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Vicarious Trauma and Its Influence on Self-Efficacy

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Abstract

Counselors work in a profession that requires they assist clients make meaning, reframe, re-story and/or cope with traumatic events. Such work and efforts with traumatized clients can, if left unchecked, result in the counselor entering a state termed “vicarious trauma.” This, in turn, may affect mental health professionals’ level of self-efficacy or perceived ability to counsel clients. A quantitative correlational design was utilized with mental health professionals ($n = 82$) to determine if the presence of vicarious trauma could impact their self-efficacy in working with traumatized clients. In this study, a multiple regressions suggested a statistically significant negative correlation, indicating that mental health professionals with higher levels of vicarious trauma had lower levels of self-efficacy.

Keywords: vicarious trauma, self-efficacy, trauma, mental health professionals, counseling

Introduction

Briere and Scott (2015) defined the traumatic experience as one in which an event causes extreme upset, temporarily overwhelms an individual’s resources to cope, and leads to long-term psychological symptoms. As McCann and Pearlman (1992) suggested, trauma is how an individual reacts to an event rather than the details of the event itself. As a result of assisting individuals who have experienced trauma and the exploration of emotional material, mental health professionals’ levels of self-efficacy or perceived ability to provide effective counseling may be altered due to changes to the professional’s cognitive schemas. These changes in schemas may influences skills, techniques, and interactions with the client during and outside of sessions.

The term *trauma* has several levels as it relates to the impact of clients’ stories on counselors (Pack, 2013; Tosone, Nuttman-Shwartz, & Stephens, 2012; Wang, Strosky, & Fletes, 2014). Terms such as secondary traumatic stress, compassion fatigue and vicarious trauma are often used to describe the impact counselors can experience from

differing degrees of exposure to traumatic events. A shift in the literature toward “shared trauma” has left vicarious trauma and its influence on self-efficacy unexplored. Therefore, the focus of this article will evaluate how levels of vicarious trauma and a high trauma caseload could influence a mental health professional’s level of self-efficacy in providing trauma counseling services.

Understanding and Differentiating Secondary Traumatic Stress From Vicarious Trauma and Shared Trauma

Post-traumatic stress consists of the development of symptoms following the exposure of a traumatic event (American Psychiatric Association [APA], 2013). Individuals who interact with those who experience post-traumatic stress may experience difficulties related to secondary traumatic stress and possibly vicarious trauma. The terms secondary traumatic stress, compassion fatigue, and vicarious trauma are often confused or used interchangeably. However, these terms are very different in the ways they affect an individual or in this case the mental health professional. In recent years, the topic of shared trauma has been added to this group of terms.

Secondary traumatic stress. Secondary traumatic stress is not necessarily specific to mental health professionals. It can, and sometimes does, affect those who merely have close contact with a trauma survivor and a desire to help (Bride, 2007). The term compassion fatigue is often connected to secondary traumatic stress and is viewed as the individual’s response to interacting specifically with trauma clients due to the conditions and experience associated with providing care (Bride, Radey, & Figley, 2007). Therefore, individuals who simply learn or hear about a traumatic event could experience the effects of secondary traumatic stress. Secondary traumatic stress focuses on the symptoms as seen through behaviors or emotions (Jenkins & Baird, 2002). In fact, symptoms of secondary traumatic stress often mirror those of post-traumatic stress disorder as defined by the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed., APA, 2013). Generally speaking, family members and close friends are privy to such information regarding the primary individual’s traumatic events and the associated details. Of significant importance, the effects of secondary traumatic stress can occur suddenly after hearing *only one* isolated account of the trauma experience and is not a cumulative response to professional stress (H. Bell, Kulkarni, & Dalton, 2003; Tosone et al., 2012).

Vicarious trauma. Vicarious trauma is more complicated than secondary traumatic stress in that it focuses on the theory of what is occurring within the context of trauma counseling (Tosone et al., 2012). Vicarious trauma is described as the counselors’ continuous emotional engagement with clients’ traumatic material that creates cognitive distortions and changes in core belief systems within the counselor (Pearlman & Mac Ian, 1995). Mental health professionals who continue to work with trauma clients are at increased risk for experiencing the effects of vicarious trauma as a result of the constant emotional engagement and continuous exposure to clients’ trauma material. Because core beliefs can be negatively altered, vicarious trauma can prove to have a long-term significant negative effect on the mental health professional’s ability to provide effective counseling services (C. H. Bell & Robinson, 2013; Tosone et al., 2012). Even though counselors may also be considered victims and under a considerable amount of stress, it

is the counselors' duty to protect their clients from further harm (American Counseling Association, 2014; C. H. Bell & Robinson, 2013).

In vicarious trauma, symptoms are more difficult to identify because they involve cognitive distortions and changes in core belief systems (H. Bell et al., 2003; Bober & Regehr, 2005; McCann & Pearlman, 1990; McCann & Pearlman, 1992). A useful view of symptoms is based on constructivist self-developmental theory (CSDT; McCann & Pearlman, 1990), which combines object relations theory, self-psychology, and social cognition theories (McCann & Pearlman, 1992; Pearlman & Saakvitne, 1995). According to CSDT, counselors' responses to trauma are characteristic of the situation and the mental health professional's unique psychological needs and cognitive schemas. Additionally, these responses are seen more as a coping mechanism for the counselor versus a true pathology.

