadequately helping them cope with the traumatized event. Symptoms exhibited by patients are a clear indication of a maladaptive use of survival strategies combination use, so the therapist in helping a patient must identify the survival strategies being used.

Within therapy, the therapist must first become attuned to the patient in order to identify the patient's needs and the survival strategies that the patient is inadequately utilizing. For example, a patient discussing feelings of abandonment and neediness because their pimp has not come to find her is demonstrating the inappropriate use of the

survival strategy. The therapist can see this and by using Valent's framework identify that the patient is inappropriately using the attachment survival strategy.

Valent (1995) indicated that within a therapy a therapist must use an opposite survival strategy to treat the individual. Following this guideline, the therapist must counter with another survival strategy to help the patient. Thus, the trainee may chose to utilize the Rescue-Caretaking survival strategy. This strategy allows the trainee to provide a warm, empathic stance and help the child mourn the loss of the pimp and process feelings of confusion over the loss and provide psychoeducation about the trauma reaction. The therapist uses the survival strategy missing from the patient's coping skills set. The manifestation of vicarious traumatization symptoms in the therapist, through this framework, is seen as a maladaptive response. This occurs in the therapist either by identifying with the patient's survival strategies or by integrating the patient's survival strategies into their own.

Because trauma narratives are psychologically and physically trying, all survival strategies experienced by a patient will also be experienced, to a degree, by the therapist (Valent, 1995). The processing and reliving of the trauma within the therapeutic relationship leaves the therapist vulnerable to experiencing and identifying with all of the patient's maladaptive survival strategies as well as their own. If the therapist is lacking the appropriate training needed to work with traumatized patients and work through the effects of such work, the therapist will undoubtedly experience vicarious traumatization. For example a therapist who utilizes survival strategies that are insufficient for resolving the patient's pain is left carrying the patient's unresolved maladaptive strategies and their own failed complementary strategies. Failed survival strategies either from the patient or

the therapist always result in being maladaptive to the individual. The therapist knows to utilize their training to continually be vigilant about what is unfolding throughout the therapeutic session. A therapist with adequate training is able to recognize the failed attempt and work at identifying and implementing the appropriate survival strategy.

Therapists become susceptible to vicarious traumatization when they fail to recognize this and instead integrate the maladaptive response into their own psyche. This model can also be adapted to understand vicarious traumatization in training therapists. The very nature of being a trainee makes it inevitable that the lack of sufficient training and education in how to treat traumatized patients may undoubtedly cause a trainee to utilize and internalize a maladaptive combination of survival strategies leaving the trainee susceptible to symptoms.

Cerney and vicarious traumatization. Cerney (1995) proposed another model of the development of vicarious traumatization. He drew from psychodynamic theory to include four main concepts: transference, countertransference, identification, and projective identification. Transference is the unconscious redirection of feelings from one person to another (Corey, 2001). Cerney argued that the trauma survivor patient will first see the therapist as “the ‘all-caring’ parent,” then as an “all-abusive” parent (p. 133). A sexually exploited child may initially sing the therapist praises. The child may then begin to identify the therapist as the only one in their life to support and listen to them. This is flattering to a trainee. However, as Cerney pointed out, the child may then hate the therapist for being unable to help them faster. This dismissal is demoralizing for a trainee who is already hypersensitive to criticism. Countertransference occurs when the therapist’s unresolved conflicts become entangled in the therapeutic relationship (Corey,

2001). As a countertransference reaction, the therapist may internalize the patient's projection of the therapists as a savior, and begin to act accordingly. Finally, through identification, the therapist may start to experience the same feelings and reactions the patient is exhibiting. Cerney argued that these concepts are foundational to the experience of vicarious traumatization.

Harris and vicarious traumatization. Harris developed a slightly different etiology for trauma effects (Figley, 1995). Although not explicitly stated, this work can then be adapted to understanding the development of vicarious traumatization. He suggested that traumatic symptoms in the therapist develop out of the therapists' inability to integrate the patient's traumatic narrative into their own world view. Thus, a therapist must change that world view to reflect the integrated belief that children are sexual beings and will be violated. Integration can be difficult because the therapist must assimilate the traumatic narrative into their sense of self and their world view. If the patient's trauma is in direct conflict with the patient's view and integration fails, or the therapist resigns from the integration, chronic effects in the therapist will develop.

Rothschild and vicarious traumatization. Rothschild and Rand (2006) drew from neurobiological research, social and folk psychology to explain the development of vicarious traumatization in therapists. She identified three major processes that when left unchecked can pose a risk to a professionals' well being. The first process is empathy. Empathy refers to understanding, being aware of, being sensitive to the feelings, thoughts, and experience of another individual. As a therapist empathically engages with the patient, the therapist is more vulnerable to developing symptoms. The second process is the regulation of arousal in the therapist. The third process, mirroring, draws from

neuroscience. Researchers studying behavior had determined that emotions can be expressed unconsciously and consciously and these expressions may or may not be observable. As a therapist becomes attuned to the patients' emotional processing, the therapist begins to mirror the patient's facial expressions and posture, which can be either conscious or not. This came to be known as mirroring neurons. For example, Rothschild and Rand (2006) attributed the contagious nature of a yawn or smile to mirror neurons.

Rothschild and Rand (2006) drew upon the mirror neuron literature and expanded this research finding to postulate that therapists' vicarious traumatization may partly be a reaction of our mirroring responses. However, Rothschild and Rand argued that mirroring these responses can become too intense for conscious awareness. Thus the therapists' begins to experience the same emotions as the patients.

Although these theorists approach the development of vicarious traumatization from varying foundational bases, a common thread is apparent. Once a therapist engages in a therapeutic relationship with a traumatized patient, the empathic engagement undeniably puts them at risk for developing vicarious traumatization. How the symptoms arise is based on contrasting theories, be it mirroring neurons, maladaptive survival strategies, countertransference, or a lack of traumatic material integration. The result is the same: if a therapist lacks the appropriate training and adaptive quality to offset the effects of this engagement, then symptoms of vicarious traumatization will progress.

Risk Factors for Developing Vicarious Traumatization

Overall a personal abuse history has been found to be a risk factor for vicarious traumatization. (Schauben & Frazier, 1995; VanDeusen & Way, 2006). Other risk factors linked to experiencing of vicarious traumatization symptoms include negative coping

strategies (Way et al., 2004), higher percentage of trauma patients in caseload (Schauben & Frazier, 1995), and being a novice to the field of trauma (VanDeusen & Way, 2006; Way et al., 2004). Symptoms of vicarious traumatization can be attributed to two sets of risk factors. The first set relates to the therapist's personality traits such as having personal trauma history. Bell, Kulkarni, and Dalton (2003) found that therapists' personal trauma histories were highly correlated with low self-regard about themselves and their role in the world. Additionally, these therapists were more likely to score higher on post traumatic stress disorder measures.

For purposes of this dissertation, they will be classified as survivor therapists. Survivor-therapists reported less psychological distress in their personal and professional life (Elliot & Guy, 1993). Survivor therapists seem to be the ideal candidate for trauma work as they are able to identify subtle affective and interpersonal experiences of other people, have highly developed empathic skills, and are deeply committed to the work and their patients (Pearlman & Saakvinte, 1995). Survivor therapists may be at risk for having reactivations of personal past symptomatology when working with patients' traumatic narrative (Baird & Jenkins, 2003; Figley, 1995; Follette, Polusny, & Milbeck, 1994; Pearlman & Mac Ian, 1995). It appears that the effect of traumatic material on a therapist with personal trauma history is dependent on how much the therapist has resolved from their personal trauma (Walker, 2004) and application of self-care practices (Pearlman & Saakvitne, 1995).

A second set of factors includes aspects of training and experience level. Working with trauma populations is an arduous task requiring extensive and continuing training on behalf of the therapist. Additionally, the more experience a therapist has with

being an emotional container for the patient, the less likely they will succumb to symptoms. An inexperienced therapist lacks the knowledge, skills, and procedural knowledge related to treating trauma patients in the moment. The lack of training and experience leaves the therapist more susceptible to emotional reactions.

Pearlman and Saakvitne (1995) defined long-term engagement with traumatized patients as affecting and transforming the therapist's way of experiencing the self, others, and the world. Some other possible risk factors for vicarious traumatization include negative coping strategies, levels of stress, and having negative reactions to sexual abuse and exploitation cases (Follette et al., 1994). Gender has also been mentioned to be a risk factor (Cornille & Meyers, 1999; Kassam-Adams, 1995), but it is unclear if being a woman makes the therapist more susceptible or if women are more likely than men to report symptoms. Additionally, the organizational nature in which the trainee finds him or herself working in can increase the trainee's risk to develop symptoms. Overwhelmingly, having an excess amount of traumatized patients on one's caseload has been found to be correlated with higher reports of vicarious traumatization symptoms compared to other therapists with only a few trauma patients on their caseload (Brady et al., 1999; Chrestman, 1995; Cunningham, 1999; Kassan-Adams, 1995; Pearlman & Mac Ian, 1995; Schauben & Frazier, 1995). Vicarious traumatization is viewed as normal, predictable, and inevitable; yet, if the therapist does not acknowledge and address the transformation that is taking place, serious effects on the therapist as an individual and professional will begin to emerge. These effects of vicarious traumatization vary greatly and may depend on personal factors, training, and experience level (Adams & Riggs,

2008).

Protective Factors against Vicarious Traumatization

Protective factors are factors that a therapist engages in to help prevent against the strain of providing therapy to patients. Therapists typically focus on changes they can make in their own life. However empirically validated research on the efficacy of personal factors is limited. Although positive individual changes are indeed helpful, research has identified environmental changes, particularly organizational and supervisory, to be the most efficacious.

Organizational. Belonging to a supportive work environment is a key protective factor. A supportive work environment will support time away from work, breaks, variability in case load, and patients. Research has suggested that by limiting the number of trauma patients per week, the potential for vicarious traumatization is minimized (Trippany et al., 2004). The environment should include a network of peers and supervisors who can identify and talk about the positive aspects of work. These interactions can encourage the recognition of human resilience.

Vicarious traumatization severs connections to the community and destroys meaning. Having a supportive work network can serve as a community to prevent symptoms. The primary function of the community is to identify and alter traumatic engagement patterns. The peer network can do this by recognizing the emotional and behavioral changes not apparent to the therapist. In turn, the network can then choose to support or confront the affected therapist as deemed necessary (McCann & Pearlman, 1999).

The established use of peer consultation can aid in the prevention of work isolation and is typically seen as a proposed strategy against vicarious traumatization (McCann & Pearlman, 1999). External connections with co-workers, friends, and family are required to remain a functional and effective professional because they keep the therapist grounded in life outside of trauma. Discussions with peers individually or in small work groups during breaks or in between patients aids in normalizing and validating a therapist's reactions. These peer connections allow the therapist to discuss reactions outside their own psyche, so it is not integrated into the therapist's world. This professional social contact can be very effective in diffusing self doubt, self blame, and by reframing of emotional reactions. This also provides a forum for discussions of frustrations and venting of strong emotions (Figley, 1995).

Research suggests that participation in training activities may help mediate vicarious traumatization in therapists. Through participation in these trainings, the therapist gains knowledge and increased professional support (Chrestman, 1999). Trainings provide a forum for identifying symptoms and increasing work competence. Similarly, in a trauma therapist sample, over two-thirds found it helpful to attend workshops, talk with colleagues between sessions, and discuss cases informally (Pearlman, 1997). Follette et al. (1994) found that 96% of mental health professionals reported sexual abuse education as imperative to effectively coping with difficult cases. Alpert and Paulson (1990) also suggested that graduate programs for mental health professionals need to include the impact of patient's childhood trauma and its effect on vicarious traumatization.

Supervision. Most training programs build in supervision into the field training,

establishing a good initial measure of preventing and/or coping with vicarious traumatization symptoms. However, this supervision is led by an individual whose role involves evaluating the trainee. Additionally, vicarious traumatization symptoms are rarely overtly discussed since the focus is on the patient's progress. Although supervision is a great buffer for symptoms, specifically tailored supervision for treating traumatized patients is the more appropriate supervision style needed yet rarely received by trainees.

Peer supervision also gives trainees a choice to learn from previous mistakes. Walker (2004) suggested that peer supervision groups are important resources for therapists working with trauma. Sharing of experiences with other therapists offers social support and more importantly normalization of vicarious traumatization symptoms. Normalization lessens the impact allowing the therapist to maintain an objective and serves as a protective factor against worldview distortions. Discussions with colleagues have been found to be the most common method for dealing with vicarious traumatization symptoms (Pearlman & Mac Ian, 1995). Talking with colleagues about their experiences with symptoms offers therapists support and validation (Dyregrov & Mitchell, 1992).

Self-care techniques. Self-care techniques are activities an individual completes with the intention of improving or restoring health or treating or preventing a disease. For purposes of this dissertation, self-care is seen as a practice a therapist integrates into their daily life to help prevent or improve mental health.

Self-care has permeated all helping professional disciplines, but the concept was first mentioned in nursing care literature. Orem's theory of self-care focused specifically on the nursing profession (Lauder, 2001). In this theory, he postulated that lack of self-

care practices leads to self-neglect. Just as therapists can become victims of vicarious traumatization, nurses and professionals within the medical field are more likely to succumb to self-neglect. Self-neglect refers to behaviors including poor diet, failure to look after one's health, poor personal hygiene, and household squalor. Additionally, mental and physical problems and an inability to maintain interpersonal relationships have also been cited as self-neglect. Overall, self-neglect is the failure to engage in self-care acts that effect life, health, and well-being.

Gast et al. (1999, as cited in Lauder, 2001) defined self-care agency (SCA) as capabilities of individuals that enable them to engage in self-care. Orem (1997, as cited in Lauder, 2001) proposed that SCA is influenced by internal and external variables. Internal variables refer to knowledge and education on the importance of self-care. Thus if an individual has compromised internal variables such as a knowledge deficit, then they will have lower levels of SCA. Lauder found that individuals with self-neglect indeed had lower levels of SCA.

Adapting this finding, individuals experiencing vicarious traumatization may also have lower levels of SCA. Central to self-care literature is the notion of responsibility (Lauder, 2001). Self-care is seen as a self-initiated, deliberate, and purposeful activity linked to psychological well-being. However, if an individual begins to exhibit symptoms of vicarious traumatization, that person is seen to have a reduced and almost nonexistent capacity for intentionally engaging in self-care acts. This is crucial for therapy trainees working with sexually exploited children to utilize self-care techniques as it may prove more difficult to engage in self-care practices voluntarily once symptoms have been experienced.

