Secondary traumatic stress among trauma counsellors: What does the research say?

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Abstract. Although posttraumatic stress theory has been extensively developed in the psychological and medical literature in the last decade, development of secondary traumatic stress theory is still in its infancy. The traumatology literature reveals a focus on the traumatized victims and, with few exceptions, excludes those who are secondarily traumatized through their counselling work with survivors of traumatic life events. Claims have recently been made that counsellors working in the field of trauma are vulnerable and at risk for developing trauma symptoms similar to those experienced by traumatized clients. The author reviews the recent research and literature on secondary traumatic stress and addresses the implications of these research findings to counsellor educators and practitioners working in the field of trauma.

There is currently a growing interest in the deleterious effects of trauma work on mental health professionals (Arvay & Uhlemann 1996; Figley 1995; Follette et al. 1994; Munroe 1995; Neumann & Gamble 1994; Pearlman & Mac Ian 1995; Schauben & Frazier 1995). Evidence of this interest can now be found at international conferences on posttraumatic stress, in recently published books and articles (Figley 1995; Pearlman & Saakvitne 1995; Stamm 1995; Wilson & Lindy 1994), and at professional workshops and trauma training seminars where symposia on vicarious traumatization and secondary traumatization are beginning to flourish.

A variety of descriptions can be found in the trauma literature that describe this phenomenon. Figley (1988) used the term 'secondary victimization' to describe effects on family members exposed to a traumatized member; Herman (1992) has written about 'traumatic countertransference' – a term used to describe the countertransference reactions that are experienced when the therapist's traumatic past experiences are triggered in the therapy session with traumatized clients, and Courtois (1988), in her description of 'contact victimization' – a term used to describe the cumulative effects of working with traumatized clients, warned that PTSD could be contagious. Eth and Pynoos (1985) and Terr (1990) found that symptoms experienced by trau-

matized children were 'contagious' to non-traumatized children who played with them. Mollica (1988) suggested that therapists became 'infected' with their clients' hopelessness, and Danieli (1984) reported, in a study on countertransference, that therapists dealing with Holocaust survivors shared the nightmares of the survivors they were treating. The predominant metaphor used by these traumatologists suggests that secondary traumatic stress is like a disease. The multiple labels or constructs point to the same phenomenon, but how does it work? What are the current conceptualizations of secondary traumatic stress and what contribution has recent research made in elucidating this phenomenon? The purpose of this article is to provide an overview of the current research findings on secondary traumatic stress among trauma counsellors working in the field of trauma and to discuss the implications of these research findings on counsellor supervision and education.

Clarification of terms

There are many descriptors of the effects upon trauma counsellors from working with survivor populations. A popular and widely accepted version of this phenomenon was delineated by McCann and Pearlman (1990). They coined the term *vicarious traumatization* to describe the cumulative transformative effects upon the trauma counsellor from working with survivors of traumatic life events. Later, Pearlman and Saakvitne (1995, p. 31) defined vicarious traumatization as:

the transformation that occurs within the trauma counsellor as a result of empathic engagement with clients' trauma experiences and their sequelae. Such engagement includes listening to graphic descriptions of horrific events, bearing witness to people's cruelty to one another, and witnessing and participating in traumatic reenactments, as either a participant or a bystander in the therapy session. It is an occupational hazard and reflects neither pathology in the therapist nor intentionality on the part of the traumatized client.

According to Figley (1995), *secondary traumatization* results from knowing about a traumatizing event experienced by a significant other and the stress results from helping or wanting to help a traumatized person. Secondary traumatization is a term used to describe the effects not only upon mental health professionals but also upon family members and friends whose lives are closely associated with the trauma survivor. Figley (1995, p. 8) states:

Secondary Traumatic Stress Disorder (STSD) is a syndrome of symptoms nearly identical to PTSD (APA, *DSM-IV* 1994), except that exposure

to knowledge about a traumatizing event experienced by a significant other is associated with the set of STSD symptoms, and PTSD symptoms directly connected to the sufferer, the person experiencing primary traumatic stress.

The difference between vicarious traumatization and secondary traumatization is that the former is a construct based on McCann and Pearlman's (1990) constructivist self development theory and the latter is subsumed under the diagnostic criteria in the *DSM-IV* (APA 1994). In my opinion, both terms refer to the same phenomenon.

