

Running head: TRAINEES AND INDIRECT TRAUMA

FACTORS AFFECTING PSYCHOLOGY TRAINEES' VULNERABILITY TO  
INDIRECT TRAUMA

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# TRAINEES AND INDIRECT TRAUMA

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## ABSTRACT

Psychologists may develop reactions of indirect trauma from trauma work, which consist of secondary traumatic stress (STS; i.e., avoidance, re-experiencing, and hyperarousal), compassion fatigue (CF; i.e., avoidance, re-experiencing, hyperarousal, and changes to work-related behaviors and beliefs), and vicarious traumatization (VT; i.e., changes to beliefs about self, others, and the world). Doctoral psychology trainees, a population minimally studied in this area, may also develop indirect trauma, which may impact training and career trajectories. The present study assessed 74 psychology trainees in their fourth year and above, 48 of whom completed the study (77% women, mean age = 29, range: 25 to 39 years) to determine their lived experiences and personal (e.g., self-compassion), training, and exposure related factors associated with indirect trauma. Participants completed measures of indirect trauma and answered questions about personal background, training, and clinical experiences. Overall, participants reported STS in the “mild” range, VT in the “average” range, and CF in the “low” range. All forms of indirect trauma were negatively associated with self-compassion. STS varied by total caseload, trauma intervention, trauma-focused externship, graduate program type, and extent of trauma training. VT varied by trauma clinical experience and extent of trauma training. CF varied by caseload total. No evidence was found for associations among indirect trauma and gender, age, personal trauma history, theoretical orientation, trauma caseload, year in program, and amount of supervision. The results suggest that amount and type of trauma training impact vulnerability to indirect trauma. Participants stressed the importance of supportive supervision in trauma training, especially discussion of trainee reactions to trauma work, including the impact of personal trauma

history. Many participants (58.7%) expressed a desire to continue trauma work due to its prevalence and rewarding nature. Future studies may use longitudinal assessment of indirect trauma during training to determine the course and impact of risk factors over time. Training and supervision recommendations include increased availability of trauma courses, implementation of programs that foster self-compassion, and the supportive supervision in which discussion of personal reactions to trauma work are openly encouraged.

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## Introduction

Psychotherapists face more than just the typical work-related stress when treating individuals for trauma; working with the details of a client's traumatic event may negatively impact the mental health of the therapist, as well. High percentages of clinical populations have experienced trauma in their lifetimes (Cusack, Frueh, & Brady 2004; Resnick et al., 1993), and issues of trauma may even arise in cases in which trauma or Post Traumatic Stress Disorder (PTSD) are not the patient's presenting problem. Therapist exposure to the details of a client's traumatic event, or "indirect" trauma, may result in negative reactions, including symptoms of PTSD, or "secondary traumatic stress" (Figley, 1995), dissatisfaction with and emotional fatigue related to one's work, or "compassion fatigue" (Figley, 1995), and/or negative disruptions to one's belief system, or "vicarious traumatization" (McCann & Pearlman, 1990). Exposure to client traumas may also result in adaptive changes, such as in satisfaction with one's work (Figley, 2002), post-traumatic growth (Arnold et al., 2005), and resilience (Hernandez, Gangsei, and Engstrom, 2007; Nuttman-Shwartz, 2015). For the purposes of this study, "indirect trauma" will be used as an umbrella term for all three of the negative reactions of indirect trauma. Psychotherapists in training are vulnerable to these reactions to indirect trauma (Adams & Riggs, 2008; Baker, 2012; Beaumont, Durkin, Hollins Martin, & Carson, 2016), even to degrees higher than those of their site supervisors (Knight, 2010). Student populations, particularly doctoral-level trainees, have been only minimally studied to date.

Overlap and ambiguity in construct operationalization and reliance on predominately correlational studies have contributed to largely equivocal prevalence rates

and factor analyses in the indirect trauma literature. The scant research on trainee populations further limits understanding of factors influencing vulnerability to indirect trauma. Such factors may be addressed during training so as to provide psychologists with tools to protect themselves while doing such demanding and necessary work. The current exploratory study utilizes a mixed-methods design to more comprehensively and effectively investigate each of the three indirect trauma reactions and their related personal, training, and exposure factors, as well as the lived experiences of psychology graduate students working with trauma patients.

### **Reactions to Indirect Trauma**

Indirect trauma comprises the cumulative negative impact that working with trauma clients can have on psychotherapists. The International Society for Traumatic Stress Studies (ISTSS) frames indirect trauma as an inevitable occupational hazard in order to de-pathologize and de-stigmatize such reactions to trauma work. Indirect trauma has been conceptualized in a number of different ways using largely overlapping constructs. The pluralistic development of constructs may result in part from efforts to de-stigmatize indirect trauma reactions (Sprang & Craig, 2015).

#### **Secondary traumatic stress.**

“Secondary traumatic stress” has been used as an umbrella term by a number of different authors to refer to reactions of indirect trauma that mimic symptoms of PTSD. Figley (1995) conceptualized secondary traumatic stress as symptoms of avoidance, reexperiencing, and hyperarousal that stem from exposure to the details of the trauma of another person while in working in a professional role. Secondary traumatic stress has

been assessed with self-report measures such as the Secondary Traumatic Stress Scale (Bride, Robinson, Yegidis, & Figley, 2004).

### **Compassion fatigue.**

Figley (1995) coined the term “compassion fatigue” as synonymous with secondary traumatic stress in order to be less stigmatizing and frame indirect trauma as a “normal occupational hazard.” He expanded upon the standard symptoms of secondary traumatic stress that mimic those of PTSD to include changes in behaviors, attitudes, and perceptions that are often work-related. As a result, “compassion fatigue” is sometimes referred to as a construct that comprises the symptoms of both secondary traumatic stress and burnout (Sprang & Craig, 2015). In fact, the commonly used measure of Compassion Fatigue, the Professional Quality of Life Scale (ProQOL; Stamm, 1995), includes separate subscales for compassion fatigue and burnout.

### **Vicarious traumatization.**

McCann and Pearlman (1990) framed vicarious traumatization as a process of disruptions to a person's sense of safety, control, trust, and intimacy. Vicarious traumatization stems from McCann and Pearlman's (1990) Constructivist Self-Development theory of trauma, which suggests that individuals construct their own realities via various schemas, or core beliefs, about the self, others, and world. The therapist's unique history and salient schemas determines her experience of and adaptation to indirect trauma. Such schemas affected by trauma often include topics such as safety/trust, power, independence, and intimacy (Pearlman & Saakvitne, 1995). Vicarious traumatization has been assessed with a number of different measures, including the Traumatic Stress Belief Scale (Jenkins & Baird, 2002, as cited in Sprang &

Craig, 2015), and Traumatic Stress Life Events Checklist (Bride, Radley, & Figley, 2007, as cited in Sprang & Craig, 2015).

### **Burnout.**

Another issue in definitional clarity is the extent to which burnout overlaps with the aforementioned constructs. Burnout consists of cynicism and a reduced sense of accomplishment and job satisfaction (Cherniss, 1980). Burnout is often measured in conjunction with indirect trauma and has definitional overlap with compassion fatigue, which comprises changes in work-related beliefs and behaviors. Intuitively, factors that may contribute to the development of adverse indirect trauma reactions, such as trauma caseload (Hensel, Ruiz, Finney, and Deva, 2015), may likely also contribute to burnout, which has also been associated with large, high-stress professional caseloads, among other factors (Cherniss, 1980).

In a recent study, Sprang and Craig (2015) conducted an inter-battery exploratory factor analysis of two measures used to assess the impact of trauma and indirect trauma, a self-report measure of subject distress caused by trauma that maps onto DSM IV PTSD criteria, and the Professional Quality of Life Scale (Stamm, 1995), that assesses compassion fatigue, compassion satisfaction, and burnout. Their analysis found support for burnout and compassion fatigue as separate constructs, as they loaded onto distinct factors.

### **Issues in Research**

Due to problems of conceptual clarity and the use of different measures, meta-analyses and reviews of the indirect trauma literature are limited. In fact, one group of authors with the intention of conducting a meta-analysis found they instead needed to



first review the methodological and conceptual issues in the indirect trauma literature, (Baird & Kracen, 2006). Despite these challenges, a number of studies have examined factors related to the presence of reactions to indirect trauma in psychotherapists. Recent literature appears to focus on, or at least include, assessment of compassion fatigue, perhaps due to the wide availability of the ProQOL online in multiple languages free of cost.

### **Generalizability and therapist populations.**

The widespread use of the ProQOL has allowed for some consistency in the recent indirect trauma literature, although studies have assessed a variety of different variables in different populations. For example, Zeidner et al. (2013) examined the role of emotional intelligence and coping as they relate to compassion fatigue in a sample of health professionals including both medical and mental health-care professionals. They utilized the third version of the ProQOL and created a combined score for the secondary traumatic stress and burnout subscales to develop a composite compassion fatigue score. Emotional intelligence and adaptive coping were both found to be inversely associated with compassion fatigue, and there was no significant difference in compassion fatigue between mental and medical healthcare professionals. However, mental health professionals reported significantly higher emotional intelligence, avoidance coping, and more negative affect than did medical health practitioners. In a study of multidisciplinary mental health providers, Sprang, Clark, and Whitt-Woosley (2007) determined that psychiatrists reported higher levels of compassion fatigue than did both masters- and doctoral- level mental health providers. To rigorously assess compassion fatigue or the effects of indirect trauma on psychotherapists, a more homogenous sample should be

used. Many studies of indirect trauma have thus explicitly focused on psychotherapist populations.

**Correlation does not imply causation.**

Sodeke-Gregson, Holtum, and Billings (2013) assessed compassion fatigue, compassion satisfaction, and burnout in psychotherapists working in a variety of settings at both doctoral and master levels in the United Kingdom. Personal trauma history, time spent in individual supervision and engaging in self-care activities were found to be predictors of compassion fatigue, and perception of management support and age were negative predictors of burnout. The seemingly counterintuitive relationship between time spent in supervision and self-care activities and compassion fatigue could reflect a phenomenon in which clinicians with more compassion fatigue recognize its impact on their wellbeing and seek more support and engage in more self-care activities as a result. Regression analyses, as used in this study, are correlational, and correlation does not imply causation. The authors did not find significant associations among secondary traumatic stress and other commonly examined factors, such as age, experience of therapist, gender, and percentage of trauma clients in caseload.

Factors associated with indirect trauma reactions cannot be distinguished as predisposing, causal, or consequential, because the literature to date consists solely of correlational studies. The direction of causality cannot be inferred from correlational data. Reactions to indirect trauma have been linked with many different factors, and solely correlational methods do not adequately capture the complexity of each of these constellations of intersecting factors.

**Construct ambiguity.**

Another issue in the indirect trauma literature is that of construct ambiguity. For example, trauma caseload volume was found to be significantly, positively associated with compassion fatigue in a study by Hensel, Ruiz, Finney, and Dewa (2015). However, this study was a meta-analysis of 38 studies that assessed risk factors for secondary traumatic stress among psychotherapists working with trauma clients, not compassion fatigue. A weakness of this study is that compassion fatigue and secondary traumatic stress were both assessed using a variety of different measures and considered as the same construct. As discussed earlier, secondary traumatic stress and compassion fatigue are related and overlapping constructs, but they consist of separate components. Compassion fatigue includes symptoms of burnout, and secondary traumatic stress does not. The validity of such a meta-analysis is thus questionable due to definitional ambiguity in constructs. The authors discuss the issue of definition ambiguity and justify the inclusion of both secondary traumatic stress and compassion fatigue measures because both conditions mimic the symptoms of PTSD, whereas vicarious traumatization relates more to changes in beliefs, or schemas (Hensel et al., 2015). The authors found trauma caseload volume, trauma caseload ratio, and personal trauma history of the client to be significantly associated. Although in the literature review the authors acknowledged the probable relationship among burnout and secondary traumatic stress, they did not assess burnout as a separate construct. Many studies have, however, assessed burnout in conjunction with secondary traumatic stress due to the inclusion of the burnout subscale on the ProQOL.

Similar to other reactions to indirect trauma, burnout has been associated with younger age of therapist and use of evidence-based practices (Craig & Sprang, 2010), as well as perceived working conditions, mindfulness, and use of coping strategies (Thompson, Amatea, & Thompson, 2014). In each of these studies, both burnout and compassion fatigue were significantly associated with the variables above, although to varying degrees. For example, perceived working conditions, mindfulness, and use of coping strategies explained 66.9% of the variance in burnout scores and only 31.1% of the variance in compassion fatigue scores. It is clear that burnout and other indirect trauma reactions are related, but as suggested by Sprang and Craig (2015), conceptually distinct. It is possible that similar factors predispose psychotherapists to the development of indirect traumatic stress reactions and burnout, and that these phenomena may also each influence one another. The assessment of burnout in conjunction with secondary traumatic stress, compassion fatigue, and vicarious traumatization will allow for further exploration of the role of different predisposing causal, and consequential factors of indirect trauma reactions.

### **Self-Compassion**

One factor that has recently been linked to indirect trauma is self-compassion (Beaumont et al., 2016). Self-compassion stems from Eastern philosophy and consists of three main components (Neff, 2003). The first component is kindness and understanding towards oneself; people with high self-compassion are kind and understanding to themselves, as well as nonjudgmental of themselves in the case of pain or failure. The second aspect of self-compassion consists of people's perception of their experiences as being part of the broader human experience. Similar to self-kindness, recognition of

common humanity is essential in the face of failure, as it helps people to realize that they are not alone in their struggles. The third aspect of self-compassion is mindfulness of thoughts and feelings, especially those of a negative nature. Self-compassion has been positively associated with mental health and wellbeing (Neff, 2009), and proposed as a healthy response to trauma (Germer & Neff, 2015).

Self-compassion may be adaptive in the face of trauma. Self-kindness may calm hyperarousal, awareness of common humanity may reduce shame, and mindfulness may allow for awareness of and distancing from intrusive symptoms (Germer & Neff, 2015). In fact, self-compassion has been found to be negatively associated with severity of PTSD symptoms in U.S. veterans of Operation Enduring Freedom and Operation Iraqi Freedom (Dahm et al., 2015), and negative associated with burnout and depression in a sample of Veterans Affairs mental health providers (Atkinson et al., 2017).

Beaumont et al. (2016), in the only study to assess self-compassion and a form of indirect trauma, found a negative relationship between self-compassion and compassion fatigue in student counselors and student cognitive behavioral therapists in the United Kingdom. Of note, is it unclear if the trainee participants surveyed in this study were students of doctoral or masters' level programs. Overall levels of compassion fatigue and burnout fell into "low" ranges, and higher levels of reported self-compassion were associated with lower levels of both compassion fatigue and burnout. The authors stress the utility of self-compassion in that it can be taught and cultivated, and possibly even used to cope with and prevent symptoms of both trauma and indirect trauma. The use of a trainee population in this study is particularly appropriate because self-compassion can be incorporated as an aspect of graduate training.

### **Trainee Populations**

Psychotherapists in training are vulnerable to reactions to indirect trauma (Adams & Riggs, 2008; Baker, 2012; Beaumont et al., 2016), possibly even to degrees higher than those of their supervisors (Knight, 2010). A number of researchers in the field of indirect trauma have stressed the importance of adequate training in trauma psychotherapy, including education concerning the impact of indirect trauma (Adams & Riggs, 2008; Knight, 2013; Baker, 2012; Beaumont et al., 2016, Carello & Butler, 2015; Courtois & Gold, 2009). A major theme that emerged from a qualitative study of doctoral trainees' experience of vicarious traumatization was that of the necessity of a graduate-level course in trauma therapy (Baker, 2012). A recent survey of North American doctoral clinical and counseling psychology programs indicated that of 151 who participated, only 48 programs offered graduate courses in trauma (Cook et al., 2017).

Adams and Riggs (2008) assessed factors associated with vicarious traumatization in clinical and counseling trainees, and 25% of their sample had no prior trauma-related training. This is one of the few studies to quantitatively assess the relationship between training and a type of indirect trauma, vicarious traumatization, and responses were limited to the selection of "substantial training," "minimal training," or "no specific trauma training." Vicarious traumatization was assessed using five subscales of the Trauma Symptom Inventory (TSI; Briere, 1995, as cited in Adams & Riggs, 2008) comprising items that capture hyperarousal symptoms, intrusions (i.e., flashbacks and nightmares), cognitive and behavioral avoidance, dissociative experiences, and "Impaired Self Reference," or issues with self-concept (e.g., low self-esteem). Such symptoms reflect the broad symptom clusters of a post-traumatic stress reaction, and thus may better

capture the construct of secondary traumatic stress. Secondary traumatic stress is commonly defined as symptoms of intrusions, avoidance, and hyperarousal (Figley, 1995), whereas vicarious traumatization is often defined as disruptions to beliefs about oneself and the world (McCann and Pearlman, 1990). TSI scale means fell in average ranges, although a third of the sample reported symptoms above the clinical threshold in at least one scale. Participants who indicated "minimal" training in trauma-focused approaches scored significantly higher in "Impaired Self Reference" than did students who indicated having had "substantial training." Further investigation is necessary to assess the impact of training on the other forms of indirect trauma, as well as more comprehensive information about the types of training gained and their utility. A limitation of Adams and Riggs' (2008) sample was the combination of masters- and doctoral-level trainees, as different training programs likely have different emphases, timeframes, and missions regarding training (e.g., social work vs. a program in clinical psychology). In order to adequately assess the impact of training on students, a more homogenous sample in terms of type of degree should be used.