Although the need for self-care was established in the nursing field, other helping professionals began to research the effectiveness of self-care practices. Empirical evidence has indicated that 38% of social workers experience moderate to high levels of vicarious traumatization (Bell et al., 2003). In addition, emergency workers, nurses, police officers, sexual assault therapists, and trauma therapists have all been documented as developing emotional reactions to traumatic material (Bell et al., 2003; Chrestman, 1999; Kassam-Adams, 1995). As the field of psychology advanced, the importance of engaging in self-care practices became a more important tenant to follow. Rodolfa et al. (1988) studied the effects of self-care on seasoned professionals and graduate level students. They found that adequate self-care was crucial in lowering the experience of stress. Thus self-care practices should be recognized as a core competency of graduate clinical training. Empirical studies among graduate level psychology students have found that self-care variables are significant for lowering psychology student's perceived sense of stress. More specifically, healthy sleep practices, higher levels of social support, and cognitive appraisals were empirically supported to significantly lower levels of perceived stress (Myers et al., 2012). Cognitive reappraisals refer to a strategy for emotional regulation. Norcross and Guy (2007) suggested that "self-care is not a narcissistic luxury to be fulfilled as time permits; it is a human requisite, a clinical necessity, and an ethical imperative" (p. 14).

Empirical studies of mental health therapists on the effects of coping strategies or self-care techniques have found spending more time engaging in leisure activities such as vacations, movies/TV, and hobbies does not reduce the level of distress experienced by therapists. Additionally, research has found that graduate students who engage in

mindfulness-based stress reduction report significant declines in perceived stress, negative affect, anxiety and increases in positive affect and self-compassion (Shapiro, Brown, & Biegel, 2007). However, having a more diverse caseload is associated with decreased vicarious traumatization (Chrestman, 1999). Bober, Regerher, and Zhou (2006) found that engaging in organization aspects of self-care such as increased supervision, reduction, and variability in case load was significant in lowering the amount of distress experienced. Thus it appears that structural self-care techniques are more efficient in reducing emotional distress than individual self-care practices. Of note, although individual self-care practices were not found to reduce acute distress among helping professions, individuals who believed in individual self-care practices engaged in these activities more often, which contributed to a healthier balanced lifestyle overall and aided in the professional advocating for more balanced life within their working environment as well. Recent studies of graduate students, however, have found that believing in the efficacy of self-care strategies is just as effective as actual measureable reduced stress.

Vicarious Traumatization Measures

Various instruments have been developed and utilized to measure vicarious traumatization symptomatology; few of these have been self-report questionnaires. This section will briefly describe some of the self-report measures utilized for assessing vicarious traumatization in therapists.

Traumatic Stress Institute (TSI) Belief Scale, Revision L (TSI-BSL). The TSI Belief Scale is based on CSDT and measures the five psychology need areas identified by Pearlman and Saakvitne (1995). These areas include trust, intimacy, control, esteem, and

safety. It is an eight item, 6-point Likert scale questionnaire used to ascertain an individual's beliefs and cognitive schemas relating to self and others.

Compassion Fatigue Self-Test for Psychotherapists (CFST). This instrument was created to measure secondary traumatic stress/compassion fatigue through the use of a 40 item, 5-point Likert scale (Figley, 1995). This measure employs two subscales separating secondary traumatic stress from burnout symptoms.

Maslach Burnout Inventory (MBI). This 22 item, 7-point Likert instrument measures emotional exhaustion, reduced sense of personal accomplishment and depersonalization (Canfield, 2005). Emotional exhaustion refers to one's mental and emotional exhaustion due to strain experienced from one's work. Reduced sense of personal accomplishment is measured the sense of competence and other positive emotions derived from one's work.

Symptom Checklist-90 Revised (SCL-90R). The SCL-90R is a 90 item, 5-point Likert scale measuring psychological symptoms experienced within a one-week period. This measurement is widely used in clinical populations and may produce skewed results when used with non-clinical populations (Jenkins & Baird, 2002).

Impact of Event Scale (IES). The IES is a 15 item measure used originally to assess avoidant and intrusive signs and symptoms of PTSD based on DSM-III criteria. Weiss and Marmar (1997) updated the instrument to accurately address the changes brought forth by the DSM-IV PTSD diagnostic criteria. Items were added to address hyperarousal and intrusive re-experiencing changing the instrument to a 22 item, 5-point Likert scale instrument.

Many studies have measured vicarious traumatization primarily utilizing the TSI-BSL scale (Jenkins & Baird, 2002; Kadambi & Truscott, 2004; Pearlman & MacIan, 1995; VanDeusen & Way, 2006). However, the other scales are instrumental in assessing for signs and symptoms of vicarious traumatization and some have been used to differentiate between vicarious traumatization, burnout, and PTSD. These measures were initially created to measure symptomatology of treating professionals and no exclusion criteria has been developed to exclude trainees from also using these scales. The use of these scales on trainees can be very beneficial in assessing whether trainees experience vicarious traumatization at higher levels than trained and seasoned therapists. Again this is another area in which trainees have not been integrated into the study of assessment and maintenance of symptomatology.

Graduate Psychology Student Trainees

As evident by the review of the literature on vicarious traumatization, this phenomenon is a known process of mental change that should be taken into account for trainee therapists and applied to their training programs when they are expected to work with trauma survivors. Training in therapeutic techniques and trauma theory is essential for the trainee to understand how to engage and work with the traumatic narrative and this knowledge also serves as a protective factor for the trainee (Canfield, 2005; Chrestman, 1999; Pearlman & Saakvitne, 1995). Training provides theoretical framework to understand trauma and its impact on the patient (Pearlman & Mac Ian, 1995). The prevalence of trauma in clinical populations is very high (Pearlman & Saakvitne, 1995) and as such trauma coursework should be required. Unfortunately very few training programs have classes geared toward working with trauma. Graduate level

trainees tend to be younger in age and less experienced. These two factors have been found to be highly correlated with the development of vicarious traumatization (Arvay & Uhlemann, 1996; Pearlman & Mac Ian, 1995). Ladany and Friedlander (1995) have found novice therapists at greater risk for developing vicarious traumatization symptoms. A trainee may be unaware and unfamiliar with the feelings being evoked by the patient's trauma narrative and as such, may find it difficult to cope. In addition, novice therapists do not have an adequate amount of experience and training and thus lack the ability to draw from prior experience as a way to navigate through these symptoms (Pearlman & Saakvitne, 1995).

Symptoms experienced by trainees may hinder the trainee from seeking out adequate supervision and support (Neuman & Gamble, 1995; Pearlman & Mac Ian, 1995). When vicarious traumatization is left unattended, there is a risk the trainee may become emotionally distant and unable to maintain a warm, empathic and responsive stance to patients (McCann & Pearlman, 1990, as cited in Adams & Riggs, 2008), which may result in burnout and subsequent departure from the field (Pearlman & Saakvitne, 1995). Thus, these effects have led to a growing consensus supporting the need for training and supervision in trauma work as part of the graduate curricula (Campbell, Raja, & Grining, 1999; Figley, 1995). Such training will help provide trainees with the necessary skills required for working with trauma survivors.

A trainee's drive to excel in her or his studies, to work harder and for longer hours, and to be at the top of the class is a quality respected and expected within higher learning institutions. However, this very drive may pose as a risk factor for vicarious traumatization. As a newly practicing clinician, trainees are eager and excited to do the

work, learn, and grow. The drive to be the best may create a norm that can be detrimental to self-care practices. It may be assumed that if trainees do not work overtime, then they are not committed to the work, or that trainees who do not take vacation time are more committed than others. This cultural norm can also be seen in the amount of cases accepted and even requested by the trainee and the lack of boundary setting in regards to extra responsibilities. As trainees become more seasoned, they may take on extra responsibilities or dual placements in service of gaining more training but at a detriment to their self-care practices, putting such trainees at higher risk for developing vicarious traumatization.

Trainees new to the counseling field may also be struggling with their role as a therapist. This coupled with an uncertainty of what their supervisor expects of them may cause them to experience more anxiety (Ramos-Sánchez et al., 2002). Neuman and Gamble (1995) identified the trainee's lack of identification to the therapist role as priming the novice to identify with the patient making them more susceptible to symptoms of vicarious traumatization. Trainees may then find themselves less likely to confide in their supervisors or seek support, which has been identified in the literature as a common risk factor. (Patton & Kivlighan, 1997; Ramos-Sánchez et al., 2002). This puts the trainee at a greater risk of vicarious traumatization and are more likely to contemplate leaving work and choosing a new profession (Neumann & Gamble, 1995).

Although numerous amounts of literature are available on vicarious traumatization and the effects associated with treating traumatized patients, research efforts to date have focused primarily on professionals treating traumatized patients (Chrestman, 1999; Pearlman & Mac Ian, 1995). Little attention has been given to the

possible negative impact on exposure to patients' traumatic material for trainees. This represents a significant gap in the literature. Thus due to the scarcity of literature on factors placing trainees at higher risks for vicarious traumatization, conclusions attributed to the trainee culture have been drawn specifically from Dutton and Rubenstein's (1995) study, which found trainees to be more vulnerable to feelings of guilt following a patients' re-experiencing of trauma within the therapeutic session.

Results from Maton, Wimms, Grant, Rogers, and Vasquez (2011) were also consulted to inform the current study on trainee's higher levels of anxiety, higher self-focus and limited awareness which provides foundational priming for the development of vicarious traumatization. Finally, conclusions were drawn from Neumann and Gamble's (1995) study, which specifically hypothesized that a trainee's novice status and reluctance to discuss reactions to patients in supervision puts them at a higher risk for developing secondary trauma and for purposes of this study, expanded to include vicarious traumatization.

Sexually Exploited Children

Prostitution is usually defined as a woman who sells sexual favors for money, products, or privileges. Schauer and Wheaton (2006) provides this definition:

forced prostitution...refers to women or girls who are compelled to engage in sexual acts with strangers in exchange for commodities with the compulsion emanating from either physical violence and abuse, threats to their lives or bodily integrity or those of their families, emotional and physical coercion based on their indebtedness to the smugglers and procurers, and/or their presence in a foreign country without legal status and any support network. (p. 263)

Although these definitions are exclusively attached to women, for purposes of the current study, males are also considered victims of sexual exploitation/prostitution.

Additionally, for purposes of this study, children forced into prostitution will be identified as sexually exploited children.

The term *prostitution* has a negative connotation and it evokes a sense of choice within the individual, which cannot be the case for children or women for that matter. However, literature on the subject still varies in the terminology used and as will be apparent in the following discussion. Prostitution is defined as domestic sex trafficking, whereas sex trafficking is equated with international or intranational prostitution. By conservative standards, 18,000 persons are trafficked into the United States per year. Ninety-six percent of these are females, and almost half are children (Mizus, Moody, Privado, & Douglas, 2003). The Central Intelligence Agency (CIA) estimates that 700,000 people are trafficked annually (Klueber, 2003). It is estimated that 100,000 to 300,000 children are exploited annually by the sex industry within the United States alone. However, the secretiveness and underground nature of this crime makes it difficult to determine the precise number of people who are victimized. In the year 2000, the U.S. Congress reported that the trafficking of women and children was the third largest source of revenue for organized crime worldwide behind drugs and firearm trafficking. The United States offers the second largest market for sex-trafficked women and girls (Mizus et al., 2003).

It is important to note that Americans are as victimized as immigrant populations (Klueber, 2003). The majority of sex trafficking literature always includes a shift into the domestic child prostitution and child pornography. This is because there is a substantial overlap between the two. Prostitution is conventionally seen as the end product of sex trafficking (Schauer & Wheaton, 2006). Human trafficking investigations have found

serious forms of trafficking occurring within the United States (Campagna & Poffenberger, 1998; Estes & Wiener, 2001). The United States Department of Justice stated that prostitution like sex trafficking and related activities “is inherently harmful and dehumanizing” (Campagna & Poffenberger, 1998, p. 11) and is an assault on human dignity.

Theorists have suggested that emotional distancing from sex and negative self-image is typical among victims of sexual abuse and may lead to early sexual behavior and subsequently prostitution. There are a number of studies that have pointed at the relationship between running away from home and becoming sexually exploited (Schauer & Wheaton, 2006). Runaway youths, lacking employment and financial resources, may turn to prostitution for survival purposes (Farley, 2003; Schauer & Wheaton, 2006). These youth have no financial resources and the peer culture in the streets supports the use of trading sex (Doezema, 1998). Typically runaways have a history of child sexual abuse and leave home as a means to escape from the perpetrator (Doezema, 1998; Schauer & Wheaton, 2006).

The treatment of sexually exploited children is especially difficult given the multiple layers of abuse and trauma central within this population. Sexual victimization is one of the most commonly presented patient traumas. It is estimated that 1 in 6 women and 1 in 10 men will experience sexual abuse during childhood, and FBI estimates indicate 1 in 4 women will be victims of sexual assault in their lifetime (Schauer & Wheaton, 2006). Children who find themselves being sexually exploited typically have a child abuse past. Once involved with prostitution, a child is indebted to the pimp or captor and faces repeated gang rapes until the child acquiesces to the demands of the

pimp, or captors if a victim of sex trafficking (Klueber, 2003). Children are often threatened by physical and sexual assault. Victims of sex trafficking have any legitimate travel and immigration documents taken away, and they are threatened by multiple threats to their family members back in their source country (Bertone, 2000). Therapists working with this population must also work through the multiple results of sexual exploitation aside from the sexual abuse and exploitation. Individuals who engage in prostitution generally exhibit a pattern of criminal behavior (Doezema, 1998). Schauer and Wheaton (2006), for example, reported that studies of youth involved in prostitution have found high correlations with theft and burglary.

Sexually exploited children complete less education than comparison groups (Dane, 2000) and are more likely to be expelled from school. Lack of formal education places these children at a disadvantage for getting jobs when they grow up, making them more likely to continue being sexually exploited out of financial necessity (Klueber, 2003). Additionally, involvement with prostitution makes children more likely to become associated with drug use as a means to dull their emotional pain and get through the act of sleeping with strangers (Schauer & Wheaton, 2006). Children are more likely to engage in drug use before the age of 14 (Bertone, 2000; Dane, 2000). Sexual exploitation and child sexual abuse rarely presents as a single traumatic event. Traumatic events have multiple variables and multiple variants of trauma imbedded within them. A therapist working with multiple traumas are pulled to be emotionally engaged. It is through this empathic engagement that patients are allowed to begin healing. Through the facilitation of the patients traumatic processing, the therapist is exposed to the patient's

overwhelmingly intense feelings. The therapist begins to internalize the patient's empathic pain and becomes susceptible to vicarious traumatization.