Figley (1995) claims that secondary traumatic stress is a disorder and its definition is found within the description of PTSD in the *DSM-IV* (APA 1994). Figley (1995, p. xv) has italicized portions of the PTSD description to highlight how an individual may become traumatized without actually being physically harmed or threatened with harm.

The person has experienced an event outside the range of usual human experience that would be markedly distressing to almost anyone: a serious threat to his or her life or physical integrity; serious threat or harm *to his children, spouse, or other close relatives or friends*; sudden destruction of his home or community; or *seeing another person seriously injured or killed in an accident or by physical violence*.

Criterion A1, in the APA (1994) specifies that the essential feature of the disorder is the development of characteristic symptoms following exposure to or witnessing an event that involves death, injury, or a threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other closely associated (APA 1994, p. 424). The fundamental difference between PTSD and STSD seems to be the position of the stressor: In Posttraumatic Stress Disorder, the stressor may directly harm or threaten people (primary stressor), and in Secondary Traumatic Stress Disorder, the stressor is the traumatized individual who has been exposed to harm (secondary traumatic stressor) (Figley 1995). Just as posttraumatic stress is a natural consequence to a markedly distressing and unusual human event, secondary traumatic stress is a natural consequence resulting from *knowing about or witnessing a traumatizing event experienced by a significant other*. The significant other in the case of the counsellor is the client. We can assume that it is not only the trauma counsellor who is at risk, but also family members and friends of the traumatized person.

Although there is mention of a secondary traumatic stress reaction in the *DSM-IV* (APA 1994), no elaboration is given to the implications. It is also interesting to note that there is very little literature on the topic. Figley

(1995), suggesting that the incidence of PTSD may be 'grossly underestimated' because these figures do not take into account those who emotionally support trauma survivors, states: "It is time to consider the least studied and least understood aspect of traumatic stress: secondary traumatic stress" (p. 7).

Empirical research findings on STS

Although there is an increased interest in secondary traumatic stress, at the present time there exists only a handful of research studies on this topic (Arvay & Uhlemann 1996; Chrestman et al. 1994; Follette et al. 1994; Kassam-Adams 1994; Munroe 1991; Pearlman & Mac Ian 1995; Schauben & Frazier 1995). All of these studies have contributed significantly to our understanding of the demographic indices and levels of stress among mental health professionals working with survivor populations. Their research data have mainly been collected by using survey methods, incorporating standardized instruments, such as the Impact of Event Scale (IES, Horowitz et al. 1979), the Brief Symptom Inventory (Derogatis & Spencer 1982), and the Trauma Symptom Checklist-40 (TSC-40, Elliot & Briere 1991) to measure levels of stress. In addition, personal history data, methods of coping, and a measurement of disruptions to one's beliefs (TSI Belief Scale, Pearlman 1996) have also been gathered. These studies have focused on common response patterns among subjects and have provided significant information on the general incidence of stress levels among those working in the field of trauma.

Given that the construct of secondary traumatic stress was only recently defined (McCann & Pearlman 1990), there is still very little research regarding its prevalence among counsellors in the field of trauma. We do not yet know all the factors contributing to the development of secondary traumatic stress, nor do we know the conditions that protect trauma counsellors from becoming traumatized. However, the following studies do provide information concerning incidence levels, correlations between symptoms and demographic variables, and, more importantly, pose questions that need to be addressed in future research.

In a study on the effects on female counsellors working with sexual violence survivors, Schauben and Frazier (1995) found that, among counsellors who completed their questionnaire, those having a higher percentage of trauma survivors in their caseload reported more disrupted beliefs, more symptoms of Posttraumatic Stress Disorder, and more self-reported vicarious trauma. Symptomatology was not related to these counsellors' own history of victimization. In addition, counsellors working with victims of violence experienced emotional distress and changes in their beliefs. Their main coping strategies were described as "active coping" – actively doing something about the problem, seeking emotional support, making a plan of action,

seeking instrumental social support, and humour. The least common coping strategies were using alcohol or drugs, denial, and disengagement in the counselling process.

Follette et al. (1994) studied general and trauma symptoms in mental health and law enforcement professionals. They found that trauma symptoms correlated with the level of personal stress experienced by these professionals; negative use of coping strategies; and negative clinical responses to their sexual abuse cases. It appears that high levels of personal stress and inability to find positive support or engage in self-protection result in the development of traumatic stress symptoms and negative clinical practices, thereby putting therapeutic relationships at risk.

