Child and Adolescent Social Work Journal
Volume 16, Number 4, August 1999

The Impact of Sexual Abuse Treatment on the Social Work Clinician

Maddy Cunningham, D.S.W.

ABSTRACT: A growing body of literature exists on the prevalence and psychological sequelae of sexual abuse and its treatment. However, less attention has been focused on the experience of clinicians who treat these clients. This article uses the concept of vicarious traumatization (McCann and Pearlman, 1990a) to describe the impact this work may have on the social work clinician. The issues addressed include the impact of the work on the clinician's worldview and the possibility that there is a grief process as clinicians come to terms with their exposure to traumatic material. Implications of this reaction and suggestions to alleviate the detrimental effects are addressed.

In the past few decades, social workers have become more aware of the prevalence of childhood sexual abuse and its traumatic impact. In a variety of settings, practitioners are working with children and adolescents who have been victimized. A growing body of literature exists regarding the psychological sequelae of abuse and its treatment, however, less attention has been given to the impact that work with this client population may have on the clinician.

Sexual abuse therapy involves "an abreaction of the trauma" and catharsis (Courtois, 1988). Clinicians who work with sexually abused children and adolescents must share the "emotional burden of the trauma" (Herman, 1992). The purpose of this article is to discuss the impact this process may have on the clinician who serves as a "witness" (Herman, 1992) to the horror the client has endured.

Interest in the concept of secondary victimization, or those who are indirectly affected by traumatic events, is beginning to emerge. The rationale for exploring the clinician's experience of working with vic-

Address communications to Maddy Cunningham, DSW, Fordham University Graduate School of Social Service, 113 W. 60th Street, New York, NY 10023.

tims comes from the literature in two primary areas: research with crisis workers and reactions of family members of victims. Several research studies (Paton, 1989; Raphael, Singh, Bradbury, and Lambert, 1983/84; Fullerton, McCarroll, Ursano and Wright, 1992; and Wright, Ursano, Bartone and Ingraham, 1990) indicate that "helpers," such as rescue workers, fire fighters, and other workers who participate in disaster recovery, are negatively affected by their experiences. The work of Terr (1990) indicates that children indirectly exposed to trauma exhibit some symptoms of post-traumatic stress disorder similar to those directly exposed. There is also evidence that the family or others close to victims experience similar trauma symptoms (Terr, 1990; Remer and Elliott, 1988; Figley, 1983; Danieli, 1985; Silverman, 1978).

Certainly, the type of exposure to trauma experienced by the clinician working with sexual abuse differs from that of other helpers, such as rescue workers, or of victims themselves (Beaton and Murphy, 1995). However, several authors (McCann and Pearlman, 1990a; Pearlman and Saakvitne, 1995; Figley, 1995; Wilson and Lindy, 1994) hypothesize that clinicians working with trauma will experience negative effects that are similar to those of the victim, though these reactions are usually milder. Among these effects are disruptions in the clinician's worldview (McCann and Pearlman, 1990a; Pearlman and Saakvitne, 1995).

The purpose of this article is to explore some of the stresses associated with clinical work with sexually abused children and adolescents. It will discuss the concept of worldview and the impact that clinical work with this population has on it. Finally, it will propose that this impact often includes a grief reaction in the clinician. Implications of this impact and suggestions of ways to alleviate the negative effects are offered.

Vicarious Traumatization

Anecdotal accounts of working with sexual abuse have proposed that clinical work with this population is particularly stressful. Recently, empirical research has emerged which supports the notion that work with traumatized clients, including those who were sexually abused, has negative consequences for the clinician (Munroe, 1990; Pearlman and McIan, 1995; Schauben and Frazier, 1995; Kassam-Adams, 1994; Cunningham, 1996; Follette, Polusny and Milbeck, 1994). The stress

of this work has been referred to as "compassion fatigue" (Figley, 1995; Joinson, 1992), "secondary traumatic stress" (Figley, 1995) and "vicarious traumatization" (McCann and Pearlman, 1990a; Pearlman and Saakvitne, 1995). This article will use "vicarious traumatization," a concept proposed by McCann and Pearlman (1990a), as a conceptual framework for understanding the impact of sexual abuse treatment on the practitioner.