Therapist Reactions to Child Sexual Abuse

Trainees working with traumatic material listen to repeated stories of sexual abuse, which often include themes of force, violence, penetration and other intrusive acts involving children. Through exposure to patient's graphic accounts of sexual abuse experiences and to the realities of people's intentional cruelty to one another and through inevitable participation in traumatic reenactments on the counseling relationship, the therapist is vulnerable to a variety of reactions (Jones, Robinson, Minatrea, & Hayes 1998). Typical therapist reactions include rage, avoidance, over-identification, guilt, feeling overwhelmed, shock and horror, and sexual feelings.

Rage. Anger expressed by therapists can be directed at a variety of sources. Therapists' can become angry at the abused, the perpetrators, and the other family members (Pearlman & Saakvitne, 1995). For instance, a therapist may become angry at the abused for not telling anyone sooner and stopping the abuse. The therapist may express anger over family members not providing a safe environment and not realizing that abuse was occurring. Finally and most often, therapists may hold anger toward the perpetrators for committing the abuse and forever changing the child's life. Therapists have also been found to become upset toward the system or toward colleagues that are not helpful or supportive. Therapists may feel frustrated with the amount of time survivors take to work through the processing of the trauma and mistrust of adults. Of note, Jones et al. (1998) found that male therapists had more difficulty than female therapists with blaming survivor patients.

Avoidance. This refers to the desire to deny, escape from or not see the situation as it really is. These reactions are based on feelings of anxiety, discomfort, repugnance, dread and horror (Jones et al., 1998). The tendency to deny and avoid the very existence or occurrence of abuse is a way of coping with the discomfort of the reality of sexual abuse. They must guard against denying forms of sexual abuse that are excessively violent, gruesome, or bizarre. However, this reaction is dangerous when working with a patient because the therapist may avoid discussing the trauma during sessions, may not engage fully in the processing, or erroneously tell the patient that processing of the trauma is not beneficial or needed. Therapists' working with this trauma must absolutely accept that this trauma occurs and that children are used and exploited by their adult caretakers (Salston & Figley, 2003).

Over-involvement/over-identification. Over-involvement and over-identification responses occur when the therapist actively wants to help the patient with his or her symptoms but in the process loses control over the role boundaries (Herman, 1997; Wilson & Lindy, 1994). They may become over-involved with survivor patients in an attempt to rescue them. This evokes feelings of fright, over protectiveness, guilt, and excessive responsibility in the therapist. Therapists with a personal history of childhood sexual abuse may be especially vulnerable to over-identification with survivor patients. Attempts to rescue patients may be an indirect way of dealing with their own unresolved abuse issues. Therapists who are experiencing these reactions typically allow their patients to go over on time, they allow their patients to change their set therapeutic time, and they allow patients to cancel without charging. Therapists may come in to work afterhours or on off days if the patient is having a crisis or blur boundaries by giving the

patient a ride home, letting them borrow money, giving them their direct line and expressing personal reactions to the patients such as giving hugs.

Guilt. Therapist may feel guilt for the patient's painful affect resulting from disclosing the details of his or her abuse. Therapists may question their competency or feel guilty that they are not helping the patient quickly enough. Therapists may treat the survivor patient as a special patient and not maintain professional boundaries (Sabin-Farrell & Turpin, 2003).

Overwhelmed. Feeling overwhelmed is attributed to the nature of treating survivors. Therapists are faced with patients recounting the memories and details of the abuse. Therapists may feel overwhelmed by hearing these details, particularly those dealing with details involving more intrusive and violent acts of abuse. Therapists feel overwhelmed with the reality of human cruelty to children such as hearing about abuse being at the hands of family members or caretakers, those whom one would expect to be the most benevolent and safe (Sabin-Farrell & Turpin, 2003).

Shock and horror. Therapists often times find themselves horrified. Even more shocking are the details of the abuse, especially those involving pleasurable, sadistic, or violent episodes. Survivors need to express and process these realities, but this causes the therapist the greatest degree of discomfort. The shock and horror can be identified through the therapist's behavior. A therapist's discomfort may lead to defensive behavior such as changing the subject, denying the situation could have been bad, or disbelieving the patient's experiences and memories (Sabin-Farrell & Turpin, 2003).

Sexual arousal. Sexual thoughts or fantasies may occur in working with this population. Discussing these emotions is especially taboo for therapists. Sexually naïve

and inexperienced or highly sexualized and seductive therapists have been found to experience sexual emotions toward their patients. Countertransference guilt and anxiety have also been found in situations where the therapists find themselves being lured by the seductiveness of these patients. Although therapists from either gender can experience sexual feelings about survivor patients, Jones et al. (1998) found that male therapists were more likely than female therapists to feel “sexually turned on” while working with survivors (p. 335). Therapists who experience sexual feelings toward their survivor patients may feel guilty or anxious about their feelings. The risk of unresolved sexual feelings toward a survivor patient could result in a break in the therapeutic relationship, or worse, sexual involvement between patient and the therapist further exploiting the patient.

Therapist’s reaction to working with sexually exploited children is an essential prong in understanding how one can become susceptible to vicarious traumatization reactions. As with trainees, therapists are typically not eager to express that they experienced reactions to their patients that are not therapeutically grounded. As therapists are trained to be a holding cell for their patient’s emotional turmoil, it would be disrespectful to assume a therapist is devoid of human emotional reactions. Thus this section, although limited by lack of empirical studies is crucial for understanding the varying emotions which could be experienced in therapists. It is essential to understanding how a trainee will little to no trainee can be effected by their patient.

Preventative Strategies

As a therapist and more specifically as a trainee, it is important to be aware of potential vicarious traumatization risk factors. However, Dyregov and Mitchell (1992)

have identified the lack of protective factors as more predictive of increased levels of vicarious traumatization symptoms. Therefore it is imperative to implement preventative measures in the form of self-care techniques throughout organizations and training programs. Saakvitne and Pearlman (1996) stressed that treatment must address the symptoms of vicarious traumatization and the demoralization, or despair, experienced by the therapist, which have both professional and personal implications. The purpose of this section is to review self-care practices as preventative measures against vicarious traumatization. If a therapist begins to experience vicarious traumatization symptoms, the therapist will be unable to maintain rational thinking, causing harm to the therapeutic relationship (Rothschild & Rand, 2006).

Figley (1995) pointed out that the strategies in prevention include balance, setting of boundaries, seeking out help and support, creating a self-care routine, and continual professional training. Saakvitne and Pearlman (1996) suggested that a treatment strategy should include self-care, nurturing activities, and escape. What this means is that the care giver will include better life balance, limits, healthy habits, and connection with others as cornerstones of a wellness strategy. Overall, however, research indicates that actively coping and planning can help protect a trainee from the effects of traumatic material (Pearlman, 1997; Schauben & Frazier, 1995). As trauma work is arduous and painful for the patient to experience, the therapist is also susceptible to psychological pain and the threat of experiencing vicarious traumatization. Vicarious traumatization is an inevitable when working with traumatized populations such as sexually exploited children. It is ludicrous to think a therapist can continue doing this work without experiencing symptoms. A trainee must evoke a standard to protect themselves before being fully

competent to protect others. A therapist must consistently and wholeheartedly employ preventative techniques.

Healthy professional aspects of self-care. There are also several recommended professional strategies for preventing vicarious traumatization. Maintaining boundaries is crucial for establishing a balanced life. Seeking out non-victim related activities such as sports, games and culturally satisfying work which is clearly distinct from the professional occupation are examples of escapes that are effective in nurturing a professional suffering from vicarious traumatization. Taking breaks outside of the office and utilizing vacation time is essential for remembering and cherishing life outside of work.

Recognizing one's own limitations is helpful to the prevention of vicarious traumatization; this can be done through allowing oneself to have personal reactions, maintaining realistic expectations for doing this type of trauma work, avoiding professional isolation, and seeking out supervision and peer support especially following difficult sessions (Armstrong, 1996; Cerney, 1995; Chrestman, 1999; Dyregrov & Mitchell, 1992; Pearlman, 1997; Pearlman & Saakvitne, 1995; Wilson & Lindy, 1994). Additionally limiting the amount and type of patients seen is crucial for maintaining a healthy balance and boundary within the work environment. These findings are consistent with the research of Hellman, Morrison, and Abramowitz (1987) that identified less work-related stress with a moderate amount of patients on ones caseload.

Unhealthy approaches to self-care. As many therapists are unaware of the vicarious traumatization symptoms, they may avoid discussing emotional reactions experienced for fear of shame or feelings of incompetence for not being able to handle

the work. Therapists may engage in unhealthy ways of coping. This can take the form of utilizing drugs and alcohol, denial, isolating themselves from co-workers, friends and family, evoking a code of silence all in service of being the best. A simple refusal to discuss work with their support system without an adequate and appropriate release can set the stage for increased isolation and a further dive into vicarious symptomatology. Isolation and denial are especially tricky, as the therapist will convince themselves that they are protecting their love ones by not burdening them with their work stories.

Deciphering whether the therapist is engaging in unhealthy self-care techniques is difficult to ascertain as many therapists are not aware that they are experiencing vicarious traumatization symptoms and many are unaware that self-care techniques can help prevent symptoms. Although not explicitly studied in the literature, trainees are more likely to engage in unhealthy techniques. However, trainees may not be aware of the reasoning for engaging in these techniques. Rather, they might just feel a need to unwind or may feel the need to have a break, yet rarely attributing these feelings to vicarious traumatization. Additionally, a trainee's status and organizational system where they obtain their field training ignores the need for preventative self-care strategies and infrequently addresses vicarious traumatization risk factors and symptomatology.

It is important to clarify that unhealthy self-care techniques are not the only risk factor for the development of vicarious traumatization; rather it is a combination of varying factors. First and foremost, treating a traumatized patient establishes the foundation for vicarious traumatization development. Secondly the lack of any self-care techniques maintains the vicarious traumatization symptoms. Some professionals would argue that involvement in any self-care practice, whether unhealthy or not, does provide

some benefits. However, these unhealthy techniques do more harm than good. Trainee's lacking the adequate knowledge for the right type of preventative care will continually engage in these unhealthy strategies as it seemingly provides an immediate *fix* for the trainee. Unlike healthy self-care techniques, engagement in unhealthy techniques, once decimated, will inevitably return the therapist to experiencing symptoms.

Personal aspects of self-care. “All therapists should establish and maintain a balance between their professional and personal lives” (Cerney, 1995, p. 140). The achievement of balance in life must occur through five key areas: physical, such as exercise and activity; psychological, such as time for self-reflection; emotional, such as through interactions with significant others and making time for friendships; spiritual, such as allowing the opportunity for experiences of awe; and within the professional realm through supervision and peer support. The different approaches will be examined in depth below.

Physical aspects of self-care. The impact of vicarious traumatization can be reduced when therapists maintain a balance of work, play, and rest (Pearlman, 1997). By focusing on pleasure, comfort, and relaxation, therapists nurture themselves and create a balanced life. Allowing time for other activities provides a natural escape for therapists. This balance can include socializing with friends and family, being physically active, exercising regularly, participating in enjoyably creative activities, getting massages, taking vacations, getting at least eight hours of sleep, turning off cell phones, and taking time off and seeking medical care when sick (Pearlman, 1997; Trippany et al., 2004). Participating in these non-work related activities allows the therapist the opportunity to maintain their personal identity.

Psychological aspects of self-care. This area covers time for self reflection and processing, which is an essential component of self-care. Allowing time for self-reflection provides the therapist with awareness into their own needs, limits and emotional resources. Being aware of the inner state allows the therapist to utilize self-care practices. Balance allows the therapists to keep priorities straight. This area can include activities such as personal psychotherapy, journaling, reading for fun, and engaging in activities that decrease stress. Therapists should engage in activities where someone else is in charge and practice saying no to extra responsibilities.

Engaging the brain in new ways through new activities apart from professional role is also crucial for creation of a balanced life. Therapists should also utilize support systems and provide support to others who may be feeling similarly. By connecting with others personally and professionally, therapists are actively working against using negative coping strategies of avoidance and isolation (Saakvitne & Pearlman, 1996).

Emotional aspects of self-care. This area focuses on comforting activities such as spending time with family and friends, listening to music, and having fun. To continue counteracting isolation and nourish a healthy life, therapists should maintain important relationships, spend time with friends and family, and participate in enjoyable activities with others. Engagement in these activities helps continually build self-esteem. Participating in activities such as journaling, personal counseling, meditation and receiving personal support from others increases the therapist personal tolerance level allowing for reconnection to their emotions (Trippany et al., 2004).

One is trained as a therapist to maintain personal emotions safely apart from the therapeutic relationship. Therapy is seen as a personal time for the patient to explore and

live in their emotions in service of a healthy psyche. Thus, therapists must also allow themselves the opportunity to engage in emotional exploration by allowing themselves moments to cry, finding ways to utilize humor and laughter, and reminding themselves to have a personal reaction. With continual work with traumatic narratives, therapists must allow themselves the opportunity to engage in activities that remind them of healthy and happy interactions such as spending time with animals, playing with children and having dinner with friends.

Spiritual aspects of self-care. This area covers world beliefs, world view, finding meaning in life, cherishing hope, experiencing awe, and engaging in other activities which replenish the therapist. This allows for the therapist to feel grounded. Vicarious traumatization typically results in a loss of a sense of meaning. Without this sense of meaning therapists may become cynical, withdrawn, and emotionally numb (Herman, 1997; Pearlman & Saakvitne, 1995). The defenses that therapists employ to protect themselves from the pain humanity can cause produces changes in the therapists' cognitive systems (Pearlman & Saakvitne, 1995) regarding their world view; therefore, the therapist may now view the world as cruel which causes a reorganization of their spirituality.

Maintaining balance within this area can be done through maintaining connections to others, to ourselves, and to something larger than ourselves. This can be done through a religious affiliation or simply through the belief in the good of others. Therapists with a "larger sense of meaning and connection" (Pearlman & Saakvitne, 1995 p.161) are less likely to experience vicarious traumatization. Activities such as making

time for reflection, spending time in nature, building community, and being aware of the nonmaterial parts of life are all essential in establishing balance within this area.

Therapist may also engage in contributing in important causes, as long as these causes are different than their daily work. For instance, a therapist working daily with former child sexually exploited children should try to avoid engaging in causes such as volunteering at organizations geared at saving these youths from the streets. Therapists can engage in praying, singing, and finding meaning in life separate from their work. Because traumatic material is believed to disrupt the professional's appreciation of the world, therapists need to work harder at identifying a meaning or purpose and engaging in activities that reinforces the therapist's personal sense of value (Saakvitne & Pearlman, 1996). Research has found that therapists find spirituality to be an effective coping mechanism (Pearlman & Mac Ian, 1995). Wittine (1995) suggested that therapists with a strong sense of spirituality are more likely to accept existential realities and as a result are more willing to accept their inability to change these realities.