Arvay and Uhlemann (1996), using a survey research design, studied levels of stress among a random sample of counsellors ($n = 161$) working in the field of trauma in British Columbia. It was proposed that counsellors working with survivors of trauma were at risk for developing stress symptoms similar to those experienced by their clients. Counsellors were assessed on measures of general life stress, burnout, and traumatic stress. Twenty-four percent perceived their lives as being stressful, 16% reported high levels of emotional exhaustion, 4% were experiencing high levels of depersonalization, 26% felt ineffective in terms of personal accomplishment at work, and 14% were experiencing high traumatic stress levels similar to clients with Posttraumatic Stress Disorder.

A profile of the impaired counsellor emerged from the demographic variables and the measures of stress used in this study. Counsellors experiencing high levels of stress were most likely to be in their early 40s, with education at less than a master's degree. They most likely were employed in a community agency, as opposed to private practice, with less than 10 years experience and a client caseload between 10 to 26 survivors per week. They perceived that they had personal and work-related support that came mainly from friends, family, and peers at work. They found their work 'challenging' and 'somewhat manageable'. However, they stated that they had 'too many' traumatized clients and felt that their caseloads are 'very intense'. They frequently experienced being affected by their clients' traumatic material. Many in this group reported experiencing countertransference issues in their sessions with traumatized clients, suggesting that there may be a link between being frequently affected by their clients' traumatic material and dealing with their own countertransference issues. For self-care, they participated in exercise or activities with friends or family, rather than seeking supervision or personal therapy. The self-care activities of this group did not appear to be an adequate buffer against stress.

In *Dissertation Abstracts International*, Munroe (1991) investigated whether therapists themselves were subject to traumatic exposure by the nature of their work with clients who had combat-related PTSD. In his findings, he reports that exposure to combat-related PTSD clients is related to therapist symptoms and he provides evidence that the effects of therapist exposure are distinct from burnout. He further reports that history of assaults and threats does not account for the obtained results. Apparently age, experience, or social support do not buffer the effects, but education and training in psychology at the doctoral level provide some protection. Munroe points out that professionals at the administrative, supervisory, training, and practitioner levels have an ethical duty to address this problem.

According to Gamble, Pearlman, Lucca and Allen (1995), burnout is distinguishable from secondary traumatic stress. In another article, Pearlman and Mac Ian (1995, p. 158) report a variety of behaviors that correlate significantly with overall schema disruptions experienced by trauma therapists. They state that this study illustrated "significantly disrupted beliefs about self and others, one hallmark of vicarious traumatization, as well as psychophysiological symptoms and experiences of intrusion and avoidance of clients' trauma material".

Two other unpublished studies that were poster presentations at an international conference on traumatic stress studies provide additional information on secondary traumatic stress. Kassam-Adams (1994) reports that therapists' level of PTSD symptoms were significantly predicted by level of exposure to sexually traumatized clients. In her study of 100 masters- or doctoral-level psychotherapists who completed self-report questionnaires consisting of three measures (Impact of Event Scale, a measure of traumatic stress; Personal Strain Questionnaire, a more general work stress measure; Occupational Stress Inventory), Kassam-Adams found trauma symptoms were not related to exposure to any other client problems or diagnoses, were not related to number of client hours, supervision, or other forms of support in the workplace, and that neither age of therapist nor years of clinical experience was related to therapists' level of posttraumatic stress symptoms. However, Kassam-Adams did find that both gender and personal trauma history were correlated with traumatic stress symptoms and were significant predictors in therapists treating sexually traumatized clients. In particular, only therapists reporting childhood incidences of trauma (as opposed to adult incidence or abuse versus non-abuse trauma) were strongly associated with posttraumatic stress symptoms.

Kassam-Adams (personal communication, November 1994), states that secondary traumatization poses a risk to therapists and is distinct from burnout and other forms of occupation stress. She suggests that there is a

need for further examination of the role of gender and therapists' personal histories of trauma as factors in the development of secondary traumatic stress. Kassam-Adams's findings support Schauben and Frazier's (1995) and Pearlman and Mac Ian's (1995) claims that burnout is a separate and distinct construct from secondary traumatic stress. However, her statement that the therapist's personal trauma history is a factor in predicting level of traumatic stress contradicts the findings of Schauben and Frazier.