According to McCann and Pearlman (1990a), clinicians who work with sexually abused clients or other victims of trauma "may experience profound psychological effects, effects that can be disruptive and painful for the helper and can persist for months or years after work with traumatized persons" (McCann and Pearlman, 1990a; Pearlman and Saakvitne, 1995). The beliefs the clinician has about one's self, others and the world may be changed by the experience of hearing the traumatic material of the client. This is a process that develops over time and is a reaction to the cumulative stories to which clinicians are exposed, not a response to an individual client. They refer to this process as "vicarious traumatization" (McCann and Pearlman, 1990a; Pearlman and Saakvitne, 1995).

Vicarious traumatization is a new concept and, while it has similarities to concepts such as countertransference and burnout, it is also distinct. Several authors (McCann and Pearlman, 1990a; Pearlman and Saakvitne, 1995; Haley, 1974; Danieli, 1988) agree that working with traumatized clients can be distinguished from working with other "difficult populations" because of the clinician's exposure "to the emotionally shocking images of horror and suffering that are characteristic of serious trauma" (McCann and Pearlman, 1990a:134).

Often the concept of countertransference focuses on the personality of the clinician, frequently suggesting that the clinician's response is due to unresolved conflicts within the clinician (McCann and Pearlman, 1990a). Furthermore, the concept of countertransference does not account for the impact on the clinician of the material the traumatized client may present in sessions (McCann and Pearlman, 1990a; Pearlman and Saakvitne, 1995).

The literature on burnout (Maslach, 1982; Freudenberger and Robbins, 1979; Farber and Heifetz, 1982; Deutsch, 1984) focuses primarily on the external causation of the clinician's reaction such as large caseloads, the isolation of the work, and other bureaucratic factors. Like countertransference, the concept of burnout does not account for the impact of the client's trauma on the clinician.

While both of these concepts add to our understanding of the im-

pact of trauma work on the clinician, neither concept address the impact of the clinician's exposure to the shocking images the traumatized client presents in treatment. Vicarious traumatization is a result of the interaction between the individual personality of the clinician, including the clinician's worldview, and situational factors such as the traumatic material presented by the client. Therefore, the concept of vicarious traumatization allows for a fuller understanding of the clinician's experience than either the concept of countertransference or burnout alone (McCann and Pearlman, 1990a; Pearlman and Saakvitne, 1995).

Worldview

Janoff-Bulman (1989; 1992) proposes that most of the anguish for the victim following victimization is the result of shattered illusions about the world and self. Similarly, much of the impact the clinician feels working with traumatized clients may be related to a disruption in their worldview. Due to the clinician's exposure to the client's trauma material, he/she may experience a change in beliefs about the world and others (McCann and Pearlman, 1990a; Pearlman and Saakvitne, 1995).

The concept of worldview is derived from the work of Janoff-Bulman (1992), Epstein (1991), Parkes (1975) and Bowlby (1969). These theorists propose that individuals use some type of cognitive structure, which enables them to organize experiences effectively and efficiently and to function with a certain amount of confidence in a complicated, changing environment. These structures serve as personal theories of reality (Epstein, 1991; Janoff-Bulman, 1992, McCann and Pearlman, 1990b; Pearlman and Saakvitne, 1995) and are based on psychological needs, such as the need to feel safe, the need to trust and the need for esteem of self and others (McCann and Pearlman, 1990a; McCann and Pearlman, 1990b; Pearlman and Saakvitne, 1995). Cognitive schemas are made up of the beliefs that individuals have about themselves, others and the world. (McCann and Pearlman, 1990a; Pearlman and Saakvitne, 1995; Janoff-Bulman, 1989; 1992).

Most individuals, while they acknowledge that bad events occur, do not expect to encounter danger on a daily basis. They also expect that those they know and love will also be protected (Janoff-Bulman, 1992; McCann and Pearlman, 1990a; 1990b; Pearlman and Saakvitne, 1995;