Makadia, Sabin-Farrell, and Turpin (2017) assessed the relationships among exposure to trauma work and factors related to well-being, including secondary traumatic stress, vicarious traumatization, and general psychological distress in doctoral-level psychology trainees in the United Kingdom. Five hundred sixty-four trainees participated, and 20 participants considered to be "at risk for PTSD" as per a Trauma Screening Questionnaire (Brewin et al., 2002, as cited in Makadia et al., 2017), which assessed for symptoms of PTSD related to personal trauma, were removed from analysis so as to control for the confound of current PTSD. Secondary traumatic stress, but not

vicarious traumatization, was significantly associated with "exposure to trauma work," which was operationalized as the amount of trauma-focused cases seen over the past six months. However, mean scores on the STSS fell into the "little or no trauma symptoms" range, while scores on the TAB fell into the "average" range.

Student populations have been only minimally studied in the context of indirect trauma, and doctoral-level students, less so. Doctoral level psychology trainees have only been assessed in regards to vicarious traumatization in three published studies (Adams & Riggs, 2008; Baker, 2012; Makadia et al., 2017), to secondary traumatic stress in one study (Makadia et al., 2017), and to "state" compassion fatigue (i.e., amount of "compassion fatigue" following a standardized clinical task) in one study (O'Brien & Haaga, 2015), while a range of studies have assessed forms of indirect trauma in social work trainees (Beaumont et al., 2016; Butler, Carello, and Maguin, 2017; Decker, et al., 2010; Knight, 2010; Shannon et al., 2014). Perhaps the field of social work, as a whole, is better attuned to negative occupational issues, such as burnout, due to the high organizational demands (e.g., large caseloads, varying roles and services provided by social work clinicians) and performance-measurement demands (e.g., performance audits) inherent in social work positions (Misca & Unwin, 2016). As a result, research may have developed to identify factors contributing to resilience against negative work-related consequences (e.g., burnout, vicarious traumatization) that may be enhanced during clinical training. For example, Butler et al. (2017) assessed the relationship between protective factors, such as self-care, and burnout and secondary traumatic stress. Participants who reported lower effort to engage in self-care reported higher amounts of burnout and secondary traumatic stress. The importance of self-care and related strategies



to maintain self-care practice may be taught during graduate training so as to inoculate trainees against the various forms of indirect trauma.

### **The Current Study**

One study to date has assessed for all three forms of indirect trauma in a student population of undergraduate social work students (Knight, 2010). The present study will assess the relationship between training and indirect trauma both quantitatively, as in the method used by Adams and Riggs (2008), as well as qualitatively, through open-ended questions.

Overlap and ambiguity in construct operationalization of forms of indirect trauma has contributed to largely equivocal prevalence rates and factor analyses in the indirect trauma literature (Baird & Kracen, 2006). For example, compassion fatigue has been associated with personal factors such as age, use of evidence-based practices (Craig & Sprang, 2010), and personal trauma history (Sodeke-Gregson, Holttum, and Billings, 2013). However, due to conceptual differences in constructs, it is inaccurate to assume that vicarious traumatization or secondary traumatic stress are associated with such factors in the same ways and to the same degrees. Research featuring the inclusion of all three constructs will allow for ease and accuracy of comparison with the literature and a more comprehensive understanding of the impact of personal, training, and exposure-related factors on indirect trauma. The current study will be the first to investigate all three constructs concurrently in a doctoral-level psychology trainee population.

The scant research on psychology trainee populations limits understanding of factors influencing vulnerability to indirect trauma. Such factors may be addressed during training so as to provide psychologists with tools to protect themselves while doing such

demanding and necessary work, and prevent attrition of trainee psychologists entering the field, as students have endorsed considerations to change careers following vicarious traumatization (Baker, 2012). The health and wellbeing of psychologists likely impacts the quality of the therapeutic services they provide, and some have argued that specific training in trauma work is necessary to provide ethical treatment of trauma (Courtois & Gold, 2009). The current exploratory study utilizes a mixed-methods design to more comprehensively and effectively investigate each of the three indirect trauma reactions and their related personal, training, and exposure factors, as well as the lived experiences of psychology graduate students working with trauma patients.

This study aims to begin to explore the following questions:

- A. How are demographic and personal factors related to vulnerability to indirect trauma?
- B. How does training and supervision influence vulnerability to indirect trauma?
- C. How does self-compassion influence vulnerability to indirect trauma?
- D. How do experiences of indirect trauma impact trainees' desire to do trauma work?

## **Method**

### **Participants**

The participants for this study were recruited from Clinical and Counseling Psychology PsyD and PhD programs in the United States via program-wide emails following approval by directors of clinical training and via graduate student and trauma-related email listservs. As per consultation with the director of clinical training of the Rutgers Graduate School of Applied and Professional Psychology, training directors were identified and their contact information collected via internet searches of individual doctoral training programs. Participants included clinical and counseling psychology graduate students in their fourth year and later of training.

The focus on a more limited population may eliminate some training and supervision-related confounding variables, such as differences in emphasis and length of training program in social work, counseling, and doctoral psychology programs. As a result, the findings of the study are only generalizable to clinical psychologists in training. The goal of the study was to examine the relationships among a number of personal, training and supervision, and practice-related factors and indirect trauma reactions in therapists in training who work with clients with a history of trauma. Participants must thus have had some experience working clinically with issues of trauma. Training programs that heavily emphasize the accumulation of clinical experience, such as psychology doctoral programs, are thus more likely to show a relationship among stage of training and the dependent variables, and students in their fourth year and later will have had more exposure to trauma clients than newer students. Because the focus on one training population may also limit demographic

generalizability, directors of training from programs across the country were contacted in order to recruit as large and broad of a sample as possible (see Appendix K).

Due to the online format of the study and necessity of approval by directors of training for its distribution to various programs, it was impossible to predict how many participants would respond. As per an a priori power analysis, a minimum of 48 complete responses were necessary to adequately power all analyses to detect a medium effect size with a significance level of  $\alpha = .05$ . Data was to be collected on a rolling basis until a more conservative 85 responses had been collected or June 1, 2017, whichever occurred first, in order to adequately power the planned statistical analyses required for the results and analysis phase. As of June 1, 2017, 74 responses had been collected, although only 48 of those responders finished the online survey (i.e., viewed all questions and indicated their responses to be complete), and only 44 of those responders completed each measure in full. Due to the sensitivity of some questions asked, the survey was anonymous. Additionally, all questions were optional (i.e., they did not require forced answers to proceed) so as to both collect as much data as possible while also remaining trauma-sensitive and allowing participants as much agency as possible in their responses.

## **Measures**

### **Secondary traumatic stress scale (Bride, Robinson, Yegidis, & Figley, 2004).**

The Secondary Traumatic Stress Scale is a 17-item self-report measure of frequency of PTSD-like symptoms in response to working with traumatized clients (see Appendix A). Participants indicated the frequency of symptoms in the previous week on a five-point, Likert-type scale ranging from 1 (“Never”) to 5 (“Very Often”). Subscales comprised intrusion symptoms (e.g., “I thought about work with my clients when I didn’t intend

to”), avoidance symptoms (e.g., “I wanted to avoid working with some clients”), and arousal symptoms (e.g., “I felt jumpy”). Internal consistency reliability ratings are high for the full measure (.93), intrusion subscale (.80), avoidance subscale (.87), and arousal subscale (.83). The measure has adequate construct validity as per convergent, discriminant, and factorial analyses (Bride et al., 2004). The measure has been frequently used to measure the construct as per Figley’s (1995) definition of STS (Bride, Radey, & Figley, 2007), and its use thus aids in comparison with the literature. This measure was untitled in the online survey.

**Trauma and attachment belief scale (Pearlman, 2003).** The Trauma and Attachment Belief Scale (TABS; see Appendix B) is an 84-item self-report measure of alterations to schemas in the areas of psychological need: Control (e.g., “I can’t do good work unless I am the leader”), Esteem (e.g., “People are no good”), Intimacy (e.g., “I hate to be alone”), Safety (e.g., “I feel threatened by others,”), and Trust (e.g., “I don’t trust my instincts”). The measure comprises ten subscales for each psychological need in relation to self and other (e.g., “Self-Safety” and “Other-Safety”). Participants responded using a Likert-scale from 1 (“disagree strongly”) to 6 (“agree strongly”). Internal consistency reliability ratings are high for the full measure (.96) and adequate for the subscales (range .67 to .87). Construct validity is generally good in clinical and nonclinical samples, and TABS scores for outpatients with trauma histories are higher than those of outpatients, in general (Pearlman, 2003). A factor analysis determined three stable factors (Self, Safety, and Other), which the authors considered to be consistent with the Constructivist Self-Development Theory (Vaara, Pearlman, Brock, & Hodgson, 2008). This measure was untitled in the online survey.

**Professional quality of life Scale 5 (ProQOL-5; Stamm, 2010).** The ProQOL-5 is a 30-item self-report measure of both the negative and positive effects of working in a helping profession, referred to as compassion fatigue and compassion satisfaction, respectively (see Appendix C). Compassion fatigue is related to both feelings of fear and a sense of being overwhelmed in relation to one's work. The compassion fatigue subscale is comprised of items related to symptoms of secondary traumatic stress and burnout. Secondary traumatic stress includes traditional symptoms of PTSD (e.g., sleep disturbance). Stamm (2010) describes burnout as characterized by feelings of hopelessness and difficulties with dealing with one's job effectively. Each subscale consists of 10 items (e.g., "I find it difficult to separate my personal life from my life as a helper") scored using a five-point Likert-type scale ranging from 1 ("Never") to 5 ("Very Often"). Internal reliability ratings are high for the compassion satisfaction (.87), and compassion fatigue (.80) and burnout (.72). Stamm (2010) suggests good construct validity for the measure due to its wide use in over 200 published papers, and good discriminant validity such that each subscale measures a different construct and they share minimal variance. Factor validity studies have not been published for this measure. The wide use of the measure aids in comparison with the literature. This measure was untitled in the online survey.

**Life events checklist for DSM-5 (LEC-5; Weathers et al., 2013).** The LEC-5 is a 17-item self-report measure used to determine if the participant has a history of lifetime exposure to a traumatic event that may be work-related, may have happened to the respondent personally, may have been witnessed happening to another person, or may have happened to a close family member or friend (see Appendix D). The items assess

exposure to sixteen events known to potentially result in traumatic stress symptoms (e.g., “Life-threatening illness or injury”). Response choices to items include “Happened to me,” “Witnessed it,” “Learned about it,” “Part of my job,” “Not sure,” and “Doesn’t apply.” Psychometric information for the LEC-5 is not yet available, although changes from the original LEC measure are minimal. They consist of revision of the wording of item 15 from “Sudden, unexpected death of someone close to you” to “Sudden accidental death,” and the addition of the response category “Part of my job.” The original LEC demonstrated adequate convergent validity and test-retest reliability (Gray, Litz, Hsu, & Lombardo, 1998).

**Self-compassion scale (Neff, 2003).** The *Self-Compassion Scale* consists of 26 items comprising 6 subscales: Self-Kindness (e.g., “I’m kind to myself when I’m experiencing suffering”), Self-Judgment (e.g., “I’m disapproving and judgmental about my own flaws and inadequacies”), Common Humanity (e.g., “When I feel inadequate in some way, I try to remind myself that feelings of inadequacy are shared by most people”), Isolation (e.g., “When I think about my inadequacies it tends to make me feel more separate and cut off from the rest of the world”), Mindfulness (e.g., “When I’m feeling down I try to approach my feelings with curiosity and openness”), and Over-identification (e.g., “When something painful happens I tend to blow the incident out of proportion”). As shown in Appendix E, participants indicated the frequency with which they engaged in behaviors related to each subscale on a 5-point rating scale ranging from 1 (“Almost Never”) to 5 (“Almost Always”). Internal consistency reliability ratings for the Self-Kindness subscale (.78), Self-Judgment subscale (.77), Common Humanity subscale (.80), Isolation subscale (.79), Mindfulness subscale (.75), and Over-

identification subscale (.81) are adequate (Neff, 2003). Similarly, the scale demonstrates adequate predictive validity, known group validity and discriminate validity (Neff, 2016).

**Qualitative questionnaire.** The questionnaire assessed personal, training and supervision, and exposure-related factors, as well as information about the lived experiences of working with trauma clients while in training (see Appendix F). The questionnaire consisted of both closed- and open-ended questions written by the researcher and will be untitled in the survey. Five separate sections addressed the categories of demographics, training factors, supervision, exposure to trauma clients, and the impact of experiences.

In the demographics section, participants were asked to provide their preferred gender, ethnicity, age, type of doctoral program (e.g., PhD or PsyD), year in program, number of years spent working with trauma clients, and primary theoretical orientation (i.e., Cognitive Behavioral, Psychodynamic, Integrative, Other).

In the exposure to trauma clients section, participants indicated the number clients in their current caseload, the number of trauma clients in their current caseload (including trauma or PTSD-focused groups), and the number of clients with whom they have conducted trauma-focused psychotherapy (e.g., Prolonged Exposure) throughout their entire training. Then they will be asked to indicate a statement that best characterizes the majority of their work with trauma clients (i.e., “Treatment focused primarily on issues unrelated to the trauma,” “Treatment included exposure-based interventions, such as Prolonged Exposure, Cognitive Processing Therapy, or EMDR,” “Skill training,” “Supportive Therapy,” “Integrative treatment,” and “Other”). Finally, participants were asked to describe, to the degree they felt comfortable, any training or clinical experiences



that may have been traumatic to them, personally. Examples, such as “client suicide,” were provided in order to increase ease of responding.

In the training factors section, participants were asked if their program provides a course in trauma therapy and if they have participated in a trauma-focused externship. They indicated the extent of their trauma training, as per the method used by Adams and Riggs (2008). Responses included “Substantial” (i.e., consisting of a semester-long course, multiple workshops, or other formal training), “Minimal” (i.e., consisting of one workshop or seminar), and “No specific trauma training.” They then were asked to briefly describe their training for working with trauma clients, and where that preparation occurred. Finally, they were asked to describe what has been most helpful in their training to work with trauma clients.

Aspects of clinical supervision were also assessed. Participants indicated the amount of weekly individual and group supervision they receive pertaining to trauma clients (i.e., “0 hours,” “1-3 hours,” and “3+ hours”). They were then asked to briefly describe the extent to which their trauma-related supervision incorporates discussion of the participants’ personal reactions to the clients and the work. Examples such as “discussion of countertransference” were provided in order to increase ease of responding. They then were asked to briefly describe the structure of their supervision (e.g., discussion, review of notes, review of notes). Participants were also asked to describe what they have found most helpful in their trauma-related supervision. They then indicated, to the extent they feel comfortable, the ways in which their own possible trauma histories, if applicable, may have impacted supervision (e.g., if they disclosed a history of trauma, how did that disclosure impact supervision and treatment).

In order to assess the impact of clinical experiences, participants answered open-ended questions about work with trauma clients. Questions included: “How has your experience working with trauma clients impacted your desire to do trauma work in the future,” “How has your experience working with trauma clients impacted your desire to stay in the field of clinical psychology,” “What has been most helpful for you in your work with trauma clients,” and “How have your personal traumatic experience(s) impacted your training, clinical work, and/or supervision?”

**Procedure.** The survey was designed using QuestionPro online survey software. The researcher input questions and instructions into the online survey. The anonymous survey instructed participants to refrain from noting the name of their training program in open-ended questions, in order to maintain their privacy. Training directors of doctoral programs in clinical psychology throughout the United States were contacted by email and asked to distribute the link to the online survey to students in their fourth year of training and above. The survey was additionally shared with graduate student and trauma related email listservs, and individuals were encouraged to pass the information on to other interested parties. Participants were given information about the nature of the study and were asked to provide consent prior to beginning the survey. Participants first completed demographic measures, measures of indirect trauma, and then completed the qualitative questionnaire. They were then debriefed, thanked, and informed that their responses have been received. Debriefing included an overview of the forms of indirect trauma, suggestions for further reading, and the provision of resources, such as hotlines, for participants who have experienced distress. The Rutgers Institutional Review Board approved all procedures and protocols for this study (Appendix I).

**Design.** The study utilized a non-experimental (correlational), mixed-methods design to determine the associations between personal, training and supervision, and exposure related variables and participants' experiences of indirect trauma. The qualitative portions of the study aimed to explore psychology trainee's lived experiences of indirect trauma and the impact on their trauma-focused clinical work on their desires to continue with trauma work and remain in the field of clinical psychology.

**Operational definitions.**

- Secondary Traumatic Stress: participants' scores on the STSS
- Vicarious Traumatization: participants' scores on the TABS
- Compassion Fatigue: participants' scores on the Compassion Fatigue subscale of the ProQOL
- Burnout: participants' scores on the Burnout subscale of the ProQOL
- Personal Trauma History: participants' score on the LEC-5
- Self-Compassion: participants' scores on the SCS

**Data collection.** Participants' responses were collected and stored in the online QuestionPro system. The researcher had access to number and content of responses through a web-based administrative platform, and data was downloaded digitally for the purposes of analysis. All files were kept in an encrypted, password-protected file on an encoded drive on the researcher's home computer. Data will be kept securely for three years, after which it will be destroyed.