Integration of these elements to a therapist's lifestyle proves to be very difficult and for some even arduous. The same can also be said for trainees. The most referred reasoning behind the lack of these elements for both groups is time. Many therapists find it difficult to carve time out of their busy schedule to integrate self-care practices into their life. Trainees have additional factors hindering this integration. Trainees lack the education and training to recognize when vicarious traumatization symptoms have begun to manifest. The competitive nature of a graduate program makes identifying symptomatology less desirable. A trainee suffering from these symptoms may inadequately judge the debriefing of these symptoms to a supervisor as being weak and as

a sign of being unable to handle the work. Additionally, trainees are extremely busy and may inadequately view integration of these above mentioned elements as another task added to their schedule. Self-care techniques, then, can seem more of a task than as a helping tool they were intended to be.

Supervisory aspects of self-care. Generally speaking, supervision for a trainee generally consists of individual, group and peer consultation/support. However, it is important for every therapist to receive supervision regardless of licensure status. Supervision can maintain a therapist's self-esteem and safety when discussing emotional reactions. If this is not available at work, outside arrangements should be made as supervision has been seen as a work-related strategy. The availability of supervision should provide emotional safety so the therapist can discuss the symptoms being experienced. Supportive supervision has been found to correlate with relieving stress in mental health professionals (Dutton & Rubinstein, 1995). It is imperative that supervision of a trainee be conducted by someone who is not in an evaluator role of the trainee's therapeutic progress. Supervision must be a safe place where emotional reactions can be discussed without shame.

Supervision of trainees working with trauma should be conducted immediately following work with a trauma patient. This supervision should focus on targeting countertransference reactions, and should include a discussion of therapeutic successes large and small in service of observing efficacy in the work (Saakvitne & Pearlman, 1995). Group supervision can also promote connection by helping examining distortions. Perhaps most importantly, as therapists learn from and support one another in this work, they remember they are not alone, which can help prevent the sense of isolation that can

come from “working under the highly demanding constraints of confidentiality” (Pearlman, 1997, p. 60). Peer supervision is critical for dealing with these constraints. Whereas confidentiality hinders the therapist from debriefing with support systems, therapists can utilize their peers to debrief within an ethical manner (Chrestman, 1999).

Overall, the potential of experiencing vicarious traumatization when working with former child sexually exploited children is exceptionally high. This coupled with the stresses involved in attending and excelling in a clinical psychology graduate training program makes the integration of trauma training and self-care practices integral to the health and well being of the therapist and their patients. The purpose of this project is to provide information on how vicarious traumatization can affect the training therapist and provide a thorough understanding of self-care measures found to be preventative.

Self-Care Challenges in Graduate Level Psychology Students

Psychologists are particularly vulnerable to stress and while they promote self-care practices to their patients, they rarely heed their own advice (Myers et al., 2012). It is not uncommon to see trainees following in supervisor’s example and fail to also engage in self-care practices. Clinical psychology training is a professional and personal challenging experience. Psychology students are more vulnerable to stress than their professional counterparts because of multiple demands placed on them. Trainees deal with juggling multiple roles including being a student, spouse, clinician, wage-earner, and parent. Oftentimes this is done in geographic locations away from primary support systems (Dearing, Maddux, & Tangeny, 2005). These demands make it difficult for students to integrate self-care-practices into their daily life activities. Empirical research focused on graduate students revealed that multiple factors influence student functioning.

These factors include academic coursework, research, clinical training, and financial constraints (Myers et al., 2012) all of which take precedence over their psychological well being.

Although trainees are aware of the implication stress can have on an individual's psyche, they are preoccupied on being the best student and trainee that their self-perception is clouded. Adding the effects of vicarious traumatization to a trainee further complicates the utilization of self-care practices. These findings were supported by Cahir and Morris's (1991) results on a 30-item Psychology Student Stress Questionnaire administered to 133 graduate psychology students in the psychology department of a large, urban university. Results suggested that seven underlying factors affect student functioning. The factors were identified as (a) problems with time constraints, (b) difficulty with feedback from specific faculty, (c) financial constraints, (d) trouble getting help from faculty, (e) limited emotional support from friends, (f) difficulty with feedback with regard to status in the department, and (g) stress from lack of input in program decisions.

The third year in graduate programs was found to be the most stressful in numerous empirical studies as this is the year when trainees are seeking internship placement (Cahir & Morris, 1991). Internship placement is rigorous, highly competitive, and for many is the last step toward licensure. Tallying large quantities of face-to-face clinical hours and work with high risk cases (i.e., trauma cases, sexual exploitation, PTSD) are seen as favorable for internship placements. Thus trainees subject themselves to high levels of patient stress to secure their professional future to the detriment of their personal functioning. Interestingly, females were found to have significantly higher

stress scores than males across all measures. Researchers attributed the gender difference to the impact gender roles allow for women to express more emotions more freely than men. Kaufman (2006) found that female graduate students were more likely than their male counterparts to receive less support from faculty and familial environments.

These results were also supported by Hudson and O'Regan's (1994) study of 244 graduate psychology students in a private Massachusetts professional school. Researchers found that female graduate students who worked full-time and were not in a committed relationship were more likely to experience higher stress levels. Empirical evidence suggests that utilization of social supports including involvement in committed relationship were a protective factor against higher levels of stress. Empirical evidence has found minority graduate students to experience higher disadvantages making them susceptible to increased levels of stress. Underrepresented minority graduate students must deal with negative stereotypes, negative perceptions of their academic merit, prejudice, discrimination, alienation, isolation, and cultural bias (Maton et al., 2011). Social supports have continually been identified in the literature to protect students against the effects of stress (Calicchia & Graham, 2006).

Trainees in clinical settings need to understand the hardships of the profession and the impact this has on their professional and personal lives. Trainees that are prepared in implementing self-care practices will be able to promote life-long professional functioning. Through the use of self-care practices, trainees will be able to view their chosen profession as manageable, will report greater access to support systems, will engage less in negative self-care practices, and will report less psychological disturbances. Finding healthy ways to cope with the demands of graduate training is

crucial in establishing effective self-care practices during the course of an individual's career.

Chapter III: Methods

The purpose of this dissertation was to create a self-care workshop for training therapists who work with sexually exploited children. The intent of the workshop is to serve as a primary prevention strategy for vicarious traumatization by providing specific self-care techniques to training therapists based on existing educational materials. This chapter will outline the steps followed to develop, formulate, and evaluate the self-care workshop.

Introduction

This workshop is intended for trainees pursuing a psychology master's degree or higher, including interns under the supervision of a licensed clinician. It is a workshop for trainees but may also be useful to supervisors treating sexually exploited children. Supervisors would be able to learn how to recognize the signs and symptoms of vicarious traumatization and help support and enhance self-care practices in their trainees. The workshop's focus is on providing psychoeducation about the signs and symptoms of vicarious traumatization and the identification of healthy self-care techniques.

This workshop is a psychoeducational tool and does not assume that trainees who participate exhibit signs of vicarious traumatization. Although the workshop has not been implemented, evaluators of the workshop were presented with information that the facilitator would possess should a trainee exhibit distress related to the topic of the workshop. Specifically, the facilitator would refer the trainee to seek consultation with their supervisor, to seek individual therapy, and the facilitator would provide recommendations for additional psychoeducational resources and training. The additional resources were also included in the final format of the workshop.

Trainees learn ways in which vicarious traumatization is experienced and expressed. Additionally, they learn how to identify and implement self-care techniques and learn to distinguish between healthy and unhealthy self-care practices

Rationale for Workshop Development

The National Center for Educational Statistics (2011) estimated that 19.7 million students would attend American colleges and universities in 2011. This represents an increase of 4.4 million students since 2000, and includes graduate level students obtaining psychological training. Concurrently, the United States ranks as the second largest market country for women and children trafficked for purposes of sexual exploitation (Mizus et al., 2003), with prostitution as the end product of sex trafficking. This alarming fact increases the likelihood that trainees will inevitably treat an individual with a history of sexual trauma and/or exploitation.

The increasing number of graduate level trainees tends to be younger in age and less experienced. These two factors have been found to be highly correlated with the development of vicarious traumatization (Arvay & Uhlemann, 1996; Pearlman & Mac Ian, 1995). Trainees do not have an adequate amount of experience or training in treating sexually abused children, and lack the ability to draw from prior training experience to navigate through these symptoms (Pearlman & Saakvitne, 1995). Ladany and Friedlander (1995) have found trainees at greater risk for developing vicarious traumatization symptoms.

The current literature is limited to signs and symptoms therapists typically experience. Limited information is available for the identification of vicarious traumatization within trainees and far less is available regarding the implementation of

self-care practices. If vicarious traumatization symptoms are left unattended, there is a risk the trainee may become emotionally distant, unable to maintain a warm, empathic, and responsive stance to patients, and may experience burnout and subsequent departure from the field (McCann & Pearlman, 1990, as cited in Adams & Riggs, 2008).

Therapists also reported experiencing low self-regard, negative coping strategies, higher levels of stress, and having negative reactions to sexual abuse and exploitation cases (Follette et al., 1994). Vicarious traumatization also hinders trainees from seeking out adequate supervision and support (Neumann & Gamble, 1995; Pearlman & Mac Ian, 1995). Thus, these effects have led to a growing consensus supporting the need for training and supervision in trauma work as part of the graduate curricula (Campbell et al., 1999; Figley, 1995). Training specifically focusing on the prevention of vicarious traumatization will help provide trainees with the necessary skills required for working with this distinct patient population.

Educational Objective

Campbell et al. (1999) identified the lack of protective factors as more predictive of increased levels of vicarious traumatization symptoms. Therefore, it is imperative to implement preventative measures throughout training programs. Trainees learn self-care techniques for prevention including balancing personal and professional responsibilities, setting of boundaries, seeking out help and support, creating a self-care routine, and understanding the need for seeking out continual professional training. Utilizing Saakvitne and Pearlman's (1996) suggestions, self-care practices including nurturing activities and developing a life apart from work was implemented in the workshop. This

workshop elucidates the need for creating a better life balance, setting limits, and employing healthy habits.

Although the workshop was designed for trainees working with sexually exploited children, the elements discussed therein are universal to all clinicians working with a multitude of traumatic material. Therefore, the information presented within this workshop can be adapted for trainees and professionals working with varying traumatic narratives.

Workshop Description

The Self-Care Practices: Preventing Vicarious Traumatization in Trainees Working with Sexually Exploited Children workshop is a 3-hour long workshop combining didactic discussion and preventative self-care techniques. The overarching objective of this workshop is aimed at facilitating the expansion of trainees' self-care practices when working with trauma narratives generated by sexually exploited children, by helping the trainees to:

1. Increase knowledge about the onset and development of vicarious traumatization symptoms when working with trauma narratives.
2. Understand the vulnerability inherent in being a graduate training student and how this contributes to a higher risk of experiencing vicarious traumatization.
3. Identify and plan implementation of self-care techniques and appreciate the distinction between healthy and unhealthy self-care practices.

Structure of the Workshop

The workshop is to be conducted in a single three-hour long format (see Appendix A). However, the facilitator could lengthen or shorten the duration of the program depending on the unique needs and circumstances of the trainees involved, as well as any logistical concerns of the setting within which the workshop is provided.

Development of the Workshop

To develop the workshop, the researcher followed the steps outlined below:

1. The researcher contacted the Traumatic Stress Institute for the most current publications for programs targeting prevention of vicarious traumatization among training therapists working with sexually exploited children and tailored them to meet the needs of trainees.
2. The researcher contacted each producer of materials regarding vicarious traumatization and self-care techniques and sought permission to modify materials for the use of trainees when applicable.
3. A resource inventory of all materials obtained was integrated into the workshop and a handout for trainees was created. The resource inventory included title, author, source, and a brief description of the program (see Appendix B).

Formulation of the Workshop

The workshop is a training therapist's resource for the primary prevention of vicarious traumatization when working with sexually exploited children. The nature and extent of the guidelines utilized for a preventative self-care techniques program was loosely based on the guidelines formulated by Geller et al. (2004) to prevent vicarious traumatization among helping professionals. Following the above completed steps, the researcher continued with the subsequent steps delineated below:

1. A review of self-care recommendations in current literature was conducted and formed the basis of the learner objectives.
2. As there is a shortage of published, empirically based tools aimed at assessing self-care, the self-care assessment tools used as part of the PowerPoint presentation (Life Style Behavior Checklist and the Self-Care Assessment Worksheet) are not empirically based. The author utilized these worksheets simply as a learning tool for attendees.
 - a. The Life Style Behavior Checklist (see Appendix C) acquired from the University of Buffalo, Graduate School of Social Work, was obtained and integrated into the workshop. This checklist is divided into two sections, negative and positive behaviors individuals engage in during times of stress. The purpose of this checklist is to enable trainees to understand the

difference between healthy and unhealthy behaviors and encourage them to start using healthy behaviors.

- b. Self-Care Assessment Worksheet (see Appendix D) also acquired from the University of Buffalo, Graduate School of Social Work, was obtained and integrated into the workshop. The worksheet was originally published in Saakvitne and Pearlman's (1996) *Transforming the pain: A workbook on vicarious traumatization*. The worksheet's foundation was based on Saakvitne and Pearlman's constructivist self-developmental theory. The worksheet is divided into four domains: mind, body, emotions and spirit. Trainees are encouraged to identify their current practice within each domain and identify new strategies that they would begin to incorporate as part of their ongoing maintenance self-care plan. The purpose of the worksheet is to encourage trainees to pay particular attention to domains that they have not been addressing in the past. The last page of the worksheet identifies barriers that could interfere with ongoing self-care, how trainees would address them, and any negative coping strategies they would like to target for change.
3. All published materials and programs identified and obtained to compile the workshop content were reviewed to assess the extent to which they would be incorporated into the workshop to help meet the learner objectives of the program. In addition, all materials were evaluated for their relevancy to treating sexually exploited children.
4. Based on the review of the literature, new self-care practices were constructed and trainees would be given techniques on how to maintain balance within their specific organizational culture.

Evaluation of the Workshop

1. Upon completion of the workshop, it was forwarded to the five experts to assess its validity. The evaluators were identified based on their expertise in the field of vicarious traumatization, self-care, working with sexually exploited children, and providing supervision to trainees.
2. The Experts were chosen from a convenience sample of this author's professional network. The author's clinical psychology professor from Pepperdine University and this author's clinical psychology internship director at Boston University School of Medicine were approached to be formal evaluators of the workshop. The author then used a snowball sampling method as each initial expert provided contact information of other experts.
3. The experts obtained through the snowball sampling methods had specialized training and experience in working with trauma populations, such as working with sexually abused female adolescents in residential treatment programs, evaluating children experiencing sexual abuse in court clinics, and working

with sexually exploited child refugees and children affected by war. The evaluators worked in a variety of settings ranging from medical hospitals, public schools, and private practice to graduate psychology programs.