Perloff, 1983; Taylor, 1983; Lerner, 1980). In our current climate, with heightened awareness of negative events, most people, professionals included, respond to personal disaster with shock and disbelief. Therefore, clinicians who are repeatedly exposed to details of their client's sexual abuse may begin to question the benevolence and safety of the world in a manner they had not previously (McCann and Pearlman, 1990a; Pearlman and Saakvitne, 1995). The world may appear dangerous and threatening. It may appear especially dangerous for children—their own, children they know, or children in general. This is not to suggest in any way that clinicians are naïve about the very negative events that occur in life or that they themselves may not have had personal experience with traumatic events. However, in the role of clinician, they are continuously exposed to intimate details of trauma and see its devastation in a way that many others do not. Benton and Murphy (1995) propose that one distinction between victims of disasters and rescue workers is that the workers are repeatedly exposed to trauma. This is applicable to those who engage in ongoing clinical work with traumatized clients. Furthermore, these practitioners see the impact of trauma on individuals they come to know and care about in a very deep way. While clinicians are trained to listen to painful stories, it seems to make sense that over time, practitioners exposed to repeated trauma will experience some reactions that clinicians who do not do trauma work are not expected to have.

Another belief that may be challenged by working with clients who were sexually abused, is the belief in the benevolence of other people or esteem for others (McCann and Pearlman, 1990a; Pearlman and Saakvitne, 1995). Clinicians who work with sexually abused clients hear about terrible acts brought about by another human being, often one who is charged with the care, protection and nurturance of the child. When victimization takes place at the hands of another human being, the effects are more devastating (McCann and Pearlman, 1990a; Janoff-Bulman, 1992; Herman, 1992; Courtois, 1988). The DSM-IV states that post-traumatic stress disorder "may be especially severe or long lasting when the stressor is of human design. . . . (p. 424). The betrayal that accompanies the experience of victimization by human design shatters the basic trust individuals feel in other people (McCann and Pearlman, 1990a; Pearlman and Saakvitne, 1995). If the person is someone known to the victim, the rupture in trust is even more acute (Janoff-Bulman, 1992). Social workers have long valued the worth of each individual. Exposure to details of the

client's sexual abuse experience may cause conflict and confusion regarding their view of humanity. Pearlman and Saakvitne (1995) state that this can cause difficulties for the clinician in terms of professional identity.

> Annemarie, a clinician for two years on an adolescent unit, listened to her 14-year-old client relate a story of how her father and his friends raped her at a family picnic. Her client's mother and other relatives were nearby, and even though she had told her mother on previous occasions about her father's abuse, her mother did not believe her and ignored her cries for help. Annemarie felt shocked, disgusted and angry with her client's father and mother. Over time, as she heard other stories like this one, she began to question whether there were "any good parents out there." She also questioned whether all fathers abused their children. She started to become depressed and, as McCann and Pearlman (1990a) propose, she began to experience despair regarding the human race.

> Marilyn led a group for sexually abused adolescent girls. Anna, a 15-year-old girl was being interviewed as a prospective member. She reported that her mother, who was a drug addict, had prostituted her from age of 3 to 7. As Anna revealed some of her memories about this experience, Marilyn like Annemarie became overwhelmed. She began having nightmares, and became depressed. She found it harder to "get up for work, only to hear about more abuse." After awhile, Marilyn started to question the "whole idea of family life."

McCann and Pearlman (1990a) state that clinicians, like Annemarie and Marilyn, may find themselves angry at the world and severely shaken by the malevolence of humans.

Along with these beliefs about the world and humanity in general, many individuals in our society hold certain beliefs or myths about family, and parents in particular. All social work practitioners hear disturbing stories about family life and parents. However, clinicians who work with children and adolescents who were sexually abused, hear about fathers and other relatives who molest or rape small children. They listen to stories of mothers who do not adequately protect their children from abuse, either knowingly or unknowingly. They may hear about parents who prostitute their children for drug money or other personal gain. Beliefs clinicians might hold about the innocence of childhood and the safety and security of family life are quickly called into question when they work with sexually abused clients.

In order to maintain one's own beliefs about the world, individuals may distort or minimize the information they hear, or blame the vic-

tim for what happened (Lerner, 1980; Taylor, Wood and Lichtman, 1983; Ryan, 1971). These reactions are common, and even understandable when one recognizes that they are used to make the person feel safe from harm. However, social work clinicians are trained to respond differently.