**Quantitative data analysis.** The questionnaire collected both quantitative and qualitative data. The quantitative data included scores on the measures of indirect trauma,

which were scored according to guidelines provided by the authors of each measure, as well as information regarding demographics and features of training. Quantitative data were analyzed using the International Business Machine (IBM) Corporation's Statistical Package for the Social Sciences (SPSS, Version 24) software for Mac (IBM Corp, 2016). Quantitative data analysis consisted of correlational analyses, univariate analysis of variances (ANOVAs), and nonparametric analyses due to limitations in the data (e.g., Kruskal Wallis H test) to determine the presence of significant relationships among variables.

***Accuracy.***

The author was responsible for exportation of the data from the QuestionPro survey program to SPSS. In SPSS, the author scored the self-report measures as per the guidelines in their instructions and created new variables for measure scores.

***Missing data.***

Of the 74 responders, 48 finished the online survey (i.e., viewed all survey pages and indicated their responses to be complete), and 44 completed all measures in full. All partially completed self-report measures were eliminated from analyses (e.g., if the participant did not complete the Self-Compassion Scale, their responses were excluded from all analyses involving Self-Compassion, although their complete responses for other measures were retained for other analyses). In order to retain as much data as possible, the author checked the data for outliers by running frequencies and descriptive statistics for the variables for each individual analysis. Outliers for each analysis were removed. When the data violated the assumptions of the necessary parametric test, outliers were retained and nonparametric tests were used. When zero or one participant comprised a

level of an independent variable (e.g., one participant identified the majority of their trauma-focused work to be “skills based interventions”), that level of the independent variable was eliminated from analyses. For qualitative analysis, all available data were used.

**Qualitative Data Analysis.** Qualitative data analysis consisted of the use of Braun and Clarke’s (2006) thematic analysis approach in order to assess the lived experiences of psychology trainees working with trauma clients. This approach utilized evaluation of data and identification of key features and patterns to identify themes within the data. The aim of the qualitative analysis was to explore the complex interaction of factors contributing to symptoms of indirect trauma in psychology trainee populations.

The thematic analysis approach utilized six phases to evaluate data and highlight themes (Braun & Clarke, 2006). The first phase consisted of familiarization with data, in which responses were read in full and the researcher noted initial ideas as to possible patterns and themes. The second phase, generation of initial codes, consisted of systematic coding of salient phrases, and searching for themes. The third phase consisted of the collation of codes into potential themes by individual question and collecting the data relevant to each theme. In the fourth phase, review of themes, a thematic “map” was generated for each question linking the themes to the codes from phase 2. An additional thematic map was created to organize themes across all questions and identify thematic overlap between questions. The fifth phase entailed naming and definition of themes via ongoing analysis and refinement of themes as they relate to both individual questions and the overall data set. In the final phase, the scholarly report of the analysis was constructed

using evocative examples of pieces of data that relate to the literature and research questions. Of note, it was beyond the scope of the present study to examine in detail all themes present in the data for all 11 open-ended questions. For a comprehensive list of all themes generated, please see Appendix G. For a comprehensive list of thematic overlap across questions, please see Appendix H. As such, only themes directly relevant to the study questions were described in the qualitative narrative. The narrative produced by this phase aims to identify and describe patterns of meaning in participant responses specifically related to the presence, experience, and related factors of indirect trauma in psychology trainee populations.

## Results

### Descriptive Statistics

**Age.** Forty-eight participants indicated their age ( $M=29.3$ ,  $SD=3.73$ ), and ages ranged from 25 to 39.

**Gender preference.** Of 74 responders, 57 (77.0%) indicated their preferred gender to be feminine, 14 (18.9%) indicated their preferred gender to be masculine, and 3 (4.05%) indicated their preferred gender to be gender nonconforming.

**Graduate program type.** Of 74 responders, 25 (33.8%) were in a Clinical Psychology PhD program, 13 (17.6%) were in a Counseling Psychology PhD program, 35 (47.3%) were in a Clinical Psychology PsyD program, and 1 (1.4%) was in a Counseling Psychology PsyD program.

**Year in graduate program.** Of 73 responders, 42 (57.5%) were in their fourth year of training, 20 (27.4%) in their fifth year of training, 10 (13.7%) in their sixth year of training, and one (1.37%) was in their seventh year and higher of training.

**Primary theoretical orientation.** Of 74 responders, 30 (40.5%) indicated their primary theoretical orientation to be “Cognitive Behavioral,” 17 (23.0%) indicated “Psychodynamic,” 20 (27.03%) indicated “Integrative,” and 7 (9.46%) indicated “Other.” “Other” fill in responses included “Existential,” “DBT,” “ACT,” “EMDR,” and “Behavioral.”

**Race/ethnicity.** Of 74 responders, 60 (81.1%) indicated their race/ethnicity to be White, 5 (6.76%) to be Hispanic or Latino/a, 2 (2.70%) to be Black or African American, 2 (2.70%) to be Native American or American Indian, 1 (1.35%) to be Asian/Pacific Islander, and 4 (5.41%) to be mixed race.

**Indirect trauma.** Descriptive data for the STSS, TAB, Burnout, and Compassion Fatigue are presented for the total sample (Table 1).

Table 1

*Means, Standard Deviations, and Clinical Considerations for Scores on Indirect Trauma Measures*

	<i>N</i>	Mean	<i>SD</i>	Clinical Considerations
STSS	44	30.02	12.69	Little to no STS (<28) Mild STS (28-37) Moderate STS (38-43) High STS (44-48)
TAB Total TAB T Score	48	173.06 48	48.13	Extremely Low (<29 T Score) Very Low (30-39 T Score) Low Average (40-44 T Score) Average (45-55 T Score) High Average (56-59 T Score) Very High (60-69 T Score) Extremely High (>70 T Score)
Burnout (ProQOL)	46	21.48	5.86	Low (<22) Average (23-41) High (>42)
Compassion Fatigue (ProQOL)	46	19.13	6.52	Low (<22) Average (23-41) High (>42)

**Note.** STSS = Secondary Traumatic Stress Scale, TAB Total T Score = Vicarious Traumatization



**Personal trauma history.** Forty-eight participants completed the Life Events Checklist ( $M=12.33$ ,  $SD=8.71$ ). Response totals ranged from 0-32; higher scores indicate exposure to a higher amount of potentially traumatic events.

**Self-compassion.** Self-compassion scores were calculated as a grand mean of the means of each subscale to represent overall level of Self-Compassion ( $M= 3.15$ ,  $SD = 0.68$ ). Scores ranged from 1.72 to 4.60; the minimum possible score is 1 suggestive of minimal to no self-compassion, and the maximum possible score is 5, suggestive of very high self-compassion.

**Amount of trauma-focused individual supervision.** Of 61 responders, 16 (26.2%) indicated receiving 0 hours of trauma-focused individual supervision a week, 42 (68.9%) indicated receiving 1-3 hours of trauma-focused individual supervision a week, and 3 (4.92%) indicated receiving 3+ hours of trauma-focused individual supervision a week.

**Amount of trauma-focused group supervision.** Of 61 responders, 27 (44.3%) indicated receiving 0 hours of trauma-focused group supervision a week, 32 (52.5%) indicated receiving 1-3 hours of trauma-focused group supervision a week, and 2 (3.28%) indicated receiving 3+ hours of trauma-focused group supervision a week.

**Format of supervision.** Of 59 responders, 48 (81.4%) indicated the format of the majority of their trauma focused supervision to be case discussion only, 9 (15.3%) indicated the format to be review of audio and/or video recordings, and 2 (3.39%) indicated the format to be in vivo supervision (e.g., supervisor present in session, or supervisor communicating with therapist via an earpiece).

**Total caseload.** Of 74 responders, 10 (13.5%) indicated a current caseload of 0-1 individual clients, 13 (21.6%) indicated a caseload of 2-5 individual clients, 27 (36.5%) indicated a caseload of 6-10 individual clients, and 21 (28.4%) indicated a caseload of 10+ individual clients.

**Trauma Caseload.** Of 73 responders, 21 (28.8%) indicated 0-1 current clients have disclosed a trauma history, 31 (42.5%) indicated 2-5 current clients have disclosed a trauma history, 12 (16.4%) indicated 6-10 current clients have disclosed a trauma history, and 9 (12.3%) indicated 10+ current clients have disclosed a trauma history.

**Extent of trauma clinical experience.** Of 74 responders, 32 (43.2%) indicated a history of 0-1 trauma-focused interventions, 19 (25.7%) indicated a history of 2-5 trauma-focused interventions, 4 (5.4%) indicated a history of 6-10 trauma-focused interventions, and 19 (25.7%) indicated a history of 10+ trauma-focused interventions.

**Number of PTSD focused groups facilitated.** Of 74 responders, 53 (71.62%) indicated experience with 0-1 trauma focused groups, 14 (18.9%) indicated experience with 2-5 trauma focused groups, 2 (2.7%) indicated experience with 6-10 trauma-focused groups, and 5 (6.76%) indicated experience with 10+ trauma focused groups. Group populations included veterans, survivors of sexual assault, women, men, victims of bullying, children and families with complex trauma, children and adults with medical trauma, older adults, active duty military members, women experiencing homelessness, individuals with substance use issues, individuals with SUD/PTSD dual diagnosis, college students, survivors of an avalanche, veteran female military sexual trauma survivors, survivors of abuse, prisoners, and first responders.

**Intervention type of majority of trauma work.** Of 74 responders, 12 (16.2%) indicated “Treatment focused primarily on issues unrelated to the trauma,” 14 (18.9%) indicated “Exposure-based interventions,” 5 (6.8%) indicated “Trauma-Focused CBT,” 9 (12.2%) indicated “Trauma-Focused Psychodynamic Psychotherapy,” 2 (2.7%) indicated “Skill training (e.g., STAIR), 2 (2.7%) indicated “Supportive therapy,” 26 (35.1%) indicated “Integrative treatment,” and 4 (5.4%) indicated “Other.” Participants who indicated “Other” provided fill-in responses which included “psychodynamic therapy dealing with the trauma but not ‘trauma-focused,’” “assessment,” “EMDR therapy,” and “therapy.”

**Extent of trauma-focused training.** Of 64 responders, 7 (10.94%) indicated that they had no specific trauma training, 26 (40.6%) indicated having had minimal trauma training (i.e., one workshop or seminar), and 31 (48.4%) indicated having had substantial trauma training (i.e., a semester-long course, multiple workshops, or other extensive formal training).

**Availability of trauma-focused graduate course.** Of 63 responders, 31 (49.2%) indicated that their graduate program offers a course in trauma-focused treatment.

**Trauma-focused externship.** Of 62 responders, 24 (38.7%) indicated having participated or that they were currently participating in a trauma-focused externship or practicum.

### **Indirect Trauma Correlations**

Correlations between the forms of indirect trauma (Table 2) indicate overlap between the different constructs of indirect trauma, including Burnout, as well as

negative relationships between Compassion Satisfaction and the forms of indirect trauma, with the exception of Compassion Fatigue.

Table 2

*Pearson correlations for Indirect Trauma Variables*

	STSS	TAB Score	Compassion Satisfaction	Burnout
STSS	.			
TAB T Score	.613**			
Compassion Satisfaction	-.398*	-.573**		
Burnout	.662**	.690*	-.661**	
Compassion Fatigue	.724**	.506**	-.264	.561**

**Note.** STSS = Secondary Traumatic Stress, TAB T Score = Vicarious Traumatization, \* = statistically significant at the  $p < .05$  level, \*\* = statistically significant at the  $P < .001$  level.

**Relationship Between Personal Factors and Indirect Trauma**

**Gender.** Gender was not found to be significantly associated with any of the outcome variables.

**Age.** Age was not found to be significantly associated with any of the outcome variables.

**Personal trauma history.** None of the outcome variables were found to vary by personal trauma history (as measured by the Life Events Checklist total score).

**Theoretical orientation.** None of the outcome variables were found to vary by theoretical orientation.

**Race.** Of the responders who completed at least three of the four self-report measures (and were thus used in quantitative analyses), 40 indicated their race as White, 1 indicated race as Hispanic or Latino/a, 2 indicated race as Black or African American, 1 indicated race as Native American or American Indian, 1 indicated race as Asian/Pacific Islander, and 2 indicated race as Mixed race. Due to the largely homogenous nature of race among responders and low numbers of individuals endorsing race other than White, race was not considered as an independent variable.

**Self-Compassion**

Correlations between Self-Compassion and the forms of indirect trauma (Table 3) indicate significant negative relationships between Self-Compassion and indirect trauma.

Table 3

*Pearson Correlations for Self-Compassion and Indirect Trauma Variables*

	STSS	TAB T Score	Compassion Fatigue	Burnout	Compassion Satisfaction
Self- Compassion	-.414*	-.668**	-.486*	-.379*	.202

**Note.** STSS = Secondary Traumatic Stress, TAB Score = Vicarious Traumatization, \* = statistically significant at the  $p < .05$  level, \*\* = statistically significant at the  $P < .001$  level.

### **Relationship Between Exposure Factors and Indirect Trauma**

**Caseload total.** Because STSS Total scores violated assumption of normality, a Kruskal Wallis H test was conducted to determine if there were differences in STSS scores between groups that differed by type total caseload: “0-1” ( $n = 5$ ), “2-5” ( $n = 8$ ), “6-10” ( $n = 22$ ), and “10+” ( $n = 9$ ) Values are mean ranks. Distributions of STSS scores were not similar for all groups, as assessed by visual inspection of a boxplot. The mean ranks of STSS scores were statistically significantly different between groups,  $\chi^2(3) = 8.730, p = .033$ . A post hoc analysis assessing pairwise comparisons using Dunn’s (1964) procedure with a Bonferroni correction for multiple comparisons only found a statistically significant difference ( $p = .02$ ) between the 0-1 (median= 18.00) caseload total and 10+ caseload total (median = 29.00) groups.

Because the data did not meet the assumption of homogeneity of variance, a one-way Welch ANOVA was conducted to determine if compassion fatigue score (score on the ProQOL STSS subscale) was different for groups with differently sized caseloads. Participants were classified into four groups: 0-1 ( $n = 8$ ), 2-5 ( $n = 7$ ), 6-10 ( $n = 18$ ) and 10+ ( $n = 9$ ). Compassion fatigue score was statistically significantly different between caseload size groups, Welch's  $F(3, 18.439) = 14.821, p = .026$ . The estimated omega squared ( $\omega^2 = 0.17$ ) indicated that approximately 17% of the variation in compassion fatigue scores is attributable to size of caseload. Compassion fatigue scores increased from the 2-5 group ( $M = 15.43, SD = 2.37$ ), to the 0-1 group ( $M = 16.75, SD = 2.55$ ), to the 6-10 ( $M = 17.85, SD = 5.29$ ) to the 10+ group ( $M = 23.11, SD = 6.31$ ), in that order. Games-Howell post hoc analysis revealed that the mean increase from 2-5 to 10+ was

statistically significant ( $p = .024$ ) with a Cohen's  $d$  effect size of 1.654, while the mean increase from 0-1 to 10+ approached statistical significance ( $p = .059$ ).

**Trauma caseload.** None of the outcome variables were found to vary by trauma caseload (i.e., total number of current cases with a disclosed trauma history).

**Trauma clinical experience.** A one-way ANOVA was conducted to determine if Vicarious Traumatization (TAB T Score) was different for groups with different amounts of clinical experience working with issues of trauma (i.e., trauma clinical experience). Participants were classified into four groups based on total number of trauma focused cases seen during entire training: 0-1 ( $n = 19$ ), 2-5 ( $n = 14$ ), 6-10 ( $n = 3$ ) and 10+ ( $n = 7$ ). TAB score was statistically significantly different between different trauma clinical experience groups,  $F(3, 39) = 4.457$ ,  $p = .009$ ,  $\omega^2 = 0.19$ , indicating that approximately 19% of the variance in TAB score is attributable to amount of trauma clinical experience. TAB score increased from the 2-5 group ( $M = 42.50$ ,  $SD = 7.22$ ) to the 0-1 group ( $M = 43.53$ ,  $SD = 8.71$ ), 10+ group ( $M = 47.29$ ,  $SD = 13.06$ ) and 6-10 group ( $M = 63.00$ ,  $SD = 11.14$ ), in that order. Tukey post hoc analysis revealed that the mean increase from 0-1 to 6-10 (19.474, 95% CI [4.11, 34.81]) was statistically significant ( $p = .008$ ) with a Cohen's  $d$  effect size of 1.95, as well as the increase from 2-5 to 6-10 (20.50, 95% CI [4.76, 36.24],  $p = .006$ ) with a Cohen's  $d$  effect size of 2.18, but no other group differences were statistically significant.