A team of researchers from the National Center for PTSD, in Boston (Chrestman, Duncan-Davis, Sullivan & Kamen 1995) distributed 2,000 questionnaire packets to psychotherapists containing (a) Personal and Professional History Questionnaire (Chrestman, unpublished); (b) Modified Mac Ian Trauma Therapist Behavior Change Checklist (Mac Ian & Pearlman 1992); (c) World Assumptions Scale (WAS, Janoff-Bulman 1992); (d) Trauma Symptom Checklist-40 (TSC-40, Elliot & Briere 1991), and (e) Impact of Event Scale (IES, Horowitz et al. 1979).

They report the following results: Therapists reporting historical trauma endorsed more distress/symptoms on the TSC-40 and the IES (Impact of Event Scale, a trauma symptom checklist) than those without a history of trauma. Therapists reporting secondary exposure to trauma endorsed more distress/symptoms on the TSC-40 and the IES than those without secondary exposure to trauma. Symptom report was mediated by years of professional experience, increased income, percentage of trauma clients in caseload, and participation in research activities. Personal therapy, whether trauma or non-trauma in focus, and similarity of client trauma to therapist trauma were not significant mediators of symptom response. Cognitive schema, as measured by WAS (Janoff-Bulman 1992), did not change in relationship to trauma caseload or historical trauma. Finally, behaviours related to personal safety became more conservative as percentage of trauma clients in caseload increased.

Here, again, we see a contradiction to the findings of Schauben and Frazier (1995), who report that there is no relationship between prior personal trauma history and level of traumatic stress symptoms reported by trauma therapists. However, their report does support Kassam-Adams's (1994) findings regarding exposure to secondary traumatic stress: Those counsellors not exposed to traumatized clients do not develop secondary traumatic stress symptoms to the same degree as counsellors working with trauma survivors. In addition, Schauben and Frazier's (1995) findings support the National Center for PTSD team's (Chrestman et al. 1994) conclusion that percentage of survivors in the counsellor's caseload is related to increased symptoms of traumatic stress among counsellors.

Schauben and Frazier's (1995) study provided the only qualitative component in all of the quantitative STS studies that were reviewed. They asked counsellors to provide open-ended descriptions of the most difficult and enjoyable aspects of working with sexual violence survivors. The respondents' reports that their work caused emotional distress and changes in core beliefs led the authors to conclude that counsellors who work with survivors report more PTSD symptoms and disruption in beliefs.

Summary of the empirical research

There is a consensus in the research on secondary traumatic stress that this phenomenon is a distinct construct from burnout. It also appears that the number of traumatized clients in the therapist's caseload is a factor related to secondary traumatic stress. The research is ambiguous concerning the issue of the therapist's personal history of trauma as a factor in the development of secondary traumatic stress. Three research studies (Chrestman et al. 1994; Kassam-Adams 1994; Pearlman & Mac Ian 1995) found that it is a factor and three other research studies (Follette et al. 1994; Munroe 1991; Schauben & Frazier 1995) claimed that it is not. Four studies (Chrestman et al. 1994; Gamble et al. 1995; Kassam-Adams 1994; Pearlman & Mac Ian 1995) investigated whether being exposed to only trauma clients as opposed to other types of clients was a factor. They found a positive correlation between this factor and the development of traumatic stress symptoms. Four studies (Arvay & Uhlemann 1996; Chrestman et al. 1994; Munroe 1991; Pearlman & Mac Ian 1995) found that the number of years of experience in the counselling profession was related to levels of traumatic stress among counsellors. Three studies (Arvay & Uhlemann 1996; Follette et al. 1994; Pearlman & Mac Ian 1995) confirmed that the counsellor's level of education was related to secondary traumatic stress, that is, those with less than a master's degree were more vulnerable. The age of the counsellor was also a factor in two of the research studies (Arvay & Uhlemann 1996; Munroe 1991), indicating that those who were younger were more vulnerable.