The literature on sexual abuse is filled with information regarding the prevalence of incest, its damaging impact, and specifies regarding responsibility (Davies and Frawley; 1994; Pearlman and Saakvitne, 1995; Briere, 1989; Herman, 1981; Courtois, 1988). To work effectively with survivors, clinicians must acknowledge that sexual abuse is prevalent, that it exists at all socioeconomic levels, and in all types of families. It also involves understanding that sexual abuse has serious negative consequences for the survivor, and that the survivor is blameless. This acknowledgment may challenge beliefs the clinician has about the world, humanity and families. Courtois (1988) states that as these assumptions are destroyed, the clinician may feel callous, detached or vulnerable. McCann and Pearlman (1990a:140) hypothesize that the clinician may experience a "loss of youthful idealism." However, not enough attention has been given to the fact that some clinicians, like survivors, may experience a grief process when their beliefs about the world and humanity are challenged.

Grief Process and the Shattering of Assumptions

The stages of denial, anger, sadness and depression, and resolution, which are characteristic of the grief process in general, are applicable to the grief process experienced by clinicians working with sexually abused clients.

Denial

Denial of the existence or prevalence of sexual abuse and its effects has been dealt with in the literature elsewhere. However, the impact of working with sexually abused clients on the clinician has not been addressed until recently. The individual clinician, the supervisor or other administrators may experience such denial. Clinicians may be ashamed of their feelings and deny they exist either to themselves or anyone else. It is not uncommon for clinicians who report feeling overwhelmed, sad or depressed to their supervisors to be shamed or blamed for their responses. They may be told they have "no bound-

aries" or are "too involved" with their clients. They may have their reactions minimized.

> Jane was working with a 4-year-old boy, who reported a particularly violent episode of abuse. Jane was feeling overwhelmed and was having difficulty sleeping. She found it hard to "get the images of the abuse out of her head." After several days she decided to report her feelings to her supervisor. After listening to Jane's distress, the supervisor merely said, "You'll get over it, we all felt that way at one time." This response added to Jane's distress.

Clinicians may be told that it is something unresolved in their own lives that accounts for their reaction. They may even be told that "they should not be doing clinical work."

Anger

Clinicians may experience anger regarding several issues. These include anger at those who violate children, and those who do not protect them. There may be a generalized sense of anger at society that abuse occurs, or at individuals who question the existence of abuse and its impact. There may be anger at the systems that are involved with the child after the abuse is disclosed. While anger can lead to increased involvement in social action on the part of the clinician, for some, at least for a period of time, it can create a feeling of helplessness, frustration and can even lead to feelings of depression and burnout.

Another issue that causes stress and can produce anger in the clinician is the current controversy regarding repressed memories. While it is incumbent on clinicians to be responsible regarding the issue of repressed memories, attitudes that suggest that repressed memories are impossible make trauma work especially difficult. Clinicians may become anxious when clients raise the possibility of repressed memories in sessions. They may dismiss their client's experience or become fearful of exploring the client's concerns in this area. They may find themselves questioning the validity of their client's story, and then feeling ashamed and guilty about their doubts. They may feel confused about the whole experience and give mixed messages to their clients. With troubled adolescent clients, the reactions may be even more confusing. There may be disagreements among staff members as to whether or not an adolescent is reporting accurate memories or "being manipulative."

And finally, clinicians working with sexually abused clients may

feel angry at all the pain sexual abuse causes, and angry at their own helplessness to take the pain away quickly. Clinicians who are overwhelmed by their client's pain may even find themselves feeling angry with their clients for being in pain. While they may recognize that this is not rational or fair, it may occur and result in a deep sense of guilt and shame.

Sadness

Clinicians may also experience sadness as their view of the world and humanity changes. They may feel disillusioned or cynical. They may lose their sense of "idealism" (Pearlman and Saakvitne, 1995). There may be intense feelings of loss as they "mourn for the world they once knew."

Resolution

For most clinicians working with sexual abuse there is also a stage of resolution. The concept of vicarious traumatization, in this author's opinion, is an attempt to help clinicians resolve the difficulties of this work by recognizing its impact, and learning ways to adequately address the effects. This is necessary to protect the individual clinician and assure the quality of work that he/she engages in with abused clients.

Implications and Conclusion

It is important to recognize that vicarious traumatization is not a pathological reaction to working with trauma survivors. Rather, it is a result of the clinician's ability to engage empathically with his/her client that leaves the clinician at risk of vicarious traumatization (Pearlman and Saakvitne, 1995; Figley, 1995). While this process may be complicated by unresolved personal factors in the clinician, these reactions are normal, just as changes in the assumptive world or symptoms of post-traumatic stress are a normal reaction in the survivors of trauma (Pearlman and Saakvitne, 1995; Figley, 1995).