- a. Evaluator # 1: is a clinical psychologist working as graduate level psychology professor. He concurrently conducts extensive research on adult survivors of trauma, specializing in improving treatment for Posttraumatic Stress Disorder in combat veterans. He continues to do research on a variety of trauma populations, including battered women, adult and child survivors of childhood sexual abuse, and adolescent survivors of gang-related violence.
- b. Evaluator # 2: is a clinical psychologist, designated forensic psychologist, researcher and internship director. Evaluator # 2 has done extensive work in multicultural behavioral health, disaster response, trauma and grief, substance abuse and co-morbid disorders. Evaluator # 2 is a member of the Behavioral Health Disaster Response Cadre of the Substance Abuse and Mental Health Services Administration (SAMHSA) and has been training pre-doctoral graduate level psychology students for over 13 years.
- c. Evaluator # 3: is a clinical psychologist with a specialization in child and Forensic Psychology. She has managed many behavioral health programs and is currently a school psychologist where she treats children with sexual and physical abuse histories. Evaluator # 3 has been training pre-doctoral graduate level psychology students for over 20 years and has worked in court clinics evaluating child victims of sexual abuse.
- d. Evaluator # 4: is a board certified clinical psychologist and has been practicing and providing supervision to psychology trainees for over 30 years. She provides evaluations and consultation for asylum-seeking refugees and maintains a private practice. Evaluator # 4 consults to schools, corporations and government agencies and is an adjunct graduate psychology professor. Evaluator # 4 was trained in Critical Incident Stress Debriefing and in Psychological First Aid for workplace and community disaster.
- e. Evaluator # 5: has been a clinical psychologist with over 20 years of experience working with individuals (adults, children, and adolescents), families and couples. is a clinical psychologist who owns a private practice focusing on child and family work. Evaluator #5 has worked as an associate psychology professor at a school of medicine and has provided training to pre-doctoral graduate level psychology students working with victims of sexual abuse for over 10 years.

Additionally, Evaluator # 5 has worked extensively with Native Americans providing trauma focused cognitive behavioral therapy.

4. As a group, the evaluators had an average of 25.2 cumulative years being licensed and 16.2 years providing supervision to trainees.
5. Experts were contacted via phone, email, and a letter drafted to explain the purpose of the correspondence (see Appendix E). The experts were provided with nine questions (see Appendix F) to ascertain whether they believed the workshop would help trainees learn self-care techniques to help prevent vicarious traumatization.
6. Because the workshop was not implemented and/or piloted for this study, and the research did not use a protected group as subjects, an IRB review process was not implemented (see Appendix G).
7. Evaluator feedback was analyzed using an abbreviated form of content analysis. Content analysis is a research technique used in quantitative and qualitative research for making inferences from responses (White & Marsh, 2006).

Completion of the Workshop

The final product of this study is presented in the form of a PowerPoint presentation that would be central to the workshop presentation. The PowerPoint workshop presents a general overview of trauma, reactions to trauma (e.g., shame, guilt, anger, sadness, fear), development of vicarious trauma, symptoms of vicarious traumatization (e.g., intrusive imagery, avoidance, emotional numbing, hypervigilance, decreased self esteem, decrease in own competence, disruptive cognitive symptoms), differences among vicarious traumatization and other commonly used conceptual terms, and risks associated with treating sexually exploited children by graduate psychology students. Finally, and at the core of the PowerPoint presentation, information about unhealthy and healthy self-care techniques is presented and trainees would be guided on how to develop and maintain a self-care plan. A copy of the PowerPoint presentation

with detailed facilitator notes and handouts for trainees is also included (see Appendix H).

Chapter IV: Results

The PowerPoint workshop was developed to provide adjunctive training on vicarious traumatization and self-care techniques for trainees working with sexually exploited children. The PowerPoint workshop was intended to provide trainees with information about how vicarious traumatization is experienced and expressed. More importantly, the workshop was developed to help trainees identify and implement self-care techniques and to distinguish between healthy and unhealthy self-care practices to help prevent and/or ameliorate the symptoms of vicarious traumatization. The results of this dissertation are presented in this chapter, including the PowerPoint presentation that was developed and the feedback from experts in the field of trauma and graduate education in psychology who were invited to evaluate this workshop.

Workshop

The *Self-Care Practices: Preventing Vicarious Traumatization in Trainees Working with Sexually Exploited Children* PowerPoint was developed as a three-hour long workshop. The overarching objective of the workshop was to facilitate the expansion of trainees' self-care practices, highlight the vulnerability in being a trainee and educate trainees on vicarious traumatization. Additionally, the workshop was designed to provide trainees with an opportunity to learn how to develop a self-care plan using the Lifestyle Behavior Checklist. This tool helps to determine whether self-care practices used by trainees are healthy or unhealthy. Through this assessment, trainees are encouraged to eliminate at least one negative self-care practice. Finally, the workshop offers trainees an opportunity to use the Maintenance Self-Care plan. This worksheet

was adapted from *Transforming the pain: A workbook on vicarious traumatization* by Saakvitne and Pearlman (1996). This worksheet is useful in helping trainees adhere to their proposed plan established, in part, during the workshop.

Evaluator Feedback

Feedback on the PowerPoint workshop was collected via an evaluation form developed by the author for the purpose of gathering feedback regarding the validity of the designed workshop (see Appendix F). Experts in the field of vicarious traumatization and self-care and with expertise working with sexually exploited children and supervising trainees in the trauma field were invited to review the PowerPoint workshop, including the facilitator notes. The experts were instructed to complete the evaluation following a review of the PowerPoint workshop. All five experts (100%) who were approached to be a part of the study completed the form and provided written comments. The qualitative data were reviewed and integrated into cohesive feedback by the Dissertation Chair and the author by conducting an abbreviated form of content analysis (White & Marsh, 2006).

Table 1

Expert Quantitative Evaluation Responses

Question	1	2	3	4	5
Did you find this workshop particularly useful as it pertains to teaching self-care practices to graduate level psychology trainees?	0%	0%	0%	40%	60%

(continued)

Question	1	2	3	4	5
Were there aspects of the workshop that you did not find particularly relevant for its intended purposes?	60%	20%	0%	20%	0%
Do you consider this workshop to be a strength in providing trainees with self-care techniques when treating sexually exploited children?	0%	0%	0%	40%	60%
Do you consider this workshop to be a weakness in providing trainees with self-care techniques when treating sexually exploited children?	80%	20%	0%	0%	0%
Did the workshop provide information in a concise, easy-to-follow manner?	0%	0%	0%	40%	60%

(continued)

Question	1	2	3	4	5
Would you recommend this workshop to trainees and supervisors?	0%	0%	0%	60%	40%

Note. Responses based on a scale of 1-5 where 1 is not at all true and 5 is very much true.

Table 2

Expert Qualitative Evaluation Responses

Question	Content Responses
What could have been added to the workshop to make it more useful for preventing vicarious traumatization in trainees?	<ul style="list-style-type: none"> • Add in practical exercises (breathing exercises, dance/movement) • Generally very complete • I might include something that normalizes the experience of vicarious traumatization so that the trainee knows that this happens with others and perhaps could be talked about more openly and preventively. • Add in examples, discussion, and community sharing of experiences. • Add a multi-media presentation with many cases and many chances for discussion. • Students need time to integrate the ideas and talk through their own experiences.
What section of the workshop would you omit, change or revise?	<ul style="list-style-type: none"> • It would be important to know how much exposure to similar training students had before the workshop. • I would like to see some visuals, pictures, and sounds added if PowerPoint is the only way to provide this information. Healing music, guided imagery, and instruction on yoga poses would be helpful. Comfort healing foods might be helpful.

(continued)

Question	Content Responses
What section of the workshop would you omit, change or revise?	<ul style="list-style-type: none"> • would not omit sections, but there are 11 slides • with word suggestions; they are as follows: 23–25; 39, 40–42; 44, 49, 55, and 81. • The following slides needed some changes in content and wording: 2, 3, 5, 6, 20–22, 34, 42, 44, 62, and 70–71. • None as I thought it was thorough and to my thinking, a comprehensive overview is valuable.
Additional comments and/or suggestions	<ul style="list-style-type: none"> • I hope this is implemented; something like this would be good for non-professional employees at clinics who work with traumatized children as well. Also, the integration of the expressive therapy modality of healing may be very beneficial. • It was helpful and concise. It labeled and described things in a simple way. It would be very useful to use in a supervision session to begin a dialogue and have concrete information in front of you. • This workshop is well-conceived and makes a very user-friendly contribution to the clinical training of graduate students. Congratulations and thank you!

Summary

Five experts in the field (i.e., evaluators) were invited to provide feedback on the PowerPoint workshop *Self-Care Practices: Preventing Vicarious Traumatization in Trainees Working with Sexually Exploited Children*. The author sought to utilize the expertise of the evaluators to evaluate the information originally developed for the workshop.

Overall, four out of five evaluators found the workshop *very* helpful for trainees to recognize vicarious traumatization symptoms. Similarly, two out of the five evaluators would *very much* recommend the workshop to trainees and supervisors and three out of the five evaluators would generally recommend it. In terms of teaching self-care practices, two out of the five evaluators found it to be generally *helpful* and three out of the five evaluators found the workshop to be *very helpful*. Likewise, three out of the five evaluators found the workshop to be *very much* a strength in providing trainees with self-care techniques, indicating that it was *very much* concise and easy to follow. Also, three out of the five evaluators did not find aspects of the workshop that were not relevant, one out of the five evaluators generally did not find any aspects of the workshop that were not relevant, and 20% found that generally some aspects of the workshop were not relevant.

The evaluators also provided qualitative comments. Using an abbreviated form of content analysis (White & Marsh, 2006), three things were identified to improve the workshop. First, several evaluators suggested increasing the level of trainee participation by integrating breaks into the PowerPoint presentation to provide trainees with opportunities for case discussion and case studies. The evaluators stated that these discussions can also help the normalization of trainees' symptoms and experiences by providing opportunities for trainees to share experiences, discuss the information presented, and begin to fully integrate what they have learned. Second, some evaluators stated there is a need to introduce and practice simple self-care techniques, such as breathing exercises, guided imagery, instruction on yoga poses, and dancing so trainees can begin to translate self-care techniques into practice. Finally, the evaluators

commented that aesthetic changes, including incorporating more pictures and sound, would be helpful.

Overall, the evaluators stated that the comprehensive and concise approach the workshop employed was well-conceived and would be a very user-friendly contribution to the clinical training of graduate students and non-professional individuals working with this population.

Chapter V: Discussion

Evaluation of the Manual

This self-care workshop was created to address the significant need for resources available to assist trainees in increasing their awareness and knowledge of vicarious traumatization when treating sexually exploited children. To assess the accuracy and usefulness of the workshop for its intended purposes, five professional, licensed psychologists with varied areas of expertise including, vicarious traumatization, trauma narratives, self-care, treating sexually exploited children and providing supervision to trainees gave feedback on its content and format. Overall, the evaluators agreed that the workshop was effective in providing trainees with a resource for vicarious traumatization and self-care practices. They rated the workshop as strong in providing a training opportunity to help trainees effectively implement self-care practices and would recommend this workshop to trainees in the field. Additionally the evaluators identified the practical implications for non-mental health professionals such as clinical staff and paraprofessionals and anticipated the implementation of this workshop in training communities.

The workshop was created to serve as a starting point for trainees treating sexually exploited children who have no formal trauma training. More importantly, the workshop development focused on providing a foundational introduction to vicarious traumatization and teaching self-care techniques to prevent and possibly ameliorate related symptoms. Based on evaluator feedback, this workshop appears to have succeeded in achieving its stated goals.

Limitations and Recommendations

Several general limitations and recommendations for the workshop emerged from a review of the evaluation results provided by the five experts. One limitation involved the need for the workshop to increase the level of trainee participation. Evaluators expressed the need for trainees to share personal examples of how they experienced vicarious traumatization. The integration of opportunities for self-disclosure by participants would enhance the learning goal of identifying the symptoms, and what steps have been undertaken by trainees to help address them.

Therefore, one recommendation would be to restructure the workshop to facilitate breaks in the presentation, specifically following didactic information, to allow trainees the opportunity to discuss the information and the impact it may have on their work as a trainee. Overall, integrating discussions into the workshop can help to normalize the experience of vicarious traumatization for trainees and validate their need for support, debriefing, and self-care. This would also provide trainees with the opportunity to absorb didactic information better. Trainees could pose questions to the facilitator and other trainees to help further their learning process. For instance, some trainees may want to share their experience of vicarious traumatization with the group, and other trainees may be able to share how they manage to integrate self-care techniques, especially when self-care is not fostered by training programs and supervisors.

Similarly, the evaluators expressed the view that an open discussion and normalization of symptoms among the trainees is important, especially in light of research showing that trainees are more vulnerable to feelings of anxiety and self-doubt about their clinical work (Cahir & Morris, 1991). Trainees attending this workshop may

inadvertently become convinced that their experience of vicarious traumatization means that they lack crucial trauma focused clinical and self-care skills or they may feel generally inadequate as therapists. Consequently, they could blame themselves either for not having or not knowing they needed to have skills to address their vicarious traumatization through self-care. Therefore, the workshop will be modified to include specific research citations on the likelihood of experiencing vicarious traumatization in trainees, to normalize the symptoms or experiences of vicarious traumatization. For example, this can be facilitated by highlighting the work of Jones et al. (1998). Based on reviewing the results of this study, Trainees will learn that exposure to patient's graphic accounts of sexual abuse experiences and to the realities of people's intentional cruelty to one another and inevitable participation in traumatic reenactments on the therapeutic relationship, leave the trainee vulnerable to a variety of emotional reactions.

The evaluators also identified the limitation that the workshop described self-care practices but did not teach attendees practical self-care techniques they could implement immediately following the workshop. This limitation can be addressed by restructuring the workshop and facilitator notes in such a way as to demonstrate information on self-care techniques. For example, the workshop could begin with an exercise in deep breathing to get the trainees in the mindset that they would benefit from greater relaxation before discussing difficult topics. This in turn will demonstrate that the same self-care techniques can be practiced before treating trauma populations. Another recommendation is to build in specific breaks where trainees are instructed to get up from their seats, move around, stretch, and talk about how they are feeling in the moment.

Another limitation the evaluators identified was the academic nature of the PowerPoint presentation. This limitation can be addressed through the integration of aesthetic changes such as converting statistical information into charts and graphs. By making the PowerPoint presentation visually more appealing, trainees can remain engaged and alert to fully participate in the workshop and integrate the information presented. This was an important recommendation, as the topic of trauma coupled with a three-hour presentation can be exhausting and overwhelming for some trainees.