**Type of trauma work.** Because the data did not meet the assumption of homogeneity of variance, a one-way Welch ANOVA was conducted to determine if Secondary Traumatic Stress (score on the STSS) was different for different trauma intervention groups. Participants were classified into eight groups: Treatment unrelated to



the trauma ( $n = 9$ ), exposure-based interventions ( $n = 11$ ), Trauma-Focused CBT ( $n = 3$ ), Trauma-Focused Psychodynamic Psychotherapy ( $n = 3$ ), skills-based interventions ( $n = 1$ ; and thus was removed from analysis), supportive therapy ( $n = 0$ , and thus was removed from analysis), integrative interventions ( $n = 13$ ), and Other ( $n = 3$ ). STSS score was statistically significantly different between trauma interventions groups, Welch's  $F(5, 7.54) = 4.945, p = .026$ . The estimated omega squared ( $\omega^2=0.34$ ) indicated that approximately 34% of the variation in STSS scores is attributable to type of trauma work. STSS score increased from the unrelated to trauma group ( $M = 20.22, SD = 2.86$ ) to the exposure-based group ( $M = 24.82, SD = 4.40$ ), to the other group ( $M = 25.33, SD = 4.04$ ), the Trauma-Focused CBT group ( $M = 32.00, SD = 13.75$ ), integrative group ( $M = 36.38, SD = 12.50$ ) and the Trauma-Focused Psychodynamic Psychotherapy group ( $M = 42.00, SD = 13.53$ ), in that order. Games-Howell post hoc analysis revealed that the mean increase from work unrelated to the trauma to integrative interventions (16.16, 95% CI [4.34, 27.98]) was statistically significant ( $p = .006$ ) with a Cohen's  $d$  effect size of 1.53, but no other group differences were statistically significant.

A one-way ANOVA was conducted to determine if Burnout (ProQOL Burnout Score) was different for groups with experience in different types of trauma work. Participants were classified into eight groups based on the type of work that categorizes the majority of interventions done with trauma clients: work unrelated to trauma ( $n = 6$ ), exposure-based interventions ( $n = 11$ ), Trauma-Focused CBT ( $n = 3$ ), Trauma-Focused Psychodynamic Psychotherapy ( $n = 3$ ), skill training ( $n = 1$ , and thus was removed from analysis), supportive therapy ( $n = 0$ , and thus was removed from analysis), integrative treatment ( $n = 15$ ), and other ( $n = 3$ ). Burnout score was statistically significantly

different between different trauma work groups,  $F(5, 36) = 2.648, p = .039, \omega^2 = 0.16$ , indicating that approximately 16% of the variance in Burnout score is attributable to type of trauma work. Burnout score increased from the unrelated to trauma group ( $M = 17.00, SD = 3.35$ ) to the exposure-based group ( $M = 19.73, SD = 4.00$ ), to the Trauma-Focused CBT group ( $M = 22.67, SD = 8.51$ ), the other group ( $M = 23.00, SD = 4.36$ ), integrative group ( $M = 23.19, SD = 5.88$ ) and the Trauma-Focused Psychodynamic Psychotherapy group ( $M = 28.67, SD = 8.08$ ), in that order. Tukey post hoc analysis revealed that the mean increase from work unrelated to trauma to Trauma-Focused Psychodynamic Psychotherapy groups (16.833, 95% CI [0.94, 32.72]) was statistically significant ( $p = .033$ ) with a Cohen's  $d$  effect size of 1.98, but no other group differences were statistically significant.

**Trauma-focused externship.** A Kendall's tau-b correlation was run to determine the relationship between completion of a trauma-focused externship and STSS score amongst 43 participants. There was a negative association between not having completed a trauma-focused externship and STSS score,  $\tau_b = -.270, p = .038$ . Individuals who completed a trauma-focused externship ( $M = 33.88, SD = 12.32$ ) tended to have higher STSS scores than those who did not ( $M = 27.77, SD = 12.73$ ).

### **Training and Supervision Factors and Indirect Trauma**

**Program type.** Because STSS Total scores violated assumption of normality, a Kruskal Wallis H test was conducted to determine if there were differences in STSS scores between groups that differed by type of graduate program: "Clinical PhD" ( $n = 17$ ), "Counseling PhD" ( $n = 6$ ), and "Clinical PsyD" ( $n = 20$ ). Values are mean ranks. Distributions of STSS scores were not similar for all groups, as assessed by visual

inspection of a boxplot. The mean ranks of STSS scores were statistically significantly different between groups,  $\chi^2(2) = 7.374, p = .025$ . However, a post hoc analysis assessing pairwise comparisons using Dunn's (1964) procedure with a Bonferroni correction for multiple comparisons only found a difference approaching statistical significance ( $p = .051$ ) between the Clinical PhD (median = 23.00) and Clinical PsyD (median = 29.00) groups, and no statistically significant differences among any other group combination. The lack of statistically significant pairwise comparisons may result from the fact that the post-hoc tests correct for multiple comparisons, and so are more conservative than the Kruskal Wallis H test.

**Year in graduate program.** None of the outcome variables were found to vary by year in program.

**Extent of trauma training.** A one-way ANOVA was conducted to determine if Vicarious Traumatization (TAB T Score) was different for groups with different levels of exposure to trauma training. Participants were classified into three groups based on the extent of their trauma training: no specific trauma training ( $n = 5$ ), minimal trauma training ( $n = 18$ ), and substantial trauma training ( $n = 25$ ). TAB T score was statistically significantly different between differing amounts of trauma training,  $F(2, 45) = 3.872, p = .028, \omega^2 = 0.069$ , indicating that approximately 6.9% of the variance in TAB score is attributable to amount of trauma training. TAB T score increased from the minimal group ( $M = 41.28, SD = 7.80$ ) to the no specific trauma training group ( $M = 49.80, SD = 15.29$ ), to the substantial group ( $M = 50.00, SD = 11.12$ ), in that order. Tukey post hoc analysis revealed that the mean increase from minimal to substantial groups (8.722, 95% CI [0.88,

16.57]) was statistically significant ( $p = .026$ ) with a Cohen's  $d$  effect size of 0.91, but no other group differences were statistically significant.

Because STSS Total scores violated assumption of normality, a Kruskal Wallis H test was conducted to determine if there were differences in STSS scores between groups that differed by amount of trauma training: no specific trauma training ( $n = 5$ ), minimal ( $n = 17$ ), and substantial ( $n = 22$ ). Values are mean ranks. Distributions of STSS scores were not similar for all groups, as assessed by visual inspection of a boxplot. The mean ranks of STSS scores were statistically significantly different between groups,  $\chi^2(2) = 6.670, p = .036$ . A post hoc analysis assessing pairwise comparisons using Dunn's (1964) procedure with a Bonferroni correction for multiple comparisons only found a statistically significant difference ( $p = .041$ ) between the minimal (median = 17.26) and substantial (median = 27.48) groups, and no statistically significant differences among any other group combination.

**Amount of trauma-focused individual supervision.** None of the outcome variables were found to vary by amount of trauma-focused individual supervision.

**Amount of trauma-focused group supervision.** None of the outcome variables were found to vary by amount of trauma-focused group supervision.

### **Personal Trauma History and Traumatic Training Experiences**

**Personal trauma history.** Personal trauma history has often been considered a possible risk factor for the development of indirect trauma. A number of participants indicated a history of personal trauma as indicated by the Life Events Checklist. Of 48 responders, 46 (95.8%) indicated some amount of exposure (i.e., direct experience, witnessing, learning about happening to a loved one, or experiencing as a part of one's

job) at least one item considered to be a potentially traumatic event. However, exposure to a potentially traumatic event does not imply the presence of related distress. For example, of 44 participants, 18 (40.9%) explicitly indicated a personal history of trauma, and three indicated a history of events that they deemed to be traumatic, but qualified as “little ‘t’ trauma.” Four participants (9.1%) indicated that they did not have a trauma history that impacted clinical work or supervision, but did not specify if they had any unrelated trauma history. Participants discussed the impact of personal trauma history on their clinical perspective, including clinical interests, understanding of trauma, and their ability to empathize with clients. Participants explored both the positive impact and the negative impact of their personal trauma histories on their trauma-focused work, including both clinical work and supervision.

***Clinical interests.*** Of 29 responders, five (17.2%) noted that a personal trauma history influenced their interest in psychology, in general, as well as in the specific area of trauma work. Participants discussed experiencing a strong sense of meaning from trauma work in the context of their personal trauma histories as they are able to connect with and help others who are suffering from similar issues.

*“My own experiences with trauma are some of the driving factors of why i got into the field of counseling psychology. it is what helps me connect with people suffering.”*

***Understanding of trauma.*** Of 29 responders, 8 (27.6%) discussed the manner in which their personal trauma history contributed to a more nuanced understanding of

trauma. Personal trauma history assisted participants in maintaining awareness of the impact of traumatic events on survivors and their families, as well as cognition and development.

*“I heard a colleague once joke that he was thankful for his parents having traumatized him in just the right way to lead him to become a psychologist. I think having experienced trauma has shaped (among many other things) my worldview that I entered training with, which influenced my orientation and approaches I use.”*

Personal trauma history also informed participants’ clinical approach to trauma, including theoretical orientation and the impact of different interventions, such as validation. Participants were better able to empathize with clients’ experiences in therapy, which informed their own approach to conceptualization and intervention.

*“I’ve been sexually assaulted and I’ve witnessed and experienced emotional abuse in which I felt my own agency was taken away (for lack of a better way of saying it). I think this has influenced my worldview/theoretical orientation and those both are the filters through which I see patient care: I believe people have agency in a philosophical sense, therefore approaches that are based on Lockean philosophies in which people are not seen as agentic are not approaches I use.”*

**Empathy for clients.** Of 29 responders, 10 (34.5%) noted increased empathy for clients as a result of their personal trauma history, including increased understanding of

and connection with clients and their experiences. Increased empathy likely impacts trainee's understanding of trauma, in general, as it allows them to incorporate data from the first-hand experience of trauma-related thoughts, feelings, and behaviors into predictions and conceptualization of client experiences. High levels of empathy may also contribute to a richer experience of meaning in conducting trauma work and assist trainees in making meaning of their own trauma history.

***Positive personal impact.*** Of 29 responders, 6 (20.7%) described a positive personal impact of trauma work in the context of their personal trauma histories. Participants described increased self-awareness (e.g., of their own avoidance), humility, and personal growth resulting from their experiencing conducting trauma work while considering their own personal trauma histories. Participants discussed finding trauma work to be more meaningful in light of their own traumatic experiences.

*"I can be more empathic, understand the impact of trauma and how it may manifest in other areas of functioning, and increases my own awareness of doing my own trauma work."*

***Negative impact on clinical work.*** While many participants discussed the positive impact of their personal trauma history on their clinical work, seven (24.1%) discussed examples of the negative impact of their personal trauma histories on clinical work, including supervision. Participants discussed discomfort when their own issues were triggered in sessions or in supervision, which caused a distraction and was difficult to avoid. They noted further discomfort regarding discussing their reactions and histories

with supervisors. Withholding such reactions could be burdensome and cause distraction for participants, reducing their overall engagement in supervision and possibly negatively impacting their work with clients. Participants discussed efforts to maintain awareness of personal reactions, feelings of sadness, and concerns about increased vulnerability to burnout as a result of their personal trauma histories.

*“Added a cognitive burden when it felt like something I had to keep secret from a supervisor and it was relevant to the work”*

**History of traumatic training experiences.** Of 74 responders, 22 (29.7%) indicated a history of traumatic training experiences, 11 of whom indicated more than one event during training they considered to be traumatic. Events included distressing client behavior (e.g., physical violence towards trainee, verbal threats towards trainee, client suicide and self-harm), distressing behavior of others towards clients (e.g., witnessing physical restraint, witnessing clients attack each other, execution of clients by the state, witnessing abuse of clients by law enforcement), exposure to client trauma histories (e.g., trainee and client share the same type of trauma history, details of client’s history cause distress), negative supervision experiences (e.g., supervisor threats to terminate trainee, supervisor’s unexpected death, critical supervisory relationship), and negative workplace experiences (e.g., work with staff inexperienced in trauma, loss of colleague through violence, trainee misled about prevalence of violence in work setting).

Three participants indicated experiences with verbal threats from clients, and three indicated experiences with physical violence from clients.



*“Assault by a client: client punched my back and grabbed my hair and tried to slam my head into the cement. I was able to get away and 'outrun' the client until help arrived. I was pregnant at the time and was worried I would miscarry.”*

Two participants indicated experience with client suicide attempts, and three indicated experience with completed client suicides.

*“When I found out that the patient I worked with had died by suicide, I broke down crying in the computer room of the inpatient unit and felt very supported by the staff.”*

Participants most frequently reported distress related to shared trauma histories with clients; seven participants (31.8%) indicated experiences conducting therapy with a client who has experienced the same type of trauma as the trainee.

When asked about the impact of traumatic training experiences on clinical work, participants indicated a range of outcomes from a negative impact to a positive impact. Seven of the 22 (31.8%) participants who answered the question noted at least some negative consequences of their traumatic training experiences. Two participants (9.09%) indicated that their traumatic training experiences previously impacted clinical work, but do not at present. Negative consequences largely comprised shifts in trainee's work preferences; six participants (27.3%) indicated that they now seek work in different clinical settings (e.g., that utilize more structured interventions) or with different

populations. Four participants (18.2%) noted that their clinical work requires increased effort to manage personal emotions, which sometimes results in “emotional distancing” from the client.

*“Also, however, I think that there has been a cumulative effect of having experienced such flash point traumatic events during my training, along with the more daily subtraumatic stresses. In my fourth year now, I do feel more vulnerable to my own emotions when working with clients experiencing trauma. I'm not able to 'push through' quite as much as before.”*

Participants more frequently reported a positive impact of their traumatic training experiences on current clinical work (15 participants; 68.2%). Participants noted that challenging training experiences often increased self-efficacy and confidence in clinical work (4 participants; 18.2%) and empathy for clients (4 participants; 18.2%). Traumatic training experiences increased participant’s awareness of their own personal reactions, preferences for boundaries, and the possible impact of reactions of indirect trauma (4 participants; 18.2%). Such self-awareness is an important aspect of self-compassion, which comprises understanding of the self and mindfulness of current thoughts and feelings. Two participants (9.1%) explicitly noted that their traumatic training experiences have increased kindness and compassion towards the self during difficult training experiences.

*“It's made me trust my instincts and training more. Taught me to be kind and gentle with myself, as I am a human in the room as well. Instilled me with the confidence and knowledge in knowing i can handle high risk scenarios within psychotherapy.”*

### **Impact of Supervision**

Participants consistently cited supervision as one of the most critical aspects of their training and clinical experience with trauma work. Of 54 responders, 29 (55.8%) indicated supervision to be most helpful in training to do trauma work, and of 44 responders, 20 (45.5%) indicated supervision to be one of most helpful in conducting trauma work. Participants described the various elements of “good” supervision, including supervisor qualities, discussion of trainee reactions, and discussion of personal trauma history.

**Supervisor qualities.** Participants described helpful and supportive supervision that was shaped by the individual supervisor’s personal and professional qualities.

**Experienced.** Five participants (9.30%) described working with experienced supervisors to be one of the most important aspects of their training in trauma work. Many other participants described elements of supervision, such as focus on various trauma-focused techniques, focus on trauma theory and literature that are likely impacted by a supervisor’s amount of clinical experience.

*“My supervisor for my first practicum was amazing, and I learned more from them during that year than all of my other clinical training experiences put together (including internship). They had decades of experience working with survivors of*

*various types of trauma including parental maltreatment, natural disasters, torture, and terrorism.”*

**Supportive.** Of 47 responders, 14 (29.8%) described aspects of a supportive supervision environment as most helpful to their experiences of supervision. Participants described supervision that was nonjudgmental, consistent, open, accepting, and attentive to the trainee’s experience. Five (10.6%) participants described supervisor empathy as a crucial element of supervision. Supervisors made trainees feel supported, validated, and able to discuss and process the challenges inherent in and their experiences of trauma-focused work.

*“A loving, patient supervisor who took all trainees under his wing while working in an extremely traumatic environment. He was understanding and empathic and talked to us about trauma extensively.”*

**Discussion of trainee reactions to clinical work.** Participants repeatedly discussed the importance of having space to discuss and process their experiences in training. Of 47 responders, 15 (31.9%) described discussion of personal reactions to trauma work as the most helpful aspect of supervision. Participants found discussion of their emotions, their experience hearing about traumas, and countertransference as useful both to their clinical experience and case conceptualization. Five participants (10.6%) described insufficient discussion of personal reactions as one of the least helpful aspects of their supervision. Participants described a range of experiences in supervision from

frequent discussions of their reactions (8 of 50 responders; 16%), and occasional discussions of reactions (5 responders; 10%), to no to minimal discussions of reactions (15 responders; 30%). Some supervisors welcomed and even elicited and encouraged discussion of reactions as relevant and important clinical information (7 responders; 14%), while other supervisors only discussed reactions when trainees volunteered the issue as a topic (5 responders; 10%). A number of participants noted discussion of reactions in the form of countertransference (18 responders; 36%), and it is possible that theoretical orientation of the supervisor directly impacts frequency of discussion of personal reactions, as countertransference is considered relevant data to psychodynamic formulations.