Clinicians, like survivors, need to find a way to integrate this new information about the world, people and family into their existing cognitive schemas (Janoff-Bulman, 1989; McCann and Pearlman, 1990a; Pearlman and Saakvitne, 1995). Several strategies may be

helpful with this process. These include advanced training in sexual abuse treatment, good supervision, personal therapy when indicated, and learning to balance the demands of work with one's personal life and interests.

One way of helping clinicians integrate the traumatic material they hear into their existing worldview, may be the utilization of support groups. The research of Ursano and Fullerton (1990) and Fullerton et al (1992) indicates that social support is an effective mediator of stress. McCann and Pearlman (1990a) also propose the use of support to help clinicians deal with the negative impact of trauma work. For support groups to be effective, there is a need for increased awareness of the possible negative effects of clinicians working with sexually abused clients. This awareness needs to take place for the individual clinician, supervisors and staff administrations who plan in-service training.

The issue of specialization also poses increased risk of developing negative consequences for the practitioner working with sexual abuse. In some agencies, one or two clinicians may specialize in sexual abuse treatment. These clinicians may have received special training and/or have extensive experience in working with this population, which may increase their effectiveness with clients. Clients who have been sexually abused are frequently assigned to these workers. This often makes it difficult for these practitioners to balance their caseload with other types of clients. A varied caseload may lessen the possible negative impact of working with survivors. Cunningham (1996) found that clinicians who worked with high percentages of sexually abused clients reported significant disruptions in their worldview, whereas those with a more varied caseload reported no significant disruptions.

While working with any trauma or painful material may strain the clinician, there are some characteristics of incest which make it different from other types of traumas, or issues that clients may present. Sexual abuse is a taboo topic. Just as there may be a stigma for the abuse survivor, clinicians working with them may also be stigmatized. Some may question the clinician's motivation for engaging in this work, or ask questions about the clinician's personal history of abuse. McCann and Pearlman (1990a) describe such a process of stigmatization.

Likewise, when these clinicians listen to case presentations, they may be very attuned to signs of sexual abuse. This can be problematic for those clinicians when others are in denial about the possibility of abuse.

> Mark was a clinician in a child care agency that dealt with abuse and neglect. He joined a peer supervision group outside of his agency, to enhance his clinical skills. At one meeting a clinician presented a case of an eight-year-old girl whose mother's boyfriend recently moved in with the family. About a month after he moved in, the girl began having nightmares, wetting the bed, sucking her thumb and crying, especially when her mother wanted to leave her alone with this man. When Mark questioned if the clinician was concerned that the mother's boyfriend might be abusing the child, she responded angrily that Mark "sees abuse everywhere!"

The myths and societal attitudes regarding sexual abuse also pose a burden for clinicians in their non-professional life. When others learn that clinicians work with survivors of sexual abuse, it is not uncommon to be asked "Isn't it true children usually make up those stories?" or "Is it true that the mother always knows about the abuse and does not stop it?" Increased media coverage on repressed memories raise even more questions. Clinicians may be questioned about the validity of repressed memories with comments such as "How could someone possibly 'forget' they were abused?" While people may just be curious, these questions place clinicians in situations where they may feel the need to "correct" distortions. This may result in frustration and the feeling that they are "always working."

Finally, clinicians may hesitate to expose others to the trauma they hear. McCann and Pearlman (1990) refer to the necessity of clinicians in their support group to balance getting support, and protecting others from the trauma. This author agrees with the necessity of clinicians being responsible in discussing the material that clients share with them. Some clinicians may hesitate to disclose the details of the traumatic material or the impact it has on them. The stress may build and become even more toxic for them. Clinicians engaged in sexual abuse treatment need to make a commitment to disclose the details of traumatic material that has the potential to harm them. However, they need to do this in a responsible manner. It is important that they choose someone with whom they feel comfortable and who they trust. It is often helpful if this person understands the impact of trauma work. This lessens the possibility that the clinician will be shamed for honest reactions. A trusted supervisor, a therapist, or some other regular confidante is the most appropriate person to engage for this type of support. At times workers tend to "dump" their reactions on any co-worker who happens to be available. It is important that clinicians recognize that if the material upsets them, it will be upsetting to whomever they tell. Regularly scheduled support will

provide the clinician the time, space and permission to disclose the impact of working with their clients. At the same time it provides safety for the listener. This safe holding environment will help the clinician to continue to provide professional service to this population. Some clinicians need to be encouraged to reveal the details of the trauma and need to be reassured that they have "permission" to discuss these issues. This type of arrangement can provide clinicians a balance between taking care of themselves and avoiding traumatizing others.