Additional Workshop Modifications

Based on the recommendations generated by the evaluators, several additional modifications to the workshop are proposed. First, slides in the PowerPoint presentation addressing definitions of related terms (e.g., burnout, traumatic countertransference, secondary traumatic stress) will be omitted to help limit the potentially overwhelming amount of information presented. Additionally, slides addressing general information on prostitution and trafficking will also be omitted in order to keep the scope of the project to the intended treating population, sexually exploited children. Further, citations to provocative statements (e.g., therapist experiencing sexual arousal when treating sexually exploited children) will be added to the PowerPoint. Finally, a practical discussion on the use of self-care practices specific to therapists treating sexually exploited children will be added. This will be facilitated through the integration of case discussions and vignettes about trainees' self-care success stories and failures.

A rationale for the use of self-care techniques by trainees will be emphasized and trainees will be provided with ways to cope with treating sexually exploited children when their environment does not provide nor support the use of organizational and

personal self-care practices. For example, emphasizing to trainees the importance of taking lunch breaks and, when possible, outside of the office. Trainees will also be encouraged to allow time between cases to debrief with peers and supervisors. If the organization environment does not allow trainees to schedule patients in such a fashion, trainees are encouraged to seek out support and debriefing at the end of each clinical day via supervisors, other trainees and colleagues.

Future Directions

From the evaluators' feedback, it appears that the workshop is a crucial training tool, and the next step in development of an effective workshop would be to conduct a pilot workshop so that the feedback collected as part of the study could be integrated to improve the workshop. Through the pilot, we would gather data on trainees' reactions to the materials presented, as well as any needs that trainees feel are not being addressed. One of the advantages of conducting the pilot study is that it might give advance warning about the shortcomings of the workshop in addressing vicarious traumatization, and whether proposed information included in the workshop or instruments used were ineffective. The pilot study might also give advance warning about whether the information covered can have adverse reactions to trainees such as, bringing to supervisors' awareness trainees that are ill equipped to deal with the impact of specific trauma related work.

The pilot study will pave the way for a research study focused on outcome data for trainees who do and do not receive the workshop. Future research can focus on the potential positive and negative outcomes of training students specifically on combating vicarious traumatization by implementing self-care practices. Additionally, this author

identified areas of research that can expand the field of self-care within graduate level psychology trainees. For instance, research is needed to identify trainee's personal factors that would make them successful and unsuccessful when treating sexually exploited children and how this relates to their risk level for experiencing vicarious traumatization. For example, research is needed to identify whether and how trainees' own personal sexual abuse history may be beneficial or detrimental to the outcome of therapy when treating exploited children. Also, future research can focus on identifying which types of personal trauma histories could be especially relevant when treating sexually exploited children, as well as identifying which factors act as a buffer against vicarious traumatization.

Another area of proposed research is exploring the motivating factors associated with the initiation and continued use of self-care practices in trainees, as well as identifying factors that would prevent a trainee from engaging in self-care techniques. For instance, does being a psychology trainee make it easier to understand self-care literature and the benefits associated with self-care practices? Or does the status of being a student and the competition inherent in any graduate level program diminish the importance of integrating self-care into trainee's daily lives? The importance of self-care can be presented such that both aspects are addressed. This will help trainees augment their self-care practices to reflect their trainee status, values and needs.

Conclusion

The development of this workshop is a first step in addressing the need for continued focus on the importance of trauma-specific training for trainees and the importance of highlighting self-care techniques. Through this workshop, trainees were

encouraged to focus on their own inner reactions and develop techniques that would help maintain a healthy sense of self. Although this workshop was developed for trainees, the applicability of the workshop's teachings is universal for all mental health professionals. The hope is that trainees would provide quality treatment to highly traumatized populations in a manner that was helpful and not detrimental to the trainee or the patient. In order to continue championing the importance of trauma-specific training for graduate students, future research is needed to undertake the creation and implementation of practical training models for trainees treating sexually exploited children. Until this is fully realized, trainees remain at risk of experiencing vicarious traumatization and will continue to lack foundational techniques needed to work through such symptoms, ultimately placing their patients at risk.

As a trainee who has experienced vicarious traumatization, I wanted to provide my community of trainees with a tool that focuses on the trainees' well-being. My hope in developing this workshop is that trainees would learn the detriments of vicarious traumatization and begin to integrate self-care practices into their daily life, regardless of what population they treat. Thus, the main focus and point of change is the trainee; however, the effects will be far reaching and ultimately improve patient outcomes.

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APPENDIX A

Structure of the Workshop

The Self-Care Practices: Preventing Vicarious Traumatization in Trainees Working with Sexually Exploited Children

- I. Workshop Objectives
- II. Trauma: What is it?
- III. Reactions to Trauma
 - a. Commonly researched post trauma symptoms
- IV. Vicarious Traumatization
 - a. Symptoms of Vicarious Traumatization
 - b. Evolution of Vicarious Traumatization from Burnout, Traumatic Countertransference, Secondary Traumatic Stress
- V. Graduate Psychology Students
 - a. Lack of training in graduate programs
 - b. Reasoning why this population is more susceptible to VT
- VI. Prostitution
- VII. Sexually Exploited Children
- VIII. Therapist Reaction to Child Sexual Abuse
- IX. Self-Care Techniques
 - a. Healthy Self-Care Practices
 - b. Unhealthy Self-Care Practices
- X. Self-Care Challenges in Graduate Students
- XI. Life Domains of Self-Care
 - a. Personal Aspects of Self-Care
 - b. Psychological Aspects of Self-Care
 - c. Emotional Aspects of Self-Care
 - d. Spiritual Aspects of Self-Care
- XII. Developing Your Self-Care Plan
 - a. Maintenance Self-Care Plan
 - b. Lifestyle Behavior Assessment
 - c. Tips to Follow Your Self-Care Plan
- XIII. Additional Resources
- XIV. Questions

APPENDIX B

Resource Inventory

Books:

Bill (2001) *Streetwise to Sex-Wise: Sexuality Education for High-Risk Youth*. New Brunswick, NJ: Planned Parenthood of Greater Northern New Jersey, Inc.

Bridgeman, D. L. (2009). *The complexities of Psychologists' Self-Care, Coping & Wellness an informal self-assessment*. Sacramento, CA: California Psychological Association.

McCann, I. L., & Pearlman, L. A. (1990). *Psychological trauma and the adult survivor: Theory, therapy, and transformation*. Levittown, PA: Brunner/Mazel, Inc.

Norcross, J. C., & Guy, J. D. (2007). *Leaving it at the office: A guide to psychotherapist Self-Care*. New York, NY: Guilford Press.

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

Saakvitne, K. W, Gamble, S., Pearlman, L. A., & Tabor, L. B. (2000). *Risking Connection: A training curriculum for working with survivors of childhood abuse*. Baltimore, MD: Sidran Press.

Saakvitne, K.W., & Pearlman. (1996). *Transforming the pain: A workbook on vicarious traumatization for helping professionals who work with traumatized clients*. New York, NY: Norton & Co.

Online Resources:

Traumatic Stress Institute (<http://traumaticstressinstitute.org>)

National Child Traumatic Stress Network (<http://www.nctsn.org/>)

University of Buffalo, School of Social Work
(<http://www.Socialwork.buffalo.edu/students/self-care>)

APPENDIX C

The Lifestyle Behavior Checklist

Below are lifestyle behaviors that affect stress levels. Please check the boxes that apply to you. Doing an honest assessment of how well or poorly you take care of yourself can help you manage your stress in the future.

Lifestyle Behaviors¹					
When you are under stress, do you:	Yes	No	When you are under stress, do you:	Yes	No
Smoke/use tobacco	<input type="checkbox"/>	<input type="checkbox"/>	Engage in physical activity at least three times a week for 30 minutes each day	<input type="checkbox"/>	<input type="checkbox"/>
Drink a lot of coffee or caffeinated drinks (more than 2-3 cups per day)	<input type="checkbox"/>	<input type="checkbox"/>	Get six to eight hours of sleep every night	<input type="checkbox"/>	<input type="checkbox"/>
Drink alcohol (more than recommended levels of 1-2 per day)	<input type="checkbox"/>	<input type="checkbox"/>	Maintain good eating habits	<input type="checkbox"/>	<input type="checkbox"/>
Overuse over-the-counter medications	<input type="checkbox"/>	<input type="checkbox"/>	Make time to relax	<input type="checkbox"/>	<input type="checkbox"/>
Overeat or under eat	<input type="checkbox"/>	<input type="checkbox"/>	Maintain a sense of humor	<input type="checkbox"/>	<input type="checkbox"/>
Spend too much money (e.g., do you have a lot of credit card debt and have trouble making payments?)	<input type="checkbox"/>	<input type="checkbox"/>	Play	<input type="checkbox"/>	<input type="checkbox"/>
Abuse/overuse tranquilizers or other over-the-counter medications	<input type="checkbox"/>	<input type="checkbox"/>	Maintain healthy rituals and routines	<input type="checkbox"/>	<input type="checkbox"/>
Watch too much television (more than 3-4 hours per day)	<input type="checkbox"/>	<input type="checkbox"/>	Be optimistic. Engage in positive thinking	<input type="checkbox"/>	<input type="checkbox"/>
Have angry outbursts	<input type="checkbox"/>	<input type="checkbox"/>	Spend time with family	<input type="checkbox"/>	<input type="checkbox"/>
Take illegal drugs	<input type="checkbox"/>	<input type="checkbox"/>	Spend time with friends	<input type="checkbox"/>	<input type="checkbox"/>
Withdraw from people	<input type="checkbox"/>	<input type="checkbox"/>	Make plans for the future	<input type="checkbox"/>	<input type="checkbox"/>
Ignore or deny stress symptoms	<input type="checkbox"/>	<input type="checkbox"/>	Figure out ways to manage stress	<input type="checkbox"/>	<input type="checkbox"/>
Engage in self-destructive relationships	<input type="checkbox"/>	<input type="checkbox"/>	Reward yourself for your accomplishments	<input type="checkbox"/>	<input type="checkbox"/>
These are negative self-care behaviors.			These are positive self-care behaviors.		

¹ Appendix C: Life Style Behavior Checklist. Adapted from the University of Buffalo School of Social

APPENDIX D

Self-Care Assessment Worksheet

Self-Care Assessment Worksheet²

Using the scale below, rate the following areas in terms of frequency:

- 5 = Frequently
- 4 = Occasionally
- 3 = Rarely
- 2 = Never
- 1 = It never occurred to me

Physical Self-Care

- _____ Eat regularly (e.g. breakfast, lunch and dinner)
- _____ Eat healthy
- _____ Exercise
- _____ Get regular medical care for prevention
- _____ Get medical care when needed
- _____ Take time off when needed
- _____ Get massages
- _____ Dance, swim, walk, run, play sports, sing, or do some other physical activity that is fun
- _____ Take time to be sexual—with yourself, with a partner
- _____ Get enough sleep
- _____ Wear clothes you like
- _____ Take vacations
- _____ Take day trips or mini-vacations
- _____ Make time away from telephones

Psychological Self-Care

- _____ Make time for self-reflection
- _____ Have your own personal psychotherapy
- _____ Write in a journal
- _____ Read literature that is unrelated to work
- _____ Do something at which you are not expert or in charge
- _____ Decrease stress in your life
- _____ Let others know different aspects of you
- _____ Notice your inner experience—listen to your thoughts, judgments, beliefs, attitudes, and feelings

- _____ Engage your intelligence in a new area, e.g. go to an art museum, history exhibit, sports event, auction, theater performance
- _____ Practice receiving from others
- _____ Be curious
- _____ Say “no” to extra responsibilities sometimes
- _____ Other:

Emotional Self-Care

- _____ Spend time with others whose company you enjoy
- _____ Stay in contact with important people in your life
- _____ Give yourself affirmations, praise yourself
- _____ Love yourself
- _____ Re-read favorite books, re-view favorite movies
- _____ Identify comforting activities, objects, people, relationships, places and seek them out
- _____ Allow yourself to cry
- _____ Find things that make you laugh
- _____ Express your outrage in social action, letters and donations, marches, protests
- _____ Play with children
- _____ Other:

Spiritual Self-Care

- _____ Make time for reflection
- _____ Spend time with nature
- _____ Find a spiritual connection or community
- _____ Be open to inspiration
- _____ Cherish your optimism and hope
- _____ Be aware of nonmaterial aspects of life
- _____ Try at times not to be in charge or the expert
- _____ Be open to not knowing
- _____ Identify what is meaningful to you and notice its place in your life
- _____ Meditate

- _____ Pray
- _____ Sing
- _____ Spend time with children
- _____ Have experiences of awe
- _____ Contribute to causes in which you believe
- _____ Read inspirational literature (talks, music, etc.)
- _____ Other:

Workplace or Professional Self-Care

- _____ Take a break during the workday (e.g. lunch)
- _____ Take time to chat with co-workers
- _____ Make quiet time to complete tasks
- _____ Identify projects or tasks that are exciting and rewarding
- _____ Set limits with your clients and colleagues
- _____ Balance your caseload so that no one day or part of a day is “too much”
- _____ Arrange your work space so it is comfortable and comforting
- _____ Get regular supervision or consultation
- _____ Negotiate for your needs (benefits, pay raise)
- _____ Have a peer support group
- _____ Develop a non-trauma area of professional interest
- _____ Other:

Balance

- _____ Strive for balance within your work-life and workday
- _____ Strive for balance among work, family, relationships, play and rest

APPENDIX E

Outreach Letter Sent to Experts

Dear Professional,

My name is Krystle K. Madrid and I am a psychology doctoral student at Pepperdine University Graduate School of Education and Psychology. I am contacting you to inquire if you would be interested in participating in a voluntary research study in which you would be reviewing and evaluating a workshop developed for psychology trainees who work with sexually exploited children.

I am presently conducting my dissertation research under the supervision of Anat Cohen, Ph.D., a member of the faculty at Pepperdine University Graduate School of Education and Psychology. The overall purpose of this research project is to develop a workshop for graduate level psychology trainees providing information about vicarious traumatization when working with sexually exploited children and addressing the importance of self care techniques as a preventative measure.

During this particular stage in the project, I have completed the workshop and I am seeking the input of experts in the field of trauma, self-care practices and/ or supervision of graduate level trainees, such as yourself to explore the validity of the workshop and provide the author with feedback that will be integrated into the final dissertation and the workshop.

This two-page attachment is provided to you as a way to facilitate your process in evaluating the workshop. Your input in this project will be strictly confidential. Although your input is greatly appreciated, please remember that you are under no obligation to complete the evaluation. In my estimation, it should take 30 to 40 minutes of your time to review the proposed presentation and complete the evaluation form.

Thank you very much for your time, assistance and feedback.