In terms of support and self-care, there does not appear to be a great deal of research in this area. Out of the five research studies that examined support and self-care, two (Arvay & Uhlemann 1996; Chrestman et al. 1994) claimed that being in personal therapy was not a buffer against the effects of secondary trauma. Seeking supervision was found to be effective in two research studies (Follette et al. 1994; Pearlman & Mac Ian 1995), and only one research study (Follette et al. 1994) found work-related support to be effective. However, social support was found to be a buffer in two of the studies (Arvay & Uhlemann 1996; Munroe 1991). The type of work setting (e.g., private practice versus community agency) was also confirmed as a

factor in two research studies (Arvay & Uhlemann 1996; Pearlman & Mac Ian 1995). Those working in private practice were less stressed than counsellors working in community or mental health agencies. Although important factors in the development of secondary traumatic stress have been examined, there appears to be an absence of agreement in the research findings to date. Figley's (1995, p. 7) words continue to haunt the research: "It is time to consider the least studied and least understood aspect of traumatic stress: secondary traumatic stress".

Implications for counsellor educators and supervisors

There are ethical and moral reasons for providing descriptions of the cost of caring to those involved in bearing witness to the aftermath of violence in our culture. The ethical imperative pertains to an obligation that mental health professionals have to provide appropriate and effective care and to 'do no harm'. If we in these professions do not recognize the personal impact of trauma work on the counsellor, we run the risk of not recognizing its effects on our work and the care we give our clients (Pearlman & Saakvitne 1995). Trauma counsellors often work in isolation, lacking social and work support and the conceptual background and practical training to do this work safely (Arvay & Uhlemann 1996). To address this issue, it is imperative that trauma counsellors be provided with regularly scheduled supervision or on-site debriefing from peers or other professionals trained in the effects of trauma counselling and with knowledge about effects and treatment approaches for secondary traumatic stress. The role of these debriefers/supervisors is crucial to early detection and treatment for counsellors struggling in the field. Managers of community agencies need to be advised of the toll this work may take upon their employees and support should be given to agencies in their applications for adequate funding and resources to address this critical issue.

To date, few counsellor graduate training programs in Canada offer education about psychological trauma, and even fewer address the risks involved for both the counsellor and client in doing this difficult work. At the community level, trauma training workshops are provided but aspects of self-care for the trauma counsellor are usually an add-on to the program. Full attention needs to be given to the training of trauma counsellors concerning this phenomenon as a means to forewarn and protect those entering the field. Scholars in the field of trauma, such as Jacobs (1991), Yassen (1995), Pearlman and Saakvitne (1995), and Wilson and Lindy (1994), agree that the self of the counsellor is the fundamental tool in trauma work; therefore, counsellor educators, clinical supervisors, and trainers in trauma therapy have a duty to warn and protect those in training (Munroe 1995), by providing proper

education and effective support to minimize the vulnerability of counsellors working in the field of trauma.

References

- American Psychiatric Association (1994). *Diagnostic and Statistical Manual of Mental Disorders* (4th edn). Washington, DC: Author.
- Arvay, M.J. & Uhlemann, M.R. (1996). Counsellor stress and impairment in the field of trauma. *The Canadian Journal of Counselling* 30(3): 193–210.
- Chrestman, K.R., Duncan-Davis, J., Sullivan, M. & Kamen, D. (November 1995). *Risky Business: Primary and Secondary Traumatization in Trauma Therapists*. Poster session presented at the annual meeting of the International Society for Traumatic Stress Studies, Chicago, IL.
- Courtois, C.A. (1988). *Healing the Incest Wound: Adult Survivors in Therapy*. New York: Basic Books.
- Danieli, Y. (1984). Psychotherapists' participation in the conspiracy of silence about the Holocaust. *Psychoanalytic Psychology* 1(1): 23–42.
- Derogatis, L.R. & Spencer, P.M. (1982). *The Brief Symptom Inventory (BSI): Scoring, Administration, and Procedures*. Baltimore: Clinical Psychometric Research.
- Elliott, D.M. & Briere, J. (1991). Sexual abuse trauma among professional women: Validating the trauma symptom checklist-40 (TSC-40). *Child Abuse and Neglect* 16: 391–398.
- Eth, S. & Pynoos, R.S. (1985). Developmental perspective on psychic trauma in childhood. In C.R. Figley (ed.), *Trauma and its Wake: The Study and Treatment of Post-Traumatic Stress Disorder* (Vol. 1, pp. 36–52). New York: Brunner/Mazel.
- Figley, C.R. (1988). Victimization, trauma, and traumatic stress. *Counseling Psychologist* 16(4): 635–641.
- Figley, C.R. (ed.) (1995). *Compassion Fatigue: Coping with Secondary Traumatic Stress Disorder in Those Who Treat the Traumatized*. New York: Brunner/Mazel.
- Follette, V.M., Polusny, M.M. & Milbeck, K. (1994). Mental health and law enforcement professionals: Trauma history, psychological symptoms, and impact of providing services to child sexual abuse survivors. *Professional Psychology: Research and Practice* 25(3): 275–282.
- Gamble, S.J., Pearlman, L.A., Lucca, A.M. & Allen, G.J. (November 1995). *Vicarious Traumatization and Burnout among Licensed Psychologists: Empirical Findings*. Paper presented at the annual meeting of the International Society for Traumatic Stress Studies, San Francisco.
- Herman, J.L. (1992). *Trauma and Recovery: The Aftermath of Violence – from Domestic Abuse to Political Terror*. New York: Basic Books.
- Horowitz, M.J., Wilner, N. & Alvarez, W. (1979). Impact of event scale: A measure of subjective stress. *Psychometric Medicine* 41(3): 209–218.
- Jacobs, T.J. (1991). *The Use of Self: Countertransference and Communication in the Analytic Situation*. Madison, CT: International Universities Press.
- Janoff-Bulman, R. (1992). *Shattered Assumptions: Toward a New Psychology of Trauma*. New York: Free Press.
- Kassam-Adams, N. (November 1994). *The Risks of Treating Sexual Trauma: Stress and Secondary Trauma in Psychotherapists*. Poster session presented at the meeting of the International Society for Traumatic Stress Studies, Chicago.