Working with sexually abused clients may have a negative impact on clinicians both personally and professionally. These clinicians may be at higher risk for depression and other symptoms of post-traumatic stress disorder. In addition to personal consequences, it may also affect the quality of work. More research is needed to determine how clinicians may be affected by working with traumatized clients, such as those who were sexually abused. We also need to learn what supports are most effective in helping clinicians resolve these issues. Increased awareness of the potential for negative consequences on the clinician is needed by the practitioners themselves and at all levels of administration. Finally, adequate support for these clinicians is essential to assure that they cope effectively with the impact of working with sexual abuse in both their personal and professional lives. Many clinicians find working with these clients very rewarding. Awareness of vicarious traumatization does not ignore the rewards of the work, but recognizes that it is very stressful, and that there are aspects that make it different from work with other difficult issues. Vicarious traumatization provides a framework for understanding these difficulties and for determining ways to address those aspects of the work without minimizing the rewards.

References

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders*. Fourth edition. Washington, D. C.: APA.

Beaton, R. D. and Murphy, S. A. (1995). In Figley, C. R. (Ed.). *Compassion fatigue: coping with secondary traumatic stress in those who treat the traumatized*. New York: Brunner/Mazel.

Briere, J. (1989). *Therapy for adults molested as children: Beyond survival*. New York: Springer.

Bowlby, J. (1969). *Attachment and loss: Attachment*. Vol. 1. London: Hogarth.

Courtois, C. (1988). *Healing the incest wound: Adult survivors in therapy*. New York: W. W. Norton and Company.

Cunningham, M. (1996). *Vicarious traumatization: Impact of trauma work on the clinician*. Unpublished doctoral dissertation. Adelphi University.

Danieli, Y. (1985). The treatment and prevention of long-term effects and intergenerational transmission of victimization. A lesson for Holocaust survivors and their families. In Figley, C. R. (Ed.). *Trauma and its wake: The study and treatment of post-traumatic stress disorder*. Vol. 1. New York: Brunner/Mazel.

Danieli, Y. (1988). Confronting the unimaginable: Psychotherapist's reactions to the victims of Nazi Holocaust. In Wilson, J. P., Harel, Z. and Kahana, B. (Eds.). *Human adaptation to extreme stress: From the Holocaust to Vietnam*. New York: Plenum.

Davies, J. M. and Frawley, M. G. (1994). *Treating the adult survivor of childhood sexual abuse: A psychoanalytic perspective*. New York: Basic Books.

Deutsch, C. J. (1984). Self-reported sources of stress among psychotherapists. *Professional Psychology: Research and Practice, 15*(6), 833–845.

Epstein, S. (1991). The self-concept, the traumatic neurosis, and the structure of the personality. In Hogan, R. (Ed.). *Perspectives in Personality*. Vol. 3A, 63–98. London: Jessica Kingsley Publishers.

Farber, B. A. and Heifetz, L. (1982). The process and dimensions of burnout in psychotherapists. *Professional Psychology, 13*(2), 293–301.

Figley, C. R. (1995). Compassion fatigue as secondary traumatic stress disorder: An overview. In Figley, C. R. (Ed.). *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized*. New York: Brunner/Mazel.

Figley, C. R. (1983). Catastrophe: An overview of family reactions. In C. R. Figley and H. I. McCubbin (Eds.). *Stress and the family*. Vol. 2. New York: Brunner/Mazel.

Figley, C. R. (Ed.). (1985). *Trauma and its wake: The study and treatment of post-traumatic stress disorder*. Vol. 1. New York: Brunner/Mazel.

Follette, V., Polusny, M. and 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.

Freudenberger, H. and Robbins, A. (1979). The hazards of being a psychotherapist. *The Psychoanalytic Review*, 66(2), 275–296.

Fullerton, C., McCarroll, J., Ursano, R. and Wright, K. (1992). Psychological responses of rescue workers: Fire fighters and trauma. *American Journal of Orthopsychiatry, 62*(3), 371–378.