Sincerely,

Krystle K. Madrid, M.A.
Pepperdine University

APPENDIX F

Workshop Evaluation Form

Workshop Evaluation Form

The purpose of the study is to design a workshop focused on teaching trainee therapists to manage vicarious traumatization through the use of self-care practices. As a result of the workshop, trainees working with trauma narratives generated by sexually exploited children will increase their knowledge about the onset and development of vicarious traumatization symptoms, understand the vulnerability inherent in being a graduate trainee and identify and plan for the implementation of self-care techniques. This workshop will serve as a primary prevention strategy for training therapists suffering from or subject to suffer from vicarious traumatization symptoms. Please note that all information provided on the evaluation form will remain strictly confidential. However, your de-identified feedback will be integrated into the final dissertation and the workshop.

Part I. Background Information

Directions: Please fill in the blank with the appropriate response. Please print all responses.

What is your professional title? (e.g., licensed psychologist, licensed clinical social worker)

In what type of clinical setting do you work? (e.g., private practice, hospital, nonpublic agency, community agency)

How many years have you been licensed in your particular discipline?

Do you hold any type of specialized training with sexually exploited children/self-care/trauma? If so, please describe?

What is the total number of years you have provided supervision to psychology graduate students working with trauma case loads?

Do you have specialized experience working with children who have experienced sexual exploitation? If so, please describe below.

Part II. Evaluation Survey

*On a scale of 1-5 where **1** is **not at all** and **5** is **very much so**:*

1) Did you find this workshop helpful for recognizing vicarious traumatization and how it can disrupt the trainee's life and influence the therapeutic relationship?

1 2 3 4 5

2) Did you find this workshop particularly useful as it pertains to teaching self-care practices to graduate level psychology trainees?

1 2 3 4 5

3) Were there aspects of the workshop that you did not find particularly relevant for its intended purposes?

1 2 3 4 5

4) Do you consider this workshop to be a strength in providing trainees with self-care techniques when treating sexually exploited children? Could you use the word “effective” instead of strength? Not very clear what you are asking here.

1 2 3 4 5

5) Do you consider this workshop to be a weakness in providing trainees with self-care techniques when treating sexually exploited children?

1 2 3 4 5

6) Did the workshop provide information in a concise easy to follow manner?

1 2 3 4 5

7) Would you recommend this workshop to trainees and supervisees?

1 2 3 4 5

8) What could have been added to the workshop to make it more useful for preventing vicarious traumatization in trainees?

9) What sections of the workshop would you omit, change, or revise?

Additional comments and/or suggestions:

APPENDIX G

IRB Exemption Letter

PEPPERDINE UNIVERSITY

Graduate & Professional Schools Institutional Review Board

May 23, 2012

Krystle Madrid

Protocol #: PN0512D07

Project Title: *The Development of Self-Care Workshop to Prevent Vicarious Traumatization in Training Therapists Working with Sexually Exploited Children*

Dear Ms. Madrid,

Thank you for submitting the Non-Human Subjects Verification Form for your project entitled, *The Development of Self-Care Workshop to Prevent Vicarious Traumatization in Training Therapists Working with Sexually Exploited Children*. Per Institutional Review Board (IRB) guidelines, all proposed research that involves either direct or indirect contact with human subjects requires an application be submitted to the Graduate and Professional Schools IRB (GPS-IRB). Research that requires IRB review must meet the definition of human subjects' research. The code of federal regulations provides the following definitions:

- For purposes of the IRB, research is defined as a systematic investigation designed to develop or contribute to generalizable knowledge.
- Human subject means a living individual about whom an investigator (whether professional or student) conducting research obtains
 - (1) Data through intervention or interaction with the individual, or
 - (2) Identifiable private information.

Because your research does not involve the participation of human subjects **and** you are not using/collecting any data that has been obtained from individual participants, your research is not subject to IRB review and approval.

Sincerely,



Jean Kang
 Manager, GPS IRB & Dissertation Support
 Pepperdine University
 Graduate School of Education & Psychology
 6100 Center Dr. 5th Floor Los
 Angeles, CA 90045
 jean.kang@pepperdine.edu
 W: 310-568-5753
 F: 310-568-5755

cc: Dr. Lee Kats, Associate Provost for Research & Assistant Dean of Research, Seaver College, Ms. Alexandra Roosa, Human Protections Administrator, Dr. Yuying Tsong, Chair, Graduate and Professional Schools IRB, Ms. Jean Kang, Manager, Graduate and Professional Schools IRB, Dr. Anat Cohen, Ms. Cheryl Saunders

APPENDIX H

PowerPoint Workshop

Self-Care Practices:

Preventing Vicarious Traumatization in Trainees
Working with Sexually Exploited Children

Workshop Objectives

- Increase knowledge of vicarious traumatization symptoms
- Understand how being a graduate training student contributes to a higher risk of experiencing vicarious traumatization.
- Identify and appreciate the distinction between healthy and unhealthy self-care practices.

Trauma

- Trauma is an interaction between psychological aspects of an event with varying aspects of the individual
- Trauma can be prevalent, pervasive and can have potentially devastating effects on the individual
- Traumatic events include natural disasters, man-made traumas and physical and sexual abuse

Overview

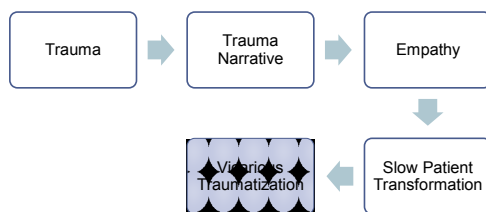
- Emotional responses can reach clinical levels of psychopathology
- Emotions expressed post trauma are typically negative
- Sexual assault victims present with the highest level of emotional reactions

Emotions Experienced Post Trauma

- Shame
- Guilt
- Anger
- Sadness
- fear

Reactions to Trauma

Process of Vicarious Traumatization



Vicarious Traumatization

- Includes the *cumulative* effects on therapists working with trauma survivors
- Caused by empathy + slow patient transformation
- Viewed as an occupational hazard
- Can have a pervasive & negative effect on:
 - Identity
 - Worldview
 - Psychological needs
 - Beliefs
 - Memory Systems

Identity

- An individual's sense of self across varying cognitive, physical and emotional states
- Incorporates the persons' inner experience of self and the varying characteristic feeling states of themselves and the world
- May cause the therapist to experience inner turmoil and question their role as a helping professional

World View

- The broadest belief about the world including moral principles and life philosophy
- Includes the justice and injustice of life occurrences including randomness and predictability of life events
- View of the world changes from just and safe to dangerous and unfair

Psychological Needs

- Safety:
 - Sense of security
- Trust:
 - Firm belief in reliability, truth & ability in someone/thing
- Esteem:
 - Value for self and others
- Intimacy:
 - Desire to want and feel a connection with another
- Control:
 - Ability for the therapist to self-manage including their ability to direct future plans, express feelings and navigate their world

Beliefs

- The psychological state in which an individual holds a proposition or premise to be true
- Simplest form of mental representation and therefore one of the building blocks of conscious thought

Memory Systems

- Includes interpersonal memory, bodily memory, verbal memory, imagery and affects
- When a patient experiences a traumatic experience, each memory system will be affected by containing a fragment of the trauma
- When a therapist is subjected to the memories of their patients' trauma history, these memories can become integrated into their own memory systems

Symptoms of Vicarious Traumatization

- Intrusive Imagery
- Avoidance
- Emotional Numbing
- Hypervigilance
- Decreased Self-Esteem
- Decreased Trust in their own Competence
- Disruptive Cognitive Systems

Intrusive Imagery

- Flashbacks
- Visual Images
- Sensory Images

Avoidance

- Therapist avoids addressing trauma and processing the trauma narrative
- Therapist avoids discussing the case or case specifics (i.e., sexual abuse) with others
- Therapist avoids working on patient's sexual identity and anything sexually related
- Therapist avoids processing the patient's emotional attachment and loss of perpetrator

Emotional Numbing

- Numbing helps the therapist avoid recognizing emotions
- Therapist will focus more on their thoughts than feelings during the session which hinders their ability to be fully present in the moment
- Emotional numbing can occur in supervision and during the therapeutic session

Hypervigilance

- An enhanced state of sensory sensitivity
- An exaggerated intensity of behaviors whose purpose is to detect threats
- Is evident in every facet of life including:
 - Within the community
 - Within personal relationships

Decreased Self-Esteem

- Person's overall sense of self-worth or personal value
- Involves a variety of beliefs about the self:
 - Appraisal of one's own appearance
 - Beliefs
 - Emotions
 - Behaviors

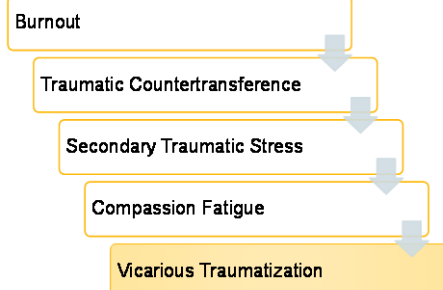
Decreased Trust In Own Competence

- Susceptible to self-doubt and doubts surrounding judgment and skill as a clinician
- Question efficacy as a clinician and efficacy in career path
- Experience despair and hopelessness
- Experience own cognitive distortions

Disruptive Cognitive Systems

- Inability to trust their instincts
- Inability to keep their identity in high regard

Evolution of Vicarious Traumatization



Burnout

- “To fail, wear out or become exhausted by making excessive demands on energy, strength, or resources” (Maslach, Schaufeli & Leiter, 2001)
- Prolonged response to chronic and emotional interpersonal stressors
- Includes three dimensions:
 - Exhaustion
 - Cynicism
 - Negative Response to self & accomplishments

Burnout

- Focuses on contact with others and factors that make contact emotionally stressful
- Occurs in all occupations for anyone at any level
- Positive aspects of the job may ameliorate symptoms
- Simply seen as job stress

Vicarious Traumatization

- Specifically involves exposure to emotionally trying images and descriptions of suffering
- Positive aspects will have little impact on changing symptoms
- Involves overall trauma to an individual's psyche

What's the difference?

Traumatic Countertransference

- The relationship between the therapists psychic connection and the emotional pull toward the patient within the therapeutic relationship
- Refers to the evoked responses by the therapist in regard to information provided by the patient
- Taps into something similar or related to the therapists life

Traumatic Countertransference

- Taps into therapists personal life situations
- Linked to Psychoanalytic thought
- Trainees experience exclusively involves the therapeutic work
- Symptoms do not permeate therapists life leading to changes in worldview

Vicarious Traumatization

- Cumulative effect of hearing another person's trauma
- Clearly grounded in trauma theory
- Does not need to be linked to anything specific to therapists life
- Symptoms can transcend the therapeutic session

What's the difference?

Secondary Traumatic Stress → Compassion Fatigue

- STS address the natural behaviors and emotions resulting from knowing about a traumatizing event
- Develops in the person close to the victim by hearing about the trauma
 - not exclusive to the helping professional
- STS was later renamed compassion fatigue

Compassion Fatigue

- Can be experienced from a single traumatic experience
- Highlights the distinction that anyone privy to traumatic material can be affected

Vicarious Traumatization

- **Cumulative** effects on a therapist working with trauma
- Direct reaction to traumatic material presented by patients
- Can only be experienced by the therapist treating the patient

What's the difference?

Vicarious Traumatization

- VT is more prominent in therapist with:
 - Personal trauma history
 - Limited training experiences
 - Limited supervision
 - Negative coping strategies
 - Higher percentage of trauma patients in caseload
 - Being a novice to the field of trauma
 - Organizational setting

Graduate Psychology Student Trainees

- Few training programs have classes geared toward working with trauma
- Trainees tend to be younger in age and less experienced
- May be unaware of emotions being evoked by the trauma narrative
- Are more likely to not seek out adequate supervision for fear of evaluation

Graduate Psychology Student Trainees

- Student life makes trainees susceptible to more stressors:
 - Excelling in studies/being in the top tier
 - Working harder to gain more face-to-face therapy hours
 - Take few (if any) vacations
 - Carry a higher average of cases
- Trainees are more vulnerable to feelings of guilt following patient's re-experiencing of trauma

Graduate Psychology Student Trainees

- Experience more anxiety
- Struggle with identity as a therapist
- Have a fear and uncertainty about what supervisors expect of them (leading to more anxiety)
- Find themselves less likely to confide in their supervisors or seek support which has been identified in the literature as a common factor

Prostitution

- *“Refers to women or girls who are compelled to engage in sexual acts with strangers in exchange for commodities with the compulsion emanating from either physical violence and abuse, threats to their lives or bodily integrity or those of their families, emotional and physical coercion based on their indebtedness to the smugglers and procurer, and/or their presence in a foreign country without legal status and any support network” (Demleitner, 2000)*

Prostitution

- 18,000 persons are trafficked into the US per year
- 96% are females → almost half are children
- CIA estimates 700,000 people are trafficked annually
- 100,000-300,000 children are exploited annually by the sex industry
- In the year 2000, US congress reported that trafficking of women and children was the 3rd largest source of revenue for organized crime worldwide

Sexually Exploited Children

- Using sexually exploited term highlights children's inability to have a choice
- Sexual victimization is one of the most commonly presented patient traumas
- 1 in 6 women and 1 in 10 men will experience sexual abuse during childhood. FBI estimates 1 in 4 women will be victims of sexual assault in their lifetime

Sexually Exploited Children

- Often experience physical and sexual abuse
- Often are indebted to the pimp or captor
- Face multiple gang rapes
- Often travel and immigration documents have been taken away
- Threats of violence to family members in source country can occur
- Often engage in patterns of criminal behavior
- Often have less education than comparison groups
- Often engage in past and/or present drug abuse

Therapist Reactions to Child Sexual Abuse

- Rage
- Avoidance
- Over-Involvement/Over-Identification
- Guilt
- Overwhelmed
- Shock and Horror
- Sexual Arousal

Rage

- Therapists can become angry at the:
 - Abused
 - The perpetrators
 - Other family members
 - Systemic Issues
 - Therapeutic Process

Avoidance

- Desire to deny, escape from or not see the situation as it really is
- Reactions are based on feelings of:
 - Anxiety
 - Discomfort
 - Repugnance
 - Dread and Horror
- Avoid discussing trauma narrative
- May not engage fully in processing

Over-Involvement/Over-Identification

- Therapist actively wants to help patient with his/her symptoms but in the process loses control over role boundaries
- Over-involved in attempt to rescue patients
- Feelings evoked:
 - Fright
 - Over-protectiveness
 - Guilt
 - Excessive responsibility in the therapist

Guilt

- Therapists experience guilt over:
 - Painful affect resulting from processing trauma
 - Inability to speed up patients therapeutic process
 - Inability to stop patient from suffering

Overwhelmed

- Therapists become overcome with emotions when listening to violent acts of abuse and may not know how to differentiate these feelings
- Must sit through often personal accounts of patients memories of abuse

Shock and Horror

- Therapist face hearing accounts of abuse involving pleasurable, sadistic and violent episodes
- Discussing patients accounts of abuse is horrifying
- May lead to defensive behavior such as changing the subject and denying negative effects of situation
- Disbelieving patients experiences and memories

Sexual Arousal

- Sexual thoughts or fantasies may occur:
 - Independent from patients actions or
 - Due to patients acting sexually seductive
- Male therapists have been found to be more likely than females to feel "sexually turned on"
- May experience guilt or anxiety in regard to sexual arousal
- Unresolved sexual feelings can
 - Rupture the therapeutic relationship
 - Lead to sexual involvement with patient

General Reactions to Trauma	Reactions to Sexual Abuse Narratives
<ul style="list-style-type: none"> • Shame • Guilt • Anger • Sadness • Fear 	<ul style="list-style-type: none"> • Rage • Avoidance • Over-involvement/Over-identification • Guilt • Overwhelmed • Shock and Horror • Sexual Arousal

How are they similar?