*“My supervision is very focused on process. It feels safe to explore these things and I've learned to be more open and curious about my reactions. I'm speaking about my current supervisor. Others have not fostered this environment and were more focused on manual adherence despite saying they were curious about your personal reaction in the room.”*

**Discussion of personal trauma history.** The supervision environment also strongly influenced participants' willingness to disclose their own personal trauma histories and the potential related impact on clinical work and risk for indirect trauma. Of 28 responders, 11 (39.3%) disclosed some amount of their personal trauma history of a supervisor, 11 (39.3%) did not disclose any amount of personal trauma history to a supervisor, and six (21.4%) indicated that they did not have any personal trauma history.

Of the trainees who did not disclose, five (45.5%) noted that they did not due to feelings of discomfort with the supervisor and related concerns about the response to disclosure. Trainees noted concerns about the appropriateness of disclosure and focus on the trainee in supervision, rather than the client. Five of the trainees who did not disclose (45.5%) noted that they would be open to disclosure in the future if such disclosure was considered necessary. Five of the responders who did disclose to their supervisor (45.5%) elaborated that they only did so when they deemed the situation to be appropriate, as in the context of case formulation for a client with a shared trauma. Disclosure was notably framed as occurring in service of the client and the clinical work, rather than the trainee's wellbeing.

*“For some supervisors, I have felt comfortable disclosing my trauma history, especially when my story is similar to a client's story. There are some supervisors I have not felt comfortable disclosing. “*

Participants described a range of reactions from supervisors following disclosure. Four of 13 responders (30.8%) described negative reactions from supervisors in which disclosure was discussed minimally and trainees felt invalidated. Nine responders (69.2%) described positive reactions from supervisors in which disclosure improved discussion of the case, enhanced the supervisory relationship, and resulted in helpful discussions.

*“The disclosure was often an emotional experience. I have usually had responsive supervisors when I have disclosed my history. These discussions have helped me gain clarity in my work and helped me to be more present and emotional available for my clients.”*

### **Desire to Continue Trauma Work**

Trainees discussed a range of impact of their experiences on their desire to continue trauma work.

**Trainee wishes to continue trauma work.** Of 46 responders, 27 (58.7%) indicated an interest in continuing with trauma work. Participants described the importance of trauma given its prevalence in clinical populations, discussed their enjoyment of trauma work due to client progress.

**Trauma is prevalent.** Five participants (10.9%) stressed the presence of trauma issues across all clinical populations, and noted that an understanding of trauma is a necessary component of conducting psychotherapy, in general. Four participants (8.7%) noted specific populations they wish to work with, for which experience in trauma work is necessary, including individuals with psychosis, children, marginalized populations, and active duty members of the military.

*“All therapy patients are trauma patients. Trauma is an inherent aspect of existence. I would not be able to be a therapist if I did not want to do trauma work.”*

***Client progress is meaningful.*** Six participants (13.0%) emphasized their enjoyment of trauma work as a primary factor in their desire to continue it. Participants highlighted the progress clients can make and efficacy of trauma-focused treatments and meaningful nature of the work. Clients were described as being hard working, brave, and engaging.

*“As difficult and painful as it is to sit with someone's trauma history, it is very meaningful and rewarding to help someone work through their trauma, and that encourages me to continue to work with clients who present with such difficult clinical issues.”*

**Trainee wishes to moderate amount of trauma work.** While many participants noted a desire to continue with or specialize in trauma work. Seven participants (15.2%) explained that they wish to continue trauma work to some degree, but not specialize in trauma. Participants desired a balance of trauma and non-trauma cases due to concerns about the emotional burden of bearing witness to trauma and its impact on therapist efficacy.

*“I think that therapists, to one degree or another, carry their clients' pain with them. Working with people who have significant trauma histories increases the weight of that pain. Therefore, I think that it has made me understand that I could not work exclusively with trauma clients, as the weight would be too much.”*



***Trainee desires additional trauma training.*** Four participants (8.7%) additionally noted a desire for additional trauma training in order to continue with trauma work. Three participants (6.5%) described feeling incompetent to effectively deliver trauma interventions due to lack of training.

*“I have found that trauma clients can make a lot of gains in therapy, so this has increased my motivation to pursue more intensive trauma-focused training. Part of that motivation also stems from the fact that this kind of work often feels delicate, and so I have a sense that I want to have advanced training before embarking on it more fully.”*

***Trainee wishes to discontinue trauma work.*** Three participants (6.5%) explicitly indicated that they plan to discontinue trauma work. Participants noted feeling burned out and drained by the emotional impact of trauma focused therapy.

*“I’m completely burnt out and exhausted by it after 5 years in a row of intensive trauma work. I need to take a serious break and may feel prepared to return to it at a later point in my career.”*

## Discussion

### Indirect Trauma in Psychology Trainees

**Secondary traumatic stress.** Participants reported rates of indirect trauma in mild, average, and low ranges (Table 1), suggesting a low to average number of symptoms in the present sample. The average reported amount of secondary traumatic stress fell into the “mild secondary traumatic stress” range, and was somewhat higher than the average in the “little to no secondary traumatic stress” range reported by doctoral level psychology trainees in the United Kingdom (Makadia et al., 2017), and consistent with the average in the “mild secondary traumatic stress” range reported by social work trainees in the United States (Butler et al., 2017). It is possible that secondary traumatic stress levels reported by Makadia et al. (2017) fell into a lower clinical range than those in the present study and reported by Butler et al. (2017) because Makadia et al. (2017) removed participants from analyses considered to be “at risk” for symptoms of PTSD related to personal trauma. Responses on the STSS may capture symptoms of traditional PTSD in addition to secondary traumatic stress, because not all items are worded in relation to one’s clinical work (e.g., “I felt emotionally numb” vs. “My heart started pounding when I thought about my work with clients”). However, the prevalence of trauma ensures that some percentage of trainees will have personal trauma histories, and personal trauma may increase vulnerability to indirect trauma (e.g., when the trainee and client share the same type of trauma). While the inclusion of participants with possible symptoms of PTSD could confound the assessment of indirect trauma (as symptoms may overlap), it is important for generalizability to consider that many psychology trainees will have a history of trauma. Another possible explanation for the lower secondary

traumatic stress reported by Makadia et al. (2017) is that of cultural differences in self-disclosure and symptom reporting, as Makadia et al.'s (2017) sample comprised trainees in Britain, while the present sample and that of Butler et al. (2017) comprised trainees in the United States.

**Vicarious traumatization.** The average reported amount of vicarious traumatization was consistent with that in the “average” range reported by Makadia et al. (2017). While Adams and Riggs (2008) also assessed vicarious traumatization in a trainee sample, they did so using subscales of the TSI, which arguably captured symptoms more consistent with the construct of secondary traumatic stress. However, TSI scale means fell into “average” ranges, which is consistent with the “average” range mean TAB score reported in the present study.

**Compassion fatigue.** The averages reported amounts of both burnout and compassion fatigue fell into the “low” range, consistent with Beaumont et al.'s (2016) study of student cognitive behavioral therapists and person-centered counselors in the United Kingdom. As such, overall amounts of each form of indirect trauma in the present study ranged from low to average and were largely consistent with published average rates for other trainee clinicians. All forms of indirect trauma were strongly significantly correlated (Table 2), consistent with theoretical overlap among constructs.

### **Personal Factors and Indirect Trauma**

**Demographics.** Indirect trauma was not found to be associated with demographic factors including gender and age. Race was not assessed in regards to any of the outcome variables due to the largely homogenous nature of the sample. While both gender and age have been associated with indirect trauma in the literature (Sprang, et al., 2007, and Craig

& Sprang, 2010, respectively), findings have not been consistent (Sodeke-Gregson et al., 2013). It is possible that such relationships were not found due to the limitations of the sample, which comprised a relatively small age range (i.e., 14 years) and was largely feminine gender-identifying (77%). The participants in the current study were all psychology doctoral students in their fourth year and higher, and so likely shared relatively similar amounts of clinical experience. It is possible that when age has been associated with indirect trauma in the literature, age covaried with clinical experience, another commonly assessed possible predictor of indirect trauma (Sprang et al., 2007).

**Self-compassion.** Consistent with the literature, higher levels of self-compassion were associated with lower levels of all forms of indirect trauma, as well as burnout. While high levels of self-compassion have been linked to lower levels of compassion fatigue and burnout (Beaumont et al., 2016; Atkinson et al., 2017), this is the first known study to assess self-compassion in relation to secondary traumatic stress and vicarious traumatization. Self-compassion may thus foster resilience to all forms of indirect trauma. However, as the study is correlational in nature, another possibility is that the experience of indirect trauma reduces self-compassion. Interventions such as Compassionate Mind Training and mindfulness training have been found to increase levels of self-compassion in trainees (Beaumont et al., 2017; Dorian & Killebrew, 2014), and so possible resilience to indirect trauma may be augmented during doctoral training.

**Personal trauma history.** While personal trauma history has been linked to secondary traumatic stress in the literature (Baird & Kracen, 2006; Sodeke-Gregson et al., 2013), extent of personal trauma history was not associated with any of the outcome variables, including all forms of indirect trauma, burnout, and self-compassion. Extent of

personal trauma history was measured using the total score for the Life Events Checklist, consisting of the total number of potentially traumatic events an individual has experienced (e.g., assault, motor vehicle accident). Exposure to a traumatic event, however, does not imply the presence of a traumatic stress reaction. It is possible that exposures that result in post-traumatic symptoms have more of an impact on vulnerability to indirect trauma, rather than exposure to traumatic events, in general. In fact, nearly the entire sample (95.8%) reported exposure to at least one potentially traumatic event.

Participants discussed the considerable positive impact of their personal trauma histories on their career and clinical work. Some participants specifically sought a career in psychology as a result of personal trauma, and a number of participants reflected on increased understanding of and ability to empathize with clients based on their personal trauma history. Participants also discussed the positive personal impact of trauma work, including personal growth and finding a sense of meaning in helping others deal with trauma. Based on an exploratory study of masters and doctoral level mental health clinicians, Chaverri, Praetorius, and Ruiz (2018) hypothesized that clinician happiness increased as number of sessions of clients increased because as clients are in treatment longer, they make more progress, contributing to clinician satisfaction. The majority of their sample (71.2%) reported a history of personal trauma, and 95.4% of those participants noted a shared trauma history with their clients.

One possible explanation for the positive impact of personal trauma history is that individuals who have experienced trauma have a certain amount of resilience, hold values about helping others (perhaps even as a result of their trauma), and then self-select into the field of psychology. It follows that an additional amount of resilience is required to

progress through psychology doctoral training given its high emotional, academic, and clinical demands. Psychology trainees who experienced a highly negative and impairing impact of their personal trauma histories may drop out prior to the latter portion of their training. An additional explanation is that of even further self-selection of the participants who elected to complete the study, as individuals who are severely impacted by their own personal trauma histories and or indirect trauma may have avoided participation in the study in order to prevent exacerbation of symptoms or distress.

Some participants also discussed the negative impact of their personal trauma history on clinical work. Distress related to personal trauma history could be triggered during sessions or supervision. Participants explained the extra burden created by maintaining awareness of one's personal reactions, as well as the decision to withhold or disclose related information in supervision.

### **Training and Supervision and Indirect Trauma**

**Availability of training.** Despite Courtois and Gold's (2009) call to action for the inclusion of trauma specific training in psychology doctoral programs, a number of programs do not offer such graduate courses. Of the current sample, 49.2% of responders indicated that their graduate program offers a course in trauma, a substantially higher percentage than the 31.8% reported by Cook et al. (2017) in a survey of North American graduate programs. One possibility for this difference is that recruitment of the present sample required program training directors to disseminate the survey to students, and training directors of programs that offered a course in trauma may have been more likely to distribute the survey link. There is no data on the percentage of training directors who

agreed to distribute the link, as only some notified the investigator of their decision to do so.

Similarly, 38.7% of the current sample indicated participating in a trauma-focused externship or “practicum.” Cook et al. (2017) noted that of 151 programs, 100 offered practicums with traumatized populations, suggesting wider availability of trauma-specific training in clinical, rather than classroom settings. In fact, in a survey of 259 psychology internship training directors, 100% indicated the availability of trauma training in supervision or didactics (Simiola et al., 2018). Perhaps the high prevalence of trauma issues in clinical populations prioritizes trauma training in clinical settings, whereas academic programs have additional organizational demands such as APA course requirements. The primary barriers to providing trauma training reported by graduate program training directors included limited availability for elective courses and limited time and resources (Cook et al., 2017).

**Amount of trauma training.** Of the present sample, 10.94% indicated no specific trauma training, a considerably lower percentage than the 25% reported by Adams and Riggs (2008). The largest percentage of participants (48%) indicated having had substantial training, and 40.6% indicated having had minimal trauma training. Participants in the substantial training group reported significantly higher levels of both vicarious traumatization and secondary traumatic stress than those in the minimal group, although mean scores overall for these forms of indirect trauma fell into “mild” and “average” ranges. Similarly, participants who completed a trauma-focused externship reported higher levels of secondary traumatic stress. It is likely that participants with minimal trauma training and participants who did not complete a trauma-focused

externship simply had less exposure to trauma work, either as a result of training and/or preference, and so had less opportunity to be negatively impacted. Another possibility that may explain this finding is that students with more training in trauma have more awareness of possible indirect trauma reactions, and are thus more self-aware of current symptoms and experiences.

Inconsistent with the results of the current study, Adams and Riggs (2008) found that participants with minimal training reported more symptoms of vicarious traumatization than did participants with substantial training. However, these symptoms only corresponded to one subscale, “Impaired Self Reference,” of the Trauma Symptom Inventory, and the present study assessed vicarious traumatization with total score on the TAB, covering shifts in beliefs across a number of categories. As such, the results of the present study represent the full construct of vicarious traumatization, rather than one component. Additionally, Adams and Riggs (2008) assessed a sample of combined masters- and doctoral- level trainees, which may have introduced confounding variables related to type and intensity of training.

**Impact of traumatic training experiences.** Traumatic training experiences in psychology doctoral training are a largely unstudied phenomenon, particularly in regards to possible indirect trauma. Nearly one-third of the current sample (29.7%) endorsed a history of at least one traumatic training experience. Participants most frequently reported upsetting client behavior (e.g., suicide, physical assault of trainee) and conducting therapy for a shared trauma (i.e., the participant had a similar trauma history to their client’s) to be traumatic experiences. They discussed the negative impact of such experiences on clinical work, such as the necessity for emotional distancing and desire to



work in different settings. However, the majority of participants who reported traumatic training experiences (68.2%) discussed the positive impact of traumatic training experiences, including an increase in both self-efficacy and self-awareness. Challenging training experiences are likely an inevitable component of doctoral training, and students may benefit from preparation for such experiences (e.g. self-care training, self-compassion training, resiliency training,) from their training programs. Future research should explore the manner in which doctoral programs prepare students for distressing clinical experiences (e.g., client suicide) so as to improve student wellbeing and increase program retention rates.

**Factors related to indirect trauma.**

***Program type.*** Although secondary traumatic stress was found to vary by doctoral program type, post hoc analyses only approached statistical significance ( $p = .051$ ). Students in Clinical PsyD programs reported more secondary traumatic stress than did students in Clinical PhD programs, although medians for each (reported in place of means due to the nonparametric nature of the test used) still fell into the “little to no STS” range, and so the difference may not be clinically significant. The training model of the PsyD degree emphasizes clinical work, while the training model for the PhD degree emphasizes research (Norcross et al., 2004), and it is possible that participants in PsyD programs may have had more clinical experience and thus exposure to client traumas. However, rates of STSS were overall very low, and it is possible that program training varies more within program types than between program types. Norcross et al. (2004) have highlighted the variance within program types, such as in PsyD programs based on location of program (i.e., university psychology department, university professional

school, and freestanding institutions), as well as variance in PhD programs in terms of relative focus on research (i.e., equal emphasis research and practice programs and research oriented programs).

***Type of trauma work.*** Secondary traumatic stress and burnout both varied by type of trauma intervention, although results should be considered with caution, due to the small sizes of some intervention groups. Trauma-Focused CBT, Trauma-Focused Psychodynamic therapy, and “Other” each comprised three participants, and skills-based interventions and supportive therapy groups were removed from analysis for comprising 1 and 0 participants, respectively. Post hoc analysis indicated a statistically significant difference in secondary traumatic stress between the “work unrelated to the trauma” group and “integrative interventions” group, and group means fell into the “little to no STS” and “mild STS” groups, respectively. Intuitively, treatment unrelated to a client’s trauma (e.g., treatment for another diagnosis, such as Major Depressive Disorder) likely results in minimal exposure to the client’s trauma narrative, and thus indirect trauma. Integrative treatment may possibly increase vulnerability to indirect trauma if the overall treatment approach is not structured and driven by an underlying theory of trauma (e.g., Emotional Processing Theory) and/or if the treatment interventions are vague or unclear, which could result in poorer treatment outcomes.