Haley, S. (1974). When the patient reports atrocities: Specific treatment considerations of the Vietnam veteran. *Archives of General Psychiatry, 30*, 191–196.

Herman, J. (1992). *Trauma and recovery*. New York: Basic Books.

Janoff-Bulman, R. (1992). *Shattered assumptions: Towards a new psychology of trauma*. New York: The Free Press.

Janoff-Bulman, R. (1989). Assumptive worlds and the stress of traumatic events: Applications of the schema construct. *Social Cognition, 7*(2), 113–136.

Joinson, C. (1992). Coping with compassion fatigue. *Nursing, 22*(4). 116–122.

Kassam-Adams, N. (1994). The risks of treating sexual trauma: Stress and secondary trauma in psychotherapists. Unpublished doctoral dissertation. University of Virginia.

Lerner, M. (1980). *The belief in a just world: A fundamental delusion*. New York: Plenum.

Maslach, C. (1982). *Burnout: The cost of caring*. New Jersey: Prentice-Hall.

McCann, I. L. and Pearlman, L. A. (1990a). Vicarious traumatization: A framework for understanding the psychological effects of working with victims. *Journal of Traumatic Stress, 3*(1), 131–149.

McCann, I. L. and Pearlman, L. A. (1990b). *Psychological trauma and the adult survivor*. New York: Brunner/Mazel.

Munroe, J. F. (1990). Therapist traumatization from exposure to clients with combat related post-traumatic stress disorder: Implications for administration and supervisors. Unpublished doctoral dissertation. Northwestern University.

Parkes, C. M. (1975). What becomes of redundant world models? A contribution to the study of adaptation to change. *British Journal of Medical Psychology, 48*, 131–137.

Paton, D. (1989). Disasters and helpers: Psychological dynamics and implications for counseling. *Counseling Psychology Quarterly, 2*(3), 303–321.

Perloff, L. S. (1983). Perceptions of vulnerability to victimization. *Journal of Social Issues, 39*(2), 41–61.

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

Pearlman, L. A. and MacIan, P. S. (1995). Vicarious traumatization: An empirical study of the effects of trauma work on trauma therapists. *Professional Psychology: Research and Practice, 26*(6), 588–565.

Raphael, B., Singh, B., Bradbury, L. and Lambert, F. (1983/84). Who helps the helpers? The effects of a disaster on the rescue workers. *Omega, 14*, (1), 9–20.

Remer, R. and Elliott, J. E. (1988). Characteristics of secondary victims of sexual assault. *International Journal of Family Psychiatry, 9*(4), 373–387.

Ryan, W. (1971). *Blaming the victim*. New York: Vintage Books.

Schauben, L. J. and Frazier, P. (1995). Vicarious trauma: The effects on female counselors of working with sexual violence survivors. *Psychology of Women Quarterly, 19*, 49–64.

Silverman, D. C. (1978). Sharing the crisis of rape: Counseling mates and families of victims. *American Journal of Orthopsychiatry, 48*(1), 16–173.

Taylor, S. E. (1983). Adjustment to threatening events: A theory of cognitive adaptation. *American Psychologist, 38*, 1161–1174.

Taylor, S. E., Wood, J. V. and Lichtman, R. R. (1983). It could be worse: Selective evaluation as a response to victimization. *Journal of Social Issues, 39*(2), 19–40.

Terr, L. (1990). *Too seared to cry: How trauma affects children and ultimately us all*. New York: Basic Books.

Terr, L. (1989). Family anxiety after traumatic events. *Journal of Clinical Psychiatry, 50*(11) (Suppl), 15–19.

Ursano, R. and Fullerton, C. (1990). Cognitive and behavioral responses to trauma. *Journal of Applied Social Psychology, 20*(21), 1766–1775.

Wilson, J. P. and Lindy, J. D. (Eds.). (1994). *Countertransference in the treatment of PTSD*. New York: Guildford.

Wilson, J. P., Harel, Z. and Kahana, B. (1988). *Human adaptation t extreme stress: From the Holocaust to Vietnam*. New York: Plenum.

Wright, K. M., Ursano, R. J., Bartone, P. T., Ingraham, L. H. (1990). The shared experience of catastrophe: An expanded classification of the disaster community. *American Journal of Orthopsychiatry, 60*(1), 35–42.