Self-Care Techniques

- Are activities an individual completes with the intention of improving or restoring health, treating or preventing a disease
- Functionally speaking → self-care is a practice integrated into daily life to help prevent or improve mental health
- Engaging in self-care has been found to significantly lower psychology students perceived sense of stress

Self-Care Techniques

- Organizational Protective Factors:
 - Supportive Environment
 - Talking about positive aspects about work
 - Provides opportunities for on-going trainings
 - Support from peer consultation
 - Allowance for breaks in schedule

Self-Care Techniques

- Supervision as a Protective Factor:
 - Supervisors recognize importance of variability in caseload and supervision
 - Supervision provides a good initial measure of preventing and coping with symptoms
 - Specifically tailored trauma supervision is provided
 - Provides normalization

Healthy Self-Care Practices

- Maintaining boundaries
- Seeking out non-victim related activities
- Taking breaks outside of the office
- Utilizing vacation time
- Recognizing own limitations
- Allowing self to have personal reactions

Healthy Self-Care Practices

- Maintaining realistic expectations
- Avoiding professional isolation
- Seeking supervision
- Seeking peer support
- Limiting amount and type of patients
- Participate in activities apart from work that nurtures the therapist

Unhealthy Self-Care Practices

- ways of coping that causes the therapist to avoid/deny symptoms without providing preventative factors
- Avoid discussing emotional reactions
- Denial
- Isolation
- Engage in drug and/or alcohol abuse

Self-Care Challenges in Graduate Students

- Seven underlying factors affecting student functioning
 - Problems with time constraints
 - Difficulty receiving feedback from specific faculty
 - Financial constraints
 - Trouble getting help from faculty
 - Limited emotional support from friends and family
 - Difficulty with feedback with regard to status in department
 - Stress from lack of input in program decisions
 - Following supervisor standards

Self-Care Challenges in Graduate Students

- Major Personal Stressors
 - Intimate relationships
 - Parental conflicts
 - Finances
 - Interpersonal conflicts with friends
- Year in Graduate Program
 - Third year was found to be the most stressful

Self-Care Challenges in Graduate Students

- Gender
 - Female graduate students endorse higher levels of stress
- Minority Status
 - Deal with negative stereotypes
 - Deal with negative perceptions of academic merit
 - Experience prejudice, discrimination and alienation, isolation and cultural bias

Personal Aspect of Self-Care

- Balance in life occurs in four key areas
 - Physical
 - Psychological
 - Emotional
 - Spiritual

Physical Aspects of Self-Care

- Balance of work, play and rest
- Socializing with friends and family
- Being physically active and exercising regularly
- Participating in enjoyable and creative activities
- Getting massages and taking vacations
- Seeking medical care when sick

Psychological Aspects of Self-Care

- Self-reflection and processing
- Personal psychotherapy
- Journaling
- Reading for fun
- Connecting with others and utilizing support systems
- Practice saying “no” to extra responsibility
- Engage in activities where somewhere else is in charge

Emotional Aspects of Self-Care

- Maintain important relationships
- Listening to music and have fun
- Nourish healthy living
- Participate in enjoyable activities
- Journaling, personal counseling, meditation
- Reminding self to have personal reactions
- Find ways to utilize humor and laughter

Spiritual Aspects of Self-Care

- Find meaning in life
- Cherish hope
- Experience awe
- Engage in other activities which replenish the therapist
- Maintain connections such as through religious affiliation or through beliefs in the good of others
- Spend time in nature and build community

Developing your Maintenance Self-Care Plan

- Refers to the activities identified as important to your well-being and that you have committed to engage in on a regular basis
- There is no “one-size-fits-all” self-care plan
- There are general principles:
 - Take care of your physical health,
 - Manage your stress and reduce it
 - Honor your emotional and spiritual needs
 - Nurture your relationships
 - Find balance in your school and work life

Now its time to develop your Self-Care Plan

How Do You Cope Now?

- Identify what you do *now* to manage stress and assess how well suited these strategies are to your long term health and well-being
- Use the Lifestyle Behaviors Assessment
- Consider how you could increase your tendency to use more positive strategies

When you are under stress do you...?	When you are under stress do you...?
<ul style="list-style-type: none"> Smoke/use tobacco Drink a lot of coffee or caffeinated drinks (more than 2-3 cups/day) Drink alcohol (more than recommended levels of 1-2/day) Overuse over-the-counter medications Overeat or under eat Spend too much money (e.g. do you have a lot of credit card debt and have trouble making payments?) 	<ul style="list-style-type: none"> Engage in physical activity at least Three times a week for 30 minutes each day Get six to eight hours of sleep every night Maintain good eating habits Make time to relax Maintain a sense of humor Play Maintain healthy rituals and Routines


Lifestyle Behaviors Assessment

When you are under stress do you...?	When you are under stress do you...?
<ul style="list-style-type: none"> Abuse/overuse tranquilizers or other Over-the-counter medications Watch too much television (more than 3-4 hours per day) Have angry outbursts Take illegal drugs Withdraw from people Ignore or deny stress symptoms Engage in self-destructive relationships 	<ul style="list-style-type: none"> Be optimistic. Engage in positive thinking Spend time with family Spend time with friends Make plans for the future Figure out ways to manage stress Reward yourself for your accomplishments

Lifestyle Behaviors Assessment


What would you like to do?

- Complete the Self-Care Assessment
- It can also give you some ideas for other things you can do in the future to help prevent stress, vicarious traumatization and enhance your well-being.
- Make a note of the items that you would like to add (or add more of) to your self-care repertoire.




PHYSICAL SELF-CARE

- ☐ Eat regularly (e.g. breakfast, lunch, and dinner)
- ☐ Eat healthily
- ☐ Exercise
- ☐ Get regular medical care for prevention
- ☐ Get medical care when needed
- ☐ Take time off when sick
- ☐ Get massages



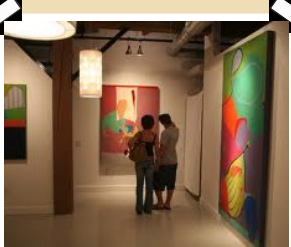
PHYSICAL SELF-CARE

- ☐ Dance, swim, walk, run, play sports, sing, or do some other fun physical activity
- ☐ Take time to be sexual - with myself, with a partner
- ☐ Get enough sleep
- ☐ Wear clothes I like




PSYCHOLOGICAL SELF-CARE

- ☐ Take day trips or mini-vacations
- ☐ Make time away from telephones, email, and the Internet
- ☐ Make time for self-reflection
- ☐ Notice my inner experience - listen to my thoughts, beliefs, attitudes, feelings
- ☐ Have my own personal psychotherapy
- ☐ Write in a journal



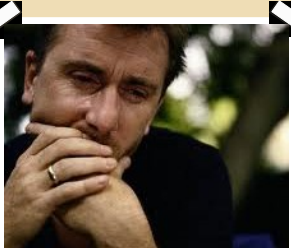
PSYCHOLOGICAL SELF-CARE

- ___ Read literature that is unrelated to work
- ___ Do something at which I am not expert or in charge
- ___ Attend to minimizing stress in my life
- ___ Engage my intelligence in a new area, e.g., go to an art show, sports event, theatre
- ___ Be curious
- ___ Say no to extra responsibilities sometimes



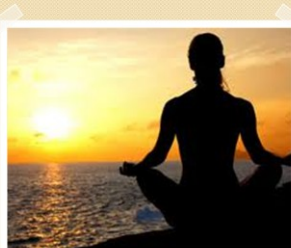
EMOTIONAL SELF-CARE

- ___ Spend time with others whose company I enjoy
- ___ Stay in contact with important people in my life
- ___ Give myself affirmations, praise myself
- ___ Love myself
- ___ Re-read favorite books, re-view favorite movies



EMOTIONAL SELF-CARE

- ___ Identify comforting activities, objects, people, places and seek them out
- ___ Allow myself to cry
- ___ Find things that make me laugh
- ___ Express my outrage in social action, letters, donations, marches, protests




SPIRITUAL SELF-CARE

- ___ Make time for reflection
- ___ Spend time in nature
- ___ Find a spiritual connection or community
- ___ Be open to inspiration
- ___ Be aware of non-material aspects of life
- ___ Identify what is meaningful to me and notice its place in my life
- ___ Meditate
- ___ Contribute to causes in which I believe



SPIRITUAL SELF-CARE

- ___ Identify what is meaningful to me and notice its place in my life
- ___ Pray
- ___ Sing
- ___ Have experiences of awe
- ___ Contribute to causes in which I believe
- ___ Read inspirational literature or listen to inspirational talks, music




RELATIONSHIP SELF-CARE

- ___ Schedule regular dates with my partner or spouse
- ___ Schedule regular activities with my children
- ___ Make time to see friends
- ___ Call, check on, or see my relatives
- ___ Spend time with my companion animals
- ___ Stay in contact with faraway friends




RELATIONSHIP SELF-CARE

- ___ Make time to reply to personal emails and letters; send holiday cards
- ___ Allow others to do things for me
- ___ Enlarge my social circle
- ___ Ask for help when I need it
- ___ Share a fear, hope, or secret with someone I trust




WORKPLACE/PROFESSIONAL SELF-CARE

- ___ Take a break during the workday (e.g., lunch)
- ___ Take time to chat with co-workers
- ___ Make quiet time to complete tasks
- ___ Identify projects or tasks that are exciting and rewarding
- ___ Set limits with clients and colleagues
- ___ Balance my caseload so that no one day or part of a day is "too much"



WORKPLACE/PROFESSIONAL SELF-CARE

- ___ Arrange work space so it is comfortable and comforting
- ___ Get regular supervision or consultation
- ___ Negotiate for my needs (benefits, pay raise)
- ___ Have a peer support group
- ___ (If relevant) Develop a non-trauma area of professional interest



OVERALL BALANCE

- ___ Strive for balance within my work-life and work day
- ___ Strive for balance among work, family, relationships, play, and rest

Outlining Your Plan

- The spaces provided in the My Maintenance Self-Care Worksheet each represent a self-care domain. In each space fill in the activities that you already engage in ("current practice") and those you would like to add ("new practice").

MY MAINTENANCE SELF-CARE WORKSHEET

Identify :
Current Practice _____
New Practice _____

- Mind
- Body
- Emotion
- Spirit
- Work
- Relationships

Obstacles To Implementation

- It is useful to identify possible barriers or obstacles that could get in the way of implementing and/or maintaining them.
- For now, though, think about what you anticipate these barriers/obstacles to be
 - how you can address them, and how you can remind yourself to follow your plan.

Make a Commitment to Yourself

- Preparing a plan is important:
 - it identifies your goals and the strategies to achieve them.
 - This kind of commitment is possible with:
 - Recognition of health and well-being as essential
 - Acknowledgement of importance in honoring yourself and your needs.
- *you need to put on your own oxygen mask first before you can be of help to others.*

Share Your Intentions

- Once you have developed your plan and made your commitment, *share your self-care plan with other students and friends/family* so you can exchange ideas/strategies and enlist support and encouragement.
- Consider also joining or starting a student support or discussion group as one way to consolidate and sustain your efforts.

Be Prepared

- Developing an Emergency Self-Care Plan helps to organize your thinking and resources *before* you are faced with a crisis or feel overwhelmed.
- It is important to figure out your plan in advance when you have the time and concentration to do so effectively

Emergency Self-Care Plan

- Make a list of what you can do when you are upset that will be good for you:
 - What will help me relax?
 - What do I like to do when I am in a good mood?
 - What can I do that will help me throughout the day?
 - What else do YOU need to do that is specific to YOU?

Emergency Self-Care Plan

- Make a list of people you can contact if you need support or distraction
- Best friend, other friends, sibling, parent, grandparent, other relative, therapist, priest/minister/rabbi/imam, etc:
 - Who can I call if I am feeling depressed or anxious?
 - Who can I call if I am lonely?
 - Who will come over to be with me if I need company?
 - Who will listen?
 - Who will encourage me to get out of the house and do something fun?
 - Who will remind me to follow my self-care plan?

Emergency Self-Care Plan

- Make a list of positive things to say to yourself when you are giving yourself a hard time
- Make a list of who and what to avoid when you are having a hard time

Follow Your Plan

- Implement your plan and keep track of how you are doing
 - Keeping track of your progress will help you recognize your successes and identify and address any difficulties you may not have anticipated
- Don't forget that you can revise your plan as needed – self-care is always a work in progress.

Resources

- Books:
 - Risking Connection: A training curriculum for working with survivors of childhood abuse—Saakvitne, K.W., Gamble, S., Pearlman, L.A., & Tabor, Lev. B. (2000)
 - Transforming the pain: A workbook on vicarious traumatization for helping professionals who work with traumatized clients—Saakvitne, K.W., & Pearlman (1996)
 - The complexities of Psychologists' Self-Care, Coping & Wellness—Bridgeman, D.L (2009)

Resources

- Online Resources:
 - Headington Institute: provides psychological and spiritual support to humanitarian aid and disaster relief personnel worldwide (headington-institute.org)
 - Beth Stamm's Traumatic Stress and Secondary Traumatic Stress Page (isu.edu/~bhstamm)
 - Dave Baldwin's Trauma Information Page (trauma-pages.com)

Resources

- Professional Training Opportunities:
 - Dr. Laurie Pearlman
lpearlmanphd@comcast.net
 - Risking connection: Steven Brown
steveb@klingberg.org
 - The role of humor: Dr. Willard Jonas authored "The Frailty of One"

Resources

- Organizations
 - International Society for Traumatic Stress Studies (issts.org)
 - TREATI-non profit organization
patw@klingberg.org
 - The green cross (greencross.org)
 - Gift from within (giftfromwithin.org)



Questions?