Burnout, however, occurred in statistically higher amounts for participants in the Trauma-Focused Psychodynamic Psychotherapy group as compared to the work unrelated to trauma group. The mean amount of burnout reported by the Trauma-Focused Psychodynamic Psychotherapy group fell into the “Average” range, while burnout in the work unrelated to trauma group was in the “Low” range. As mentioned previously, the

Trauma-Focused Psychodynamic group comprised three participants, and so results should be considered with caution. It is possible that burnout was higher in the Trauma-Focused Psychodynamic group because psychodynamic interventions often involve longer term therapy, while interventions unrelated to trauma (e.g., problem solving, manualized interventions for insomnia) may have been shorter term and less emotionally demanding in nature.

### **Supervision and indirect trauma.**

*Amount of supervision.* None of the forms of indirect trauma were found to vary by amount of either individual or group supervision per week. This finding may be an artefact of the relatively small range in amount of supervision; over two thirds of the sample indicated receiving 1-3 hours of individual supervision, while just under a third of the sample indicated receiving 0 hours of trauma-focused individual supervision a week. Participants may have reported similar amounts of supervision because in training settings there may be a standard ratio of supervision hours to clinical hours (e.g., 1 hour of supervision per 4 clinical hours). As participants were either participating in externships or currently on internship, the amount of supervision they received may have been relatively similar.

Sodeke-Gregson et al. (2013) reported an association between amount of individual supervision and compassion fatigue such that participants who reported receiving more supervision had higher levels of compassion fatigue, but they assessed a sample of both masters- and doctoral- level psychotherapists. Independent practitioners make seek supervision as needed, whereas trainees receive regular supervision as a part of clinical training. It is possible that participants in Sodeke-Gregson et al.'s (2013) study

sought additional supervision as a result of their compassion fatigue, while the participants in the present study received a relative pre-established amount of supervision.

***Impact of supervision.*** However, over half of participants listed supervision as one of the most helpful aspects of their training in trauma work. As such, it may be the quality, rather than the quantity of the supervision that most benefits trainees. Participants discussed the importance of empathic, supportive supervision that values discussion of trainee reactions and experiences. Amount of such discussions varied widely, as did participants' perceptions of their supervisors' willingness to have such discussions. Some supervisors welcomed and encouraged such discussions, some only discussed trainee reactions if the trainee volunteered the topic, and some supervisors reacted negatively to trainee self-disclosures. Supervisor beliefs about the utility and appropriateness of discussion of trainee reactions likely vary based on a number of factors. For example, for supervisors of psychodynamic theoretical orientation, discussion of "countertransference" may be routine, while supervisors of other theoretical orientations may have concerns about respecting the trainee's privacy regarding their thoughts and feelings.

Trainee beliefs about self-disclosure in supervision, particularly in regards to personal trauma history that may impact clinical work, also varied. Participants expressed concerns about supervisor response to disclosures and the appropriateness of self-disclosure in supervision, as the focus of supervision would shift to the trainee, rather than the client. Participants who did disclose information about personal trauma history were careful to note that they did so "when appropriate," and only in the context of the clinical work. Psychology trainees expressed similar reservations about self-disclosure of

personal life concerns in a study of trainee nondisclosure (Mehr, Ladany, & Caskie, 2010); namely, that such topics make be irrelevant and inappropriate for supervision. Different models of supervision have different expectations for the role of the supervisor in terms of the provision of support, guidance, and evaluation (Knight, 2018). Subsequently, the balance of discussion of personal issues (e.g., personal trauma history, current life stressors impacting clinical work and training) and clinical material will vary by supervisor and supervision model. In the case of personal trauma history and its possible impact on indirect trauma, an argument could be made that self-disclosure in supervision may be necessary for ethical client care, as indirect trauma may influence the trainee's clinical efficacy. If personal issues such as a history of trauma negatively impact clinical work, supervision can provide the support and feedback necessary to proceed with treatment in a manner that does not harm the client, as per APA Ethics Code (2017) Principle A: Beneficence and Nonmaleficence. In fact, the APA Ethics Code (2017) Standard 7.04 "Student Disclosure of Personal Information" requires that trainees self-disclose personal information "if the information is necessary to evaluate or obtain assistance for students whose personal problems could reasonably be judged to be preventing them from performing their training or professionally related activities in a competent manner or posing a threat to the students or others," (p. 10). As such, explicit discussion of when and how to disclose such information is an important ethical concern for supervision.

While amount of supervision was not found to relate to the forms of indirect trauma, the importance of supportive supervision and open discussions of trainee reactions emerged as qualitative themes. Future research should assess trainee's

perceptions of supervision (e.g., perceived “quality” and amount of support), and the impact of such perceptions on self-disclosure. Additional information about supervisors’ awareness of indirect trauma, perceptions of supervision, and reactions to self-disclosure would further develop a working conceptualization of the supervision mechanisms that may protect trainees from indirect trauma.

### **Impact of Trauma Work on Trainees**

#### **Impact of exposure to trauma work.**

***Caseload.*** Secondary traumatic stress varied by total caseload such that participants who reported a caseload of 0-1 clients reported less secondary traumatic stress than those who reported a caseload of 10+ clients. However, the median score (reported in place of the mean, as the data violated normality and a nonparametric test was used) for the 0-1 group fell into the “little to no STS” range, while the median for the 10+ group fell into the “Mild STS” range. This finding suggests that participants with higher exposure to clinical work experience more secondary traumatic stress. Internship status may have been a possible confound, because one would expect interns, who work full time clinically, to have substantially more clients than students on externship or in practicum one or two days a week. It is possible that unique factors inherent to internship training, such as higher clinical demands, contributed to amount of secondary traumatic stress.

Of note, trauma caseload (i.e., the number of current trauma cases) was not related to any of the forms of indirect trauma or burnout. One might expect a relationship between secondary traumatic stress and trauma caseload, given the relationship between secondary traumatic stress and total caseload. One possibility for this finding is that

participants were asked the number of clients in their current caseload who had disclosed a trauma history, not the number of clients for whom they were conducting trauma-focused treatment. It is possible that some clients disclosed a trauma history one time and did not reference it again, resulting in minimal exposure to the client's trauma.

***Trauma clinical experience.*** Vicarious traumatization varied by total number of trauma cases seen during participants' entire training, or "trauma clinical experience." Participants in the 0-1 and 2-5 groups reported lower vicarious traumatization (in the "Low Average" range) than those in the 6-10 group (in the "Very High" range). As such, participants who had seen 6-10 trauma cases during their entire training reported more disruption to their beliefs about themselves, others, and the world, than those who saw from 0-5 cases. However, participants in the 10+ group reported vicarious traumatization in the "Average" range, and scores were not significantly different from those for any other group. If total number of trauma cases seen directly increases vulnerability to vicarious traumatization, one would expect participants in the 10+ group to report the highest amount of vicarious traumatization. Variance in group sizes may account for this issue; the 6-10 group was smallest with only three participants, which may have resulted in an overall higher mean (e.g., seven participants comprised the 10+ group).

**Impact of clinical experience on desire to do trauma work.** While three participants reported that they wish to discontinue trauma work, consistent with trainee reports in the literature (Baker, 2012), the majority of participants in the present study reported a desire to continue trauma work. Participants viewed trauma work as important due to the high prevalence of trauma, and found client progress to be motivating and meaningful. A number of participants also discussed a desire to moderate the amount of

trauma work they do, so as to preserve their emotional and clinical resources. This desire suggests that trainees are both aware of the emotional toll of trauma work and symptoms of indirect trauma, and motivated to continue in the field in a manner that balances self-care (including seeking additional training) and the needs of clients.

### **Training and Supervision Implications**

**Trauma specific training.** While availability and prevalence of trauma-specific training have increased since Courtois and Gold's (2009) call to action, roughly half of participants in the present study attend graduate programs that do not offer a course in trauma, despite the wide prevalence of trauma in clinical populations. Simple availability of trauma training, whether in graduate courses, workshops, didactics, and/or externship/practicum settings, is important to the prevention of indirect trauma. Basic knowledge of common trauma presentations, interventions, and the possible impact of conducting trauma work, and even clinical work, in general (e.g., indirect trauma, burnout, etc.), should be mandatory in all curricula. Even students who choose not to specialize in trauma work will inevitably work with clients with trauma histories, and such knowledge is necessary for conceptualization, treatment planning, and maintaining self-awareness.

Psychology training may also benefit from interventions that foster self-compassion, given the consistently negative relationships found among self-compassion and all forms of indirect trauma as found in both the present study and the literature. In fact, multiple self-compassion interventions have already been found to be effective in psychology trainee populations (Beaumont et al., 2017; Dorian & Killebrew, 2014). Benefits of such training would be multifold: not only would trainees maintain well-being



and potentially increase resilience to indirect trauma and burnout, they would also gain experience as the recipients of a psychological intervention (and thus likely increase empathy for clients), as well as be able to model self-compassion for clients.

**Implications for supervision.** Participants reported a substantial impact of supervisor behavior on their experience of supervision. Supervisors who were warm, supportive, and empathic created a safe environment in supervision to discuss personal reactions to trauma work and even personal trauma history. When supervisors reacted negatively to self-disclosure or minimized discussion of participant reactions, participants found supervision to be unhelpful. Knight (2018) stresses the importance of maintaining a sense of safety in trauma supervision in which supervisees feel supported, have clear expectations for supervision, and are encouraged to discuss their experiences openly. Additionally, supervisors must be aware of the signs of indirect trauma reactions so as to avoid misinterpreting or ignoring the trainee's behavior as an issue that should only be addressed in the supervisee's personal therapy (Knight, 2018).

Regular check-ins about supervisee reactions to clinical work would communicate to supervisees that the topic is not only acceptable, but encouraged in supervision. The most frequent concerns about self-disclosure listed by participants in the present study involved worries that the information would inappropriately shift focus from the client to the supervisee. A supervisory relationship might begin with discussion of clear expectations regarding self-disclosure (e.g., that it is welcomed, but not required, so as to maintain supervisee autonomy) and its utility in clinical work (e.g., that it may give important clinical data about the client, and is an ethical consideration if trainee reactions may interfere with or influence treatment). Supervisors should be careful in monitoring

the stimulus value of their responses (e.g., verbal and nonverbal cues) to appropriate supervisee self-disclosure so as to encourage open discussion. Supervisors may additionally remain alert for possible signs of indirect trauma in supervisees, and provide ongoing education and normalization of the impact of trauma work on clinicians.

### **Limitations and Directions for Future Study**

#### **Limitations of the sample.**

***Statistical power.*** An a priori power analysis determined a minimum of 48 responses were necessary to detect a medium effect size with a significance level of  $\alpha = .05$ . Participants were not required to answer all questions, and as a result, a number of responses were incomplete and the total number of participants for each analysis varied. Subsequently, analyses were at times slightly underpowered, which may have contributed to a relatively low number of significant findings. A larger sample size would have allowed for consistently adequate statistical power.

***Homogeneity.*** An additional limitation of the sample was that it was largely homogenous in terms of gender and race, with the majority of participants identifying as White women. While this demographic trend may reflect that present within doctoral psychology, it substantially limits the generalizability of results, and eliminated the possibility of assessing the possible relationship between race and indirect trauma.

***Self-report bias.*** A substantial limitation of the methodology of the present study was the self-report nature of all measures used. As such, responses may be limited by lack of participant insight or participant desire to represent themselves in a particular way. Responses regarding supervision experiences, in particular, may have been limited by trainee bias, and additional information regarding supervisor experiences of the same

interactions would contribute to understanding of the role of supervision in mitigating indirect trauma.

***Self-selection bias.*** Similarly, participants who completed the study, which was advertised as a study of the different personal, training, supervision, and exposure factors related to indirect trauma, elected to do so of their own accord and were not compensated. Participants who had a preexisting interest in trauma work or prior experiences with indirect trauma may have been most likely to elect to complete the study. Or, conversely, individuals with negative indirect trauma experiences and/or reactions related to personal trauma may have avoided completion of the study so as to avoid related distress or triggering of symptoms.

**Construct overlap.** While the present study is one of the very few to assess all three forms of indirect trauma, as the study is exploratory in nature, results do not necessarily contribute to the differentiation of constructs. All three constructs were highly correlated with one another, which suggests overlap between constructs. However, the majority of significant findings involved only one or two constructs, which provides possible evidence for distinction between constructs, despite their considerable overlap. The precise nature of those differences, however, is beyond the scope of the current study. Future research should consistently assess all three forms of indirect trauma, so as to determine trends among associated risk factors and contribute to distinct conceptualizations of related mechanisms and symptom presentations.

**Qualitative analysis.** Limitations of the qualitative analysis utilized in the study include the use of one coder, which increases possible subjectivity in coding and the generation of themes. Additionally, while thematic analysis was conducted across all

qualitative data, only the themes directly relevant to the study questions were reported for the purposes of the study. The selection of the themes thus added an additional element of subjectivity. Future qualitative investigation of indirect trauma may utilize multiple coders to reduce subjectivity in both coding and the presentation of data.

**Correlational quantitative analysis.** A limitation of the quantitative analyses used in the study is that analyses were correlational, and thus directionality of relationships cannot be assumed. While a number of the independent variables were considered as “risk factors” for indirect trauma, it is entirely possible that reactions of indirect trauma influence those variables. Longitudinal investigation of trainees’ experiences of indirect trauma would allow for a more nuanced understanding of various factors and their impact on indirect trauma over time.

**Directions for future study.** Future research should continue to determine risk factors for all forms of indirect trauma, with a particular emphasis on the processes of training and supervision, areas which have been minimally assessed. Participants stressed the importance of empathy, support, experience, and discussions of personal reactions in supervision. Assessment of trainee perceptions of supervision, as well as the role of model of supervision model and theoretical orientation, would clarify the role of supervision in preventing and addressing indirect trauma.

Longitudinal assessment of risk, training, supervision, and exposure related factors throughout doctoral training would not only substantially contribute to the literature, it would allow for identification of at-risk trainees and timely implementation of preventative interventions. Investigation of the relationship between self-compassion and indirect trauma, as well as interventions that augment self-compassion, would

provide clinicians with tangible skills to mitigate the deleterious effects of trauma work not just as trainees, but well into their psychology careers.

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## Appendix A

### APPENDIX SECONDARY TRAUMATIC STRESS SCALE

The following is a list of statements made by persons who have been impacted by their work with traumatized clients. Read each statement, then indicate how frequently the statement was true for you in the past *seven (7) days* by circling the corresponding number next to the statement.

	<i>Never</i>	<i>Rarely</i>	<i>Occasionally</i>	<i>Often</i>	<i>Very Often</i>
1. I felt emotionally numb.	1	2	3	4	5
2. My heart started pounding when I thought about my work with clients.	1	2	3	4	5
3. It seemed as if I was reliving the trauma(s) experienced by my client(s).	1	2	3	4	5
4. I had trouble sleeping.	1	2	3	4	5
5. I felt discouraged about the future.	1	2	3	4	5
6. Reminders of my work with clients upset me.	1	2	3	4	5
7. I had little interest in being around others.	1	2	3	4	5
8. I felt jumpy.	1	2	3	4	5
9. I was less active than usual.	1	2	3	4	5
10. I thought about my work with clients when I didn't intend to.	1	2	3	4	5
11. I had trouble concentrating.	1	2	3	4	5
12. I avoided people, places, or things that reminded me of my work with clients.	1	2	3	4	5
13. I had disturbing dreams about my work with clients.	1	2	3	4	5
14. I wanted to avoid working with some clients.	1	2	3	4	5
15. I was easily annoyed.	1	2	3	4	5
16. I expected something bad to happen.	1	2	3	4	5
17. I noticed gaps in my memory about client sessions.	1	2	3	4	5

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NOTE: "Client" is used to indicate persons with whom you have been engaged in a helping relationship. You may substitute another noun that better represents your work such as consumer, patient, recipient, and so forth.

## Appendix B

### Trauma and Attachment Belief Scale

Directions: This questionnaire is used to learn how individuals view themselves and others. As people differ from one another in many ways, there are no right or wrong answers. Please indicate the number next to each item which you feel most clearly matches your own beliefs about yourself and your world. Try to complete every item.

Use the following response scale.

1=Disagree Strongly 2=Disagree 3=Disagree Somewhat 4=Agree Somewhat 5=Agree 6=Agree Strongly

1. I believe I am safe.
2. You can't trust anyone.
3. I don't feel like I deserve much.
4. Even when I am with friends and family, I don't feel like I belong.
5. I can't be myself around people.
6. I never think anyone is safe from danger.
7. I can trust my own judgment.
8. People are wonderful.
9. When my feelings are hurt, I can make myself feel better.
10. I am uncomfortable when someone else is the leader.
11. I feel like people are hurting me all the time.
12. If I need them, people will come through for me.
13. I have bad feelings about myself.
14. Some of my happiest times are with other people.
15. I feel like I can't control myself.
16. I could do serious damage to someone.
17. When I am alone, I don't feel safe.
18. Most people ruin what they care about.
19. I don't trust my instincts.
20. I feel close to lots of people.
21. I feel good about myself most days.
22. My friends don't listen to my opinion.
23. I feel hollow inside when I am alone.
24. I can't stop worrying about others' safety.
25. I wish I didn't have feelings.
26. Trusting people is not smart.
27. I would never hurt myself.
28. I often think the worst of others.
29. I can control whether I harm others.
30. I'm not worth much.
31. I don't believe what people tell me.