- Mac Ian, P.S. & Pearlman, L.A. (1992). Development and the use of the TSI life event questionnaire. *Treating Abuse Today* 2(1): 9–11.
- McCann, I.L. & Pearlman, L.A. (1990). *Psychological Trauma and the Adult Survivor: Theory, Therapy, and Transformation*. New York: Brunner/Mazel.
- Mollica, R.F. (1988). The trauma story: The psychiatric care of refugee survivors of violence and torture. In F.M. Ochberg (ed.), *Posttraumatic Therapy and Victims of Violence* (pp. 295–314). New York: Brunner/Mazel.
- Munroe, J.F. (1991). Therapist traumatization from exposure to clients with combat-related posttraumatic stress disorder: Implications for administration and supervision. *Dissertation Abstracts International* 52(3): 1731B.
- Munroe, J.F. (1995). Ethical issues associated with secondary trauma in therapists. In B.H. Stamm (ed.), *Secondary Traumatic Stress: Self-care Issues for Clinicians, Researchers, and Educators* (pp. 211–229). Lutherville, MD: Sidran Press.
- Neumann, D.A. & Gamble, S. (1994). Issues in the professional development of psychotherapists: Countertransference and vicarious traumatization in the new trauma therapist. *Psychotherapy* 32(2): 341–347.
- Pearlman, L.A. (1996). Psychometric review of TSI belief scale, revision-L. In B.H. Stamm (ed.), *Measurement of Stress, Trauma and Adaptation*. Lutherville, MD: Sidran Press.
- Pearlman, L.A. & Mac Ian, P.S. (1995). Vicarious traumatization: An empirical study of the effects of trauma work on trauma therapists. *Professional Psychology: Research and Practice* 26(6): 558–565.
- Pearlman, L.A. & Saakvitne, K.W. (1995). Treating therapists with vicarious traumatization and secondary traumatic stress disorder. In C.R. Figley (ed.), *Compassion Fatigue: Coping with Secondary Traumatic Stress Disorder in Those Who Treat the Traumatized* (pp. 150–177). New York: Brunner/Mazel.
- Schauben, L. J. & Frazier, P.A. (1995). Vicarious trauma: The effects on female counselors of working with sexual violence survivors. *Psychology of Women Quarterly* 19: 49–64.
- Stamm, B.H. (Ed.) (1995). *Secondary Traumatic Stress: Self-care Issues for Clinicians, Researchers, and Educators*. Lutherville, MD: Sidran Press.
- Terr, L. (1990). *Too Scared to Cry*. New York: Basic Books.
- Wilson, J.P. & Lindy, J.D. (eds.) (1994). *Countertransference in the Treatment of PTSD*. New York: Guilford Press.
- Yassen, J. (1995). Preventing secondary traumatic stress disorder. In C.R. Figley (ed.), *Compassion Fatigue: Coping with Secondary Traumatic Stress Disorder in Those Who Treat the Traumatized* (pp. 178–208). New York: Bruner/Mazel.