32. The world is dangerous.
33. I am often in conflicts with other people.
34. I have a hard time making decisions.
35. I feel cut off from people.
36. I feel jealous of people who are always in control.
37. The important people in my life are in danger.
38. I can keep myself safe.
39. People are no good.
40. I keep busy to avoid my feelings.
41. People shouldn't trust their friends.
42. I deserve to have good things happen to me.
43. I worry about what other people will do to me.
44. I like people.
45. I must be in control of myself.
46. I feel helpless around adults.
47. Even if I think about hurting myself, I won't do it.
48. I don't feel much love from anyone.
49. I have good judgment.
50. Strong people don't need to ask for help.
51. I am a good person.
52. People don't keep their promises.
53. I hate to be alone.
54. I feel threatened by others.
55. When I am with people, I feel alone.
56. I have problems with self-control.
57. The world is full of people with mental problems.
58. I can make good decisions.
59. I often feel people are trying to control me.
60. I am afraid of what I might do to myself.
61. People who trust others are stupid.
62. I am my own best friend.
63. When people I love aren't with me, I believe they are in danger.
64. Bad things happen to me because I am a bad person.
65. I feel safe when I am alone.
66. To feel okay, I need to be in charge.
67. I often doubt myself.
68. Most people are good at heart.
69. I feel bad about myself when I need help.
70. My friends are there when I need them.
71. I believe that someone is going to hurt me.
72. I do things that put other people in danger.
73. There is an evil force inside of me.
74. No one really knows me.

- 75. When I am alone, it's as if there's no one there, not even me.
- 76. I don't respect the people I know best.
- 77. I can usually figure out what's going on with people.
- 78. I can't do good work unless I am the leader.
- 79. I can't relax.
- 80. I have physically hurt people.
- 81. I am afraid I will harm myself.
- 82. I feel left out everywhere.
- 83. If people really knew me, they wouldn't like me.
- 84. I look forward to time I spend alone.



# Appendix C

PROFESSIONAL QUALITY OF LIFE SCALE (PROQOL)				
COMPASSION SATISFACTION AND COMPASSION FATIGUE (PROQOL) VERSION 5 (2009)				
When you [help] people you have direct contact with their lives. As you may have found, your compassion for those you [help] can affect you in positive and negative ways. Below are some questions about your experiences, both positive and negative, as a [helper]. Consider each of the following questions about you and your current work situation. Select the number that honestly reflects how frequently you experienced these things in the <u>last 30 days</u> .				
1=Never	2=Rarely	3=Sometimes	4=Often	5=Very Often
_____	1.	I am happy.		
_____	2.	I am preoccupied with more than one person I [help].		
_____	3.	I get satisfaction from being able to [help] people.		
_____	4.	I feel connected to others.		
_____	5.	I jump or am startled by unexpected sounds.		
_____	6.	I feel invigorated after working with those I [help].		
_____	7.	I find it difficult to separate my personal life from my life as a [helper].		
_____	8.	I am not as productive at work because I am losing sleep over traumatic experiences of a person I [help].		
_____	9.	I think that I might have been affected by the traumatic stress of those I [help].		
_____	10.	I feel trapped by my job as a [helper].		
_____	11.	Because of my [helping], I have felt "on edge" about various things.		
_____	12.	I like my work as a [helper].		
_____	13.	I feel depressed because of the traumatic experiences of the people I [help].		
_____	14.	I feel as though I am experiencing the trauma of someone I have [helped].		
_____	15.	I have beliefs that sustain me.		
_____	16.	I am pleased with how I am able to keep up with [helping] techniques and protocols.		
_____	17.	I am the person I always wanted to be.		
_____	18.	My work makes me feel satisfied.		
_____	19.	I feel worn out because of my work as a [helper].		
_____	20.	I have happy thoughts and feelings about those I [help] and how I could help them.		
_____	21.	I feel overwhelmed because my case [work] load seems endless.		
_____	22.	I believe I can make a difference through my work.		
_____	23.	I avoid certain activities or situations because they remind me of frightening experiences of the people I [help].		
_____	24.	I am proud of what I can do to [help].		
_____	25.	As a result of my [helping], I have intrusive, frightening thoughts.		
_____	26.	I feel "bogged down" by the system.		
_____	27.	I have thoughts that I am a "success" as a [helper].		
_____	28.	I can't recall important parts of my work with trauma victims.		
_____	29.	I am a very caring person.		
_____	30.	I am happy that I chose to do this work.		

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# Appendix D

LEC-5

**Instructions:** Listed below are a number of difficult or stressful things that sometimes happen to people. For each event check one or more of the boxes to the right to indicate that: (a) it happened to you personally; (b) you witnessed it happen to someone else; (c) you learned about it happening to a close family member or close friend; (d) you were exposed to it as part of your job (for example, paramedic, police, military, or other first responder); (e) you're not sure if it fits; or (f) it doesn't apply to you.

Be sure to consider your entire life (growing up as well as adulthood) as you go through the list of events.

Event	Happened to me	Witnessed it	Learned about it	Part of my job	Not sure	Doesn't apply
1. Natural disaster (for example, flood, hurricane, tornado, earthquake)						
2. Fire or explosion						
3. Transportation accident (for example, car accident, boat accident, train wreck, plane crash)						
4. Serious accident at work, home, or during recreational activity						
5. Exposure to toxic substance (for example, dangerous chemicals, radiation)						
6. Physical assault (for example, being attacked, hit, slapped, kicked, beaten up)						
7. Assault with a weapon (for example, being shot, stabbed, threatened with a knife, gun, bomb)						
8. Sexual assault (rape, attempted rape, made to perform any type of sexual act through force or threat of harm)						
9. Other unwanted or uncomfortable sexual experience						
10. Combat or exposure to a war-zone (in the military or as a civilian)						
11. Captivity (for example, being kidnapped, abducted, held hostage, prisoner of war)						
12. Life-threatening illness or injury						
13. Severe human suffering						
14. Sudden violent death (for example, homicide, suicide)						
15. Sudden accidental death						
16. Serious injury, harm, or death you caused to someone else						
17. Any other very stressful event or experience						

## Appendix E

### Self-Compassion Scale

### HOW I TYPICALLY ACT TOWARDS MYSELF IN DIFFICULT TIMES

Please read each statement carefully before answering. To the left of each item, indicate how often you behave in the stated manner, using the following scale:

Almost  
never  
1

2

3

4

Almost  
always  
5

- \_\_\_\_\_ 1. I'm disapproving and judgmental about my own flaws and inadequacies.
- \_\_\_\_\_ 2. When I'm feeling down I tend to obsess and fixate on everything that's wrong.
- \_\_\_\_\_ 3. When things are going badly for me, I see the difficulties as part of life that everyone goes through.
- \_\_\_\_\_ 4. When I think about my inadequacies, it tends to make me feel more separate and cut off from the rest of the world.
- \_\_\_\_\_ 5. I try to be loving towards myself when I'm feeling emotional pain.
- \_\_\_\_\_ 6. When I fail at something important to me I become consumed by feelings of inadequacy.
- \_\_\_\_\_ 7. When I'm down and out, I remind myself that there are lots of other people in the world feeling like I am.
- \_\_\_\_\_ 8. When times are really difficult, I tend to be tough on myself.
- \_\_\_\_\_ 9. When something upsets me I try to keep my emotions in balance.
- \_\_\_\_\_ 10. When I feel inadequate in some way, I try to remind myself that feelings of inadequacy are shared by most people.
- \_\_\_\_\_ 11. I'm intolerant and impatient towards those aspects of my personality I don't like.
- \_\_\_\_\_ 12. When I'm going through a very hard time, I give myself the caring and tenderness I need.
- \_\_\_\_\_ 13. When I'm feeling down, I tend to feel like most other people are probably happier than I am.
- \_\_\_\_\_ 14. When something painful happens I try to take a balanced view of the situation.
- \_\_\_\_\_ 15. I try to see my failings as part of the human condition.
- \_\_\_\_\_ 16. When I see aspects of myself that I don't like, I get down on myself.
- \_\_\_\_\_ 17. When I fail at something important to me I try to keep things in perspective.

- \_\_\_\_\_ 18. When I'm really struggling, I tend to feel like other people must be having an easier time of it.
- \_\_\_\_\_ 19. I'm kind to myself when I'm experiencing suffering.
- \_\_\_\_\_ 20. When something upsets me I get carried away with my feelings.
- \_\_\_\_\_ 21. I can be a bit cold-hearted towards myself when I'm experiencing suffering.
- \_\_\_\_\_ 22. When I'm feeling down I try to approach my feelings with curiosity and openness.
- \_\_\_\_\_ 23. I'm tolerant of my own flaws and inadequacies.
- \_\_\_\_\_ 24. When something painful happens I tend to blow the incident out of proportion.
- \_\_\_\_\_ 25. When I fail at something that's important to me, I tend to feel alone in my failure.
- \_\_\_\_\_ 26. I try to be understanding and patient towards those aspects of my personality I don't like.

## Appendix F

### Questionnaire

1. Please indicate your preferred gender:
  - Masculine
  - Feminine
  - Gender nonconforming
  
2. Please indicate your age: \_\_\_\_\_
  
3. Please indicate your graduate program type
  - Clinical Psychology PhD
  - Counseling Psychology PhD
  - Clinical Psychology PsyD
  - Counseling Psychology PsyD
  
4. Please indicate your program year
  - Fourth Year
  - Fifth Year
  - Sixth Year
  - Seventh Year and Higher
  
5. Please indicate your primary theoretical orientation
  - Cognitive Behavioral
  - Psychodynamic
  - Integrative
  - Other: \_\_\_\_\_
  
6. Please indicate your race/ethnicity
  - White
  - Hispanic or Latino/a
  - Black or African American
  - Native American or American Indian
  - Asian/Pacific Islander
  - Mixed Race
  
7. Please indicate the total number of individual clients in your current caseload:
  - 0-1
  - 2-5
  - 6-10
  - 10+

8. Please indicate the number of individual clients with trauma histories that they have disclosed to you in your current caseload:
  - 0-1
  - 2-5
  - 6-10
  - 10+
  
9. Please indicate the number of clients with whom you have conducted trauma-focused (e.g., Prolonged Exposure) interventions throughout your *entire* training:
  - 0-1
  - 2-5
  - 6-10
  - 10+
  
10. Check the statement that best characterizes the *majority* of your work with trauma clients:
  - Treatment focused primarily on issues unrelated to the trauma
  - Exposure-based interventions, (e.g., Prolonged Exposure, Cognitive Processing Therapy, EMDR, or Narrative Exposure Therapy)
  - Trauma-Focused CBT
  - Trauma-Focused Psychodynamic Psychotherapy
  - Skill training (e.g., stress inoculation techniques, STAIR, DBT emotion regulation skills)
  - Supportive Therapy
  - Integrative treatment (e.g., combined elements of multiple approaches)
  - Other (describe)
  
11. Please indicate the number of type of trauma or PTSD focused groups that you have facilitated (e.g., one group of veterans with PTSD and one group of college students with PTSD):
  - 0-1
  - 2-5
  - 6-10
  - 10+
  
12. What types of populations did these groups involve (e.g., military veterans, first responders, college students, survivors of sexual assault, etc.)?
  
13. To the degree you feel comfortable, please describe any training, supervision, or clinical experiences that have been traumatic to you, personally. Examples include but are not limited to: assault by a client, client suicide, witnessing physical abuse of clients, being threatened by a client, the traumatic loss (e.g., death) of a supervisor, and conducting treatment for a trauma which you have also directly experienced, such as a disaster.

14. If applicable, how have the experiences mentioned in the above question impacted your current work with clients?
15. Does your program offer a course in working with issues of trauma?
  - Yes
  - No
16. Please indicate the extent of your trauma training:
  - No specific trauma training
  - Minimal (one workshop or seminar)
  - Substantial (semester-long course, multiple workshops, or other extensive formal training)
17. Have you or are you currently participating in a trauma-focused externship or internship (i.e., at least 50% of work focuses on trauma clients, or experience includes a PTSD rotation)?
  - Yes
  - No
18. Briefly describe your training and preparation for working with trauma clients. Please indicate if training occurred as a part of your doctoral program, as a part of an externship, in supervision, or elsewhere.
19. What has been most helpful in your training to work with trauma clients?
20. Please indicate the total amount of weekly individual supervision you receive pertaining to clients with trauma histories
  - 0 hours
  - 1-3 hours
  - 3+ hours
21. Please indicate the total amount of weekly group supervision you receive pertaining to clients with trauma histories
  - 0 hours
  - 1-3 hours
  - 3+ hours
22. Briefly describe the extent to which your trauma-related supervision incorporates discussion of your reactions to trauma clients. Examples include but are not limited to: discussion of countertransference, discussion of the impact of hearing a traumatic narrative, and discussion of your experience of conducting an exposure with a client.
23. Please indicate the format of the *majority* your trauma-focused supervision.
  - Case discussion only

- Review of audio and/or video recordings
  - In vivo supervision (e.g., supervisor present in session, or supervisor communicating with therapist via an earpiece)
24. What has been the most helpful from your supervision in working with trauma clients? What has been the least helpful?
  25. To the degree you feel comfortable, describe the ways in which your own possible trauma history has impacted your supervision. For example, if you had a similar trauma history as your client, did you disclose that to your supervisor?
  26. How did such a disclosure, if applicable, impact the supervision and your treatment of the client? How did your supervisor respond?
  27. How has your experience working with trauma clients impacted your desire to do trauma work in the future?
  28. How has your experience working with trauma clients impacted your desire to stay in the field of clinical psychology?
  29. What has been most helpful for you in your work with trauma clients?
  30. How have your personal traumatic experience(s) impacted your training, clinical work, and/or supervision?



## Appendix G

### THEMES AND SUBTHEMES BY QUESTION

**To the degree you feel comfortable, please describe any training, supervision, or clinical experiences that have been traumatic to you, personally. Examples include but are not limited to: assault by a client, client suicide, witnessing physical abuse of clients, being threatened by a client, the traumatic loss (e.g., death) of a supervisor, and conducting treatment for a trauma which you have also directly experienced, such as a disaster.**

- ❖ None or don't consider experiences to be traumatic
- ❖ Client behavior towards trainee
  - Physical violence
  - Verbal threats
  - Upsetting behavior
- ❖ Behavior of others towards client
- ❖ Exposure to client trauma history
- ❖ Negative supervision experiences
- ❖ Negative workplace events/factors

**If applicable, how have the experiences mentioned in the above question impacted your current work with clients?**

- ❖ Positive impact on clinical work
  - Increased confidence
  - Increased awareness in session
- ❖ Positive impact on personal life/self
- ❖ Negative impact on clinical work
- ❖ More effort to manage personal emotion/distance emotionally
- ❖ No impact
- ❖ Impact on work preferences
  - preference for certain types of clients

**What has been most helpful in your training to work with trauma clients?**

- ❖ Supervision
  - Specific Elements of supervision
  - Types of supervisors
- ❖ Knowledge of theory
- ❖ Knowledge of skills
  - Skills related to process of therapy
  - Therapeutic Techniques
- ❖ Clinical experience
- ❖ Trainee Personal attributes

❖ Formal training

**Briefly describe the extent to which your trauma-related supervision incorporates discussion of your reactions to trauma clients. Examples include but are not limited to: discussion of countertransference, discussion of the impact of hearing a traumatic narrative, and discussion of your experience of conducting an exposure with a client.**

❖ Discussions of reactions in supervision

- Discussions occur often
- Discussions of Countertransference
- Supervision welcomes discussion of reactions

❖ Some discussion of reactions

❖ Minimal discussion of reactions

**What has been helpful from your supervision in working with trauma clients? What has been the least helpful?**

Most Helpful

- ❖ Supervisor qualities
- ❖ Supportive supervision environment
- ❖ Focus on skills
  - Interventions
  - Conceptualization
  - Treatment process
- ❖ Focus on knowledge
- ❖ Discussion of trainee's experience
  - Self-Care
  - Personal Reactions
- ❖ Methods of supervision (tape, video, live)

Least Helpful

- ❖ Overemphasis on a particular area
- ❖ Insufficient focus on a particular area
  - Impact of work on trainee
- ❖ Methods of supervision (tape, video, live)
- ❖ Supervision structure
- ❖ Discrepant theoretical or structural approach from trainee's

**To the degree you feel comfortable, describe the ways in which your own possible trauma history has impacted your supervision. For example, if you had a similar trauma history as your client, did you disclose that to your supervisor?**

- ❖ No relevant trauma history
  - Trauma history does not match clients'

- No trauma history
- ❖ Disclosed
  - Disclosure influences trajectory of supervision
  - Trainee disclosed in specific circumstances
  - Partial disclosure
- ❖ Did not disclose
  - Didn't disclose due to discomfort
- ❖ Would disclose
- ❖ Personal trauma history shapes trainee perspective

**How did such a disclosure, if applicable, impact the supervision and your treatment of the client? How did your supervisor respond?**

- ❖ Negative supervisor response to disclosure
- ❖ Disclosure improved clinical work
- ❖ Positive supervisor response to disclosure

**How has your experience working with trauma clients impacted your desire to do trauma work in the future?**

- ❖ Trainee does not wish to focus solely on trauma
- ❖ Trainee wishes to continue trauma work
- ❖ Trainee wishes to discontinue trauma work
- ❖ Desire for additional trauma training
- ❖ Negative impact of trauma work
- ❖ Interest in trauma has increased
- ❖ Trainee enjoys trauma work
  - Trainee enjoys trauma work because of clients
- ❖ Trainee has interest in specific populations
- ❖ Trainee considers trauma work to be prevalent

**How has your experience working with trauma clients impacted your desire to stay in the field of clinical psychology?**

- ❖ Trauma work increases motivation to stay in clinical psych
  - Trauma client progress increases motivation
- ❖ Trauma work decreases motivation to stay in clinical psych
- ❖ Trainee is unsure of impact of trauma work on desire to stay in clinical psych
- ❖ No impact of trauma work on desire to stay in clinical psych
- ❖ Trauma work increased trainee's confidence in clinical work
- ❖ Negative impact of trauma work
- ❖ Positive impact of trauma work
  - Trainee has confidence in efficacy of trauma treatment
- ❖ Trainee sees trauma work as important
  - Trainee sees trauma issues as prevalent

**What has been most helpful for you in your work with trauma clients?**

- ❖ Support
- ❖ Supervision
  - High Quality Supervision
  - Kind and experienced supervisors
- ❖ Consultation
- ❖ Aspects of the therapeutic process
  - Skill in interventions
  - Client factors
    - Client progress
  - Trainee factors
    - Openness
    - Self-Care
- ❖ Academic learning/knowledge
- ❖ Managing expectations for treatment

**How have your personal traumatic experience(s) impacted your training, clinical work, and/or supervision?**

- ❖ Increased empathy for clients
- ❖ Increased understanding of trauma
- ❖ No impact
- ❖ Negative impact on clinical work
- ❖ Negative impact on supervision
- ❖ Influence on clinical interests
- ❖ Positive personal impact

## Appendix H

### THEMATIC OVERLAP ACROSS QUESTIONS: THEMES/SUBTHEMES AND CODES

- ❖ Client Progress Increases Motivation
  - Seeing improvement in clients
  - Seeing progress in clients
  - Client progress inspires trainee's hope for healing
  - Witnessing clients engaging in activities and feeling positive emotions they were unable to previously
  - Trauma clients' progress reinforces trainee's desire to stay in psychology (3)
  - Client progress in trauma work encourages trainee to stay in clinical psych
- ❖ Trainee sees trauma as prevalent
  - Trainee believes all clients are trauma clients
  - Trainee believes trauma issues are present in all clinical work (3)
  - Trainee believes desire to do trauma work is necessary to do therapy
  - trainee believes most clients have a trauma history
  - Trainee sees trauma as more prevalent than many people think
  - Trauma work has reminded trainee of the prevalence of trauma
- ❖ Supervisor qualities important to supervision
  - Experienced
    - ◆ Experienced supervisor (2)
    - ◆ Well-educated supervisors
    - ◆ Working with a supervisor experienced in trauma (2)
    - ◆ Group supervision with more advanced peers
  - Supportive
    - ◆ Supportive supervisors (3)
    - ◆ Supervisors have been supportive of work
    - ◆ MH: open, nonjudgmental communication
    - ◆ MH: strong supervisory relationship
    - ◆ Supervisors have been kind
    - ◆ Caring supervision (2)
  - Empathic
    - ◆ MH: empathy (4)
    - ◆ Understanding, empathic supervisors
- ❖ Discussion of trainee's reactions/experience are important to supervision
  - Discussions of reactions in supervision occur
    - ◆ Trainee must volunteer own reactions
    - ◆ Conversations in supervision about reactions (7)
    - ◆ Discussion of experience conducting exposure (2)

- ◆ In previous supervision discussion of personal reactions
- ◆ Conversations in supervision about transference (2)
- ◆ Conversations in supervision about reactions to hearing traumatic material
- ◆ Focus on personal trauma when triggered by clients' trauma
- ◆ Conversations in supervision about intergenerational trauma, self-care, and vicarious trauma
- ◆ Personal Reactions were a focus of prior supervision because the supervisor had specialized training in trauma
- Discussions of Countertransference occur
  - ◆ Weekly seminar focuses on countertransference
  - ◆ Conversations in supervision about Countertransference (15)
  - ◆ Supervision is dynamic and so often discuss countertransference (2)
- Supervision welcomes discussion of reactions
  - ◆ Discussions welcome
  - ◆ In previous supervision supervisors invite discussion of reactions
  - ◆ Supervisor "checks in" with how trainee is doing with trauma of clients (2)
  - ◆ In previous supervision discussion of vicarious trauma
  - ◆ Supervision feels safe to explore reactions
  - ◆ Supervision is focused on process, which makes it feel safe to explore reactions
- Discussion of trainee's experience are "most helpful" (MH) to trauma work
  - ◆ MH: Place to process experience of hearing about trauma
  - ◆ MH: processing personal reactions (4)
  - ◆ MH: discussion of Countertransference (2)
  - ◆ MH: discussion of experiences with client
  - ◆ Frequent asking about personal reactions
  - ◆ MH: sharing personal feelings with supervisor (2)
  - ◆ MH: processing the intensity of the work
  - ◆ MH: processing personal feelings (2)
  - ◆ MH: personal reactions treated as useful information

## Appendix I IRB Approval

**RUTGERS**

Office of Research and Regulatory Affairs  
Arts and Sciences IRB  
Rutgers, The State University of New Jersey  
335 George Street / Liberty Plaza / Suite 3200  
New Brunswick, NJ 08901

orra.rutgers.edu/artsci  
732-235-9806

January 9, 2017

Ashley Sutton  
152 Frelinghuysen Road  
Piscataway NJ 08854

P.I. Name: Sutton  
Protocol #: 17-343M

Dear Ashley Sutton:

Initial      Amendment      Continuation      Continuation w/ Amend      Adverse Event

Protocol Title: "Factors Affecting Psychology Trainees' Vulnerability to Indirect Trauma"

This is to advise you that the above-referenced study has been presented to the Institutional Review Board for the Protection of Human Subjects in Research, and the following action was taken subject to the conditions and explanations provided below:

Approval Date: 12/20/2016      Expiration Date: 12/19/2017      Expedited Category(s):7  
Approved # of Subject(s): 100      Currently Enrolled: 0

This approval is based on the assumption that the materials you submitted to the Office of Research and Sponsored Programs (ORSP) contain a complete and accurate description of the ways in which human subjects are involved in your research. The following conditions apply:

- **This Approval**-The research will be conducted according to the most recent version of the protocol that was submitted. This approval is valid **ONLY** for the dates listed above;
- **Reporting**-ORSP must be immediately informed of any injuries to subjects that occur and/or problems that arise, in the course of your research;
- **Modifications**-Any proposed changes **MUST** be submitted to the IRB as an amendment for review and approval prior to implementation;
- **Consent Form(s)**-Each person who signs a consent document will be given a copy of that document, if you are using such documents in your research. The Principal Investigator must retain all signed documents for at least three years after the conclusion of the research;
- **Continuing Review**-You should receive a courtesy e-mail renewal notice for a Request for Continuing Review before the expiration of this project's approval. However, it is **your responsibility** to ensure that an application for continuing review has been submitted to the IRB for review and approval prior to the expiration date to extend the approval period;

**Additional Notes:**      ■ Expedited Approval per 45 CFR 46.110.

**Failure to comply with these conditions will result in withdrawal of this approval.**

Please note that the IRB has the authority to observe, or have a third party observe, the consent process or the research itself. The Federal-wide Assurance (FWA) number for the Rutgers University IRB is FWA00003913; this number may be requested on funding applications or by collaborators.

Respectfully yours,



Acting For--  
Beverly Tepper, Ph.D.  
Professor, Department of Food Science  
IRB Chair, Arts and Sciences Institutional Review Board  
Rutgers, The State University of New Jersey

cc: Monica Indart (MW:hb)

## Appendix J: Consent Form

### Attachment 4: Consent Form

You are invited to participate in a research study that is being conducted by Ashley Sutton, Psy.M., a doctoral candidate in the Graduate School of Applied and Professional Psychology at Rutgers University. The purpose of this research is to determine personal, training and supervision, and exposure-related factors associated with psychology trainees' vulnerability to indirect trauma.

This research is anonymous; no information will be recorded that could identify you. **In order to maintain anonymity, please refrain from mentioning yourself or your training program by name in free response sections.** There will be no linkage between your identity and your response in the research, meaning your name, address, phone number, date of birth, etc. will not be recorded. If you agree to take part in the study, there will be no way to link your responses back to you.

The research team and the Institutional Review Board at Rutgers University are the only parties that will be allowed to see the data, except as may be required by law. If a report of this study is published, or the results are presented at a professional conference, only group results will be stated. All study data will be kept for three years, after which it will be destroyed.

#### Risks:

The survey explores your experiences working with clients with trauma histories. The types of questions asked are consistent with those that you may face in the normal course of training, supervision, and self-reflection. However, recalling some experiences may be unpleasant for you and you may experience some discomfort when answering questions. If you experience emotional distress related to the study, please contact the researcher and discuss this with her, so that she can assist you and help provide you with referrals as necessary. You may additionally contact the Substance Abuse and Mental Health Services Administration National Helpline for free, confidential, 24/7 information and referral services at 1-800-662-HELP (4357).

#### Benefits:

Participation in this study may be beneficial in that it could increase self-awareness of personal, training and supervision, and exposure related factors that may influence vulnerability to indirect trauma. The debriefing may will provide you with psychoeducation about the forms of indirect trauma, suggestions for further reading, and referral resources.

Participation in this study is voluntary. You may choose not to participate, and you may withdraw at any time during the study procedures without any penalty to you. In addition, you may choose not to answer any questions with which you are not comfortable.

If you have any questions about the study or study procedures, you may contact myself at:

Ashley Sutton, Psy.M.  
Principal Investigator  
Rutgers University, GSAPP  
152 Frelinghuysen Road  
Piscataway, NJ 08854-8085

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Telephone: (732) 788-6145.  
Email: [ashley.sutton@rutgers.edu](mailto:ashley.sutton@rutgers.edu)

You can also contact my faculty advisor:  
Monica Indart, Psy.D.  
Faculty Advisor  
Rutgers University GSAPP  
152 Frelinghuysen Road  
Piscataway, NJ 08854-8085  
Telephone: (973) 762-6878.  
Email: [monica.indart@gmail.com](mailto:monica.indart@gmail.com)

If you have any questions about your rights as a research subject, please contact an IRB Administrator at the Rutgers University, Arts and Sciences IRB:

Institutional Review Board  
Rutgers University, the State University of New Jersey  
Liberty Plaza / Suite 3200  
335 George Street, 3<sup>rd</sup> Floor  
New Brunswick, NJ 08901  
Phone: 732-235-9806  
Email: [humansubjects@orsp.rutgers.edu](mailto:humansubjects@orsp.rutgers.edu)

Please retain a copy of this form for your records. By participating in the above stated procedures, then you agree to participation in this study.

If you are 18 years of age or older, understand the statements above, and will consent to participate in the study, click on the "I Agree" button to begin the survey/experiment. If not, please click on the "I Do Not Agree" button which you will exit this program.

I Agree

I Do Not Agree

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# Appendix K Advertisement for Recruitment



## Attachment 3: Advertisement for Recruitment Notice

Dear Training Director, faculty, and students,

My name is Ashley Sutton and I am a fourth year Psy.D. candidate in Clinical Psychology at Rutgers Graduate School of Applied and Professional Psychology. I am reaching out in the hope that you may be able to assist with my IRB-approved doctoral dissertation project, *Factors Affecting Psychology Trainees Vulnerability to Indirect Trauma*.

For this study I am seeking graduate students in clinical and counseling psychology doctoral programs in their fourth year and above, including students currently on internship. I would very much appreciate your assistance with the distribution of this email to graduate students at your program, including the subject title, text, and survey link.

If you have any further questions, please feel free to contact me at [ashley.sutton@rutgers.edu](mailto:ashley.sutton@rutgers.edu) or (732)-788-6145. You may also contact my research chair, Dr. Monica Indart, at [monica.indart@gmail.com](mailto:monica.indart@gmail.com).

Dear Potential Participants,

Hello, I hope this email finds you well! My name is Ashley Sutton and I am a fourth year Psy.D. candidate in Clinical Psychology at Rutgers Graduate School of Applied and Professional Psychology. I am in the process of collecting data for my doctoral dissertation project that investigates the impact of different personal, training and supervision, and exposure related factors on the experience of indirect trauma in psychology trainees. The study is an anonymous, online survey that will take about sixty minutes.

I am seeking clinical and counseling Psy.D. and Ph.D. students in their fourth year or higher, including students currently on internship. The aim of my study is to explore the impact of your experiences working with clients who have disclosed a history of trauma. Psychology doctoral students have been assessed very minimally in this regard, and I hope to shed light on the phenomenon of indirect trauma in this population.

I would greatly appreciate your participation in this study, as well as the distribution of this message to any other parties who may meet criteria. Please feel free to reach out with any questions you may have. Thank you for your time and your consideration!

Best,

Ashley Sutton, Psy.M.  
Clinical Psychology Doctoral Candidate  
Graduate School of Applied and Professional Psychology  
Rutgers, The State University of New Jersey

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## Appendix L Debriefing Statement



### Attachment 9: Debriefing Statement

Thank you for participating in our study. The survey assessed various personal, training and supervision, and exposure related factors as they relate to reactions of indirect trauma. Indirect trauma includes the separate but related constructs of secondary traumatic stress, vicarious traumatization, and compassion fatigue. Indirect trauma has been framed as a normal and common occupational hazard of working in a helping profession. The current body of literature on indirect trauma is limited by issues of conceptual clarity due to the equation of separate constructs. Further, psychotherapist trainee populations have been minimally investigated in this regard, and psychology trainees, that is, graduate students in clinical psychology programs, even less so.

Psychotherapists face more than just the typical work-related stress when treating individuals for trauma and post-traumatic stress; working with the details of a client's traumatic event may negatively impact the mental health of the therapist, as well. Therapist exposure to the details of a client's traumatic event, or "indirect trauma" may result in symptoms of PTSD, or "secondary traumatic stress" (Figley, 1995), negative changes in work-related behaviors, attitudes, and perceptions (Figley, 1995). "Secondary traumatic stress" refers to reactions of indirect trauma that mimic symptoms of PTSD. Figley (1995) conceptualized secondary traumatic stress as symptoms of avoidance, reexperiencing, and hyperarousal that stem from exposure to the details of the trauma of another person while in working in a professional role.

"Compassion fatigue" consists of both the standard symptoms of secondary traumatic stress that mimic those of PTSD and include changes in behaviors, attitudes, and perceptions that are often work-related (Figley, 1995). As a result, "compassion fatigue" is sometimes referred to as a construct that comprises the symptoms of both secondary traumatic stress and burnout. McCann and Pearlman (1990) framed "vicarious traumatization" as a process of disruptions to a person's sense of safety, control, trust, and/or intimacy. Vicarious traumatization stems from McCann and Pearlman's (1990) Constructivist Self-Development theory of trauma, which suggests that individuals construct their own realities via various schemas, or core beliefs, about the self, others, and world. The therapist's unique history and salient schemas determines his/her experience of and adaptation to indirect trauma. Such schemas affected by trauma often include topics such as safety/trust, power, independence, and intimacy (Pearlman & Saakvitne, 1995).

Psychotherapists in training are vulnerable to reactions to indirect trauma (Adams & Riggs, 2008; Baker, 2012; Beaumont, Hollins Martin, & Carson, 2016), even to degrees higher than those of their supervisors (Knight, 2010). A number of researchers in the field of indirect trauma have stressed the importance of adequate training in trauma psychotherapy, including education concerning the impact of indirect trauma (Adams & Riggs, 2008; Knight, 2013; Baker, 2012; Beaumont et al., 2016; Courtois & Gold, 2009). The goal of the present study is to shed light on the lived experiences of psychology trainees working with trauma clients and examine the relationships among a personal, training and supervision, and practice-related factors and indirect trauma.

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If your participation in this study has caused you distress and you wish to debrief by phone, please feel free to contact the researcher, Ashley Sutton, Psy.M., at (732) 788-6145, or the faculty advisor, Monica Indart, Psy.D., at (973) 762-6878. If you have interest in a referral for psychotherapy, you may additionally contact the Substance Abuse and Mental Health Services Administration National Helpline for free, confidential, 24/7 information and referral services at 1-800-662-HELP (4357), or online at <https://findtreatment.samhsa.gov/>.

### References and Further Reading

- Adams, S. A., & Riggs, S. A. (2008). An exploratory study of vicarious trauma among therapist trainees. *International Journal of Emergency Mental Health*, 10(1), 70-72. <http://doi.org/10.1037/19313918.2.1.26>
- Baker, A. (2012). Training the resilient psychotherapist: What graduate students need to know about vicarious traumatization. *Journal of Social, Behavioral, and Health Sciences*, 6(1), 1-12.
- Beaumont, E., Durkin, M., Hollins Martin, C. J., & Carson, J. (2016). Measuring relationships between self-compassion, compassion fatigue, burnout and well-being in student counsellors and student cognitive behavioural psychotherapists: A quantitative survey. *Counselling and Psychotherapy Research*, 16(1), 15-23.

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