In utilizing CSDT (McCann & Pearlman, 1990), mental health professionals who become self-aware of current effects of trauma can modify and alter specific aspects of the self. Aspects of the self that can be altered include: 1) frame of reference or the sense of the self and in an essence who one is; 2) self-capacities or the capacity to recognize, tolerate, integrate affect, and maintain a benevolent inner connection with the self and others; 3) ego resources or the ability to be self-aware and use cognitive and social skills to maintain relationships; 4) central psychological needs, which include trust, safety, control, esteem, and intimacy; and lastly, 5) perceptual and memory systems, which include individual adaptations and sensory experiences the mental health professional may utilize to avoid a clients' traumatic memories within their own personal memory system.

Shared trauma. Shared trauma is when a client and counselor experience the same trauma, which can enhance the likelihood of vicarious trauma and cause additional difficulties within the therapist relationship with the self and the client (C. H. Bell & Robinson, 2013). The literature suggests that the concept of shared trauma (C. H. Bell & Robinson, 2013; Tosone et al, 2012) is becoming more of a phenomenon in working with clients who have experienced traumatic events. As a result of the shared trauma, in addition to the effects of vicarious trauma, in such cases there is an increased risk of countertransference occurring within the counseling relationship (Baum, 2010; Saakvitne, 2002). Tosone, et al., (2012) suggested the outcome of treating a trauma client ultimately depends on the counselor's ability to work through their own trauma. It follows then that if a counselor avoids their own (trauma-related) triggers within the counseling session with the client, counseling effectiveness will be reduced because the client is not encouraged to process their trauma.

Self-Efficacy and the Counselor

Bandura (1993) defined self-efficacy as the belief in one's ability to perform a specific task. Successful performance of the specific behavior not only requires knowledge and skills but also the belief in the ability to perform the task (Bandura, 1986). Larson et al. (1992) and others (Lent et al., 2006) indicated that clinical supervision, supervisory feedback, and performance feedback increases counselor self-efficacy. According to Bandura and Locke (2003), beliefs regarding self-efficacy predict behavioral functioning between individuals at different levels of perceived self-efficacy in addition to changes in functioning over time. High levels of self-efficacy are especially

important in working with clients who have experienced trauma because of the likelihood of cognitive disturbances arising from the constant engagement with a client's trauma material. Additionally, Leach and Stoltenberg (1997) indicated that self-efficacy may be client specific in regards to previous clinical experience and knowledge about working with trauma clients.

Preparedness of Counselors

There is limited data on whether vicarious trauma is a consistent aspect of training in counselor education programs. Many researchers suggest that education on vicarious trauma is a key area for mental health professionals (Enns, Campbell, & Courtois, 1997; Neumann & Gamble, 1995; Pearlman & Mac Ian, 1995; Pearlman & Saakvitne, 1995). Hesse (2002) amplified this belief by stressing the importance of raising awareness about how working with trauma clients can affect mental health professionals. A review of literature and graduate programs indicated very few programs specifically educate students in the area of trauma. Because the estimated crime rate is currently 20.1 victimizations per 1,000 in the United States for residents 12 years of age or older (Truman & Langton, 2015) and there is high likelihood of mental health professionals treating trauma clients, it is now even more imperative that trauma coursework be included within graduate programs.

Pearlman and Saakvitne (1995) argued that counselor educators and supervisors, along with graduate programs, have a responsibility to educate future counselors about vicarious trauma, which is often inevitable with trauma work. Additionally, they encouraged the validation of counselors who experience these difficulties by promoting an open and frank discussion of the effects vicarious trauma has on mental health professionals. Gere, Dass-Brailsford, and Hoshmand (2009) noted that the vast majority of trauma training appears most prevalently in the form of post-graduate clinical settings and through continuing education workshops.

Counselors and counselor education programs should be cognizant of the value and importance of attending to the potential risks inherent in working with traumatized clients. The following study resulted from the identified gap in the literature related to vicarious trauma and self-efficacy.

Methods

After receiving approval from the Texas A&M University-Commerce Institutional Review Board (IRB) in 2011, numerous community agencies, mental health hospitals, and organizations that provide mental health services in the Southern region of the United States were contacted to participate. These settings were specifically sought out because of the large likelihood they would be in contact with high numbers of trauma clients. At the time of initial contact, community agencies, mental health hospitals, and other organizations were informed that mental health professionals would be asked to take an online survey indicating demographic information (gender, license, years of experience, percentage of trauma clients, perceived preparedness, etc.) and how working with trauma clients affects them personally and professionally.

Participants

Participants included 102 mental health professionals who currently worked with trauma clients; however, the final sample size was reduced to 82 because of 20 incomplete surveys. Professionals who qualified for participation had at least a master's degree and were licensed as a mental health professional. Licenses held by participants included Licensed Professional Counselor Intern (n = 8), Licensed Professional Counselor (n = 39), Licensed Master Social Worker (n = 11), Licensed Clinical Social Worker (n=15), Licensed Marriage and Family Therapist (n = 7), and psychologist (n = 2). The female to male ratio of mental health professionals was 81.7% (n=67) to 18.3% (n = 15), respectively. Approximately 78% (n = 64) of the mental health professionals identified themselves as Caucasian, with 4.9% (n = 4) Hispanic, 2.4% (n = 2) Latino, 9.8% (n = 8) African American, 1.2% (n = 1) Persian, 1.2% (n = 1) Native American, and 2.4% (n = 2) as other ethnic status.

Participants indicated years of clinical experience, percentage of trauma clients they were currently working with, and perceived preparedness via graduate training. The majority of the participants indicated less than 16 years of experience with 1 to 3 years (n = 29), and 4 to 15 years (n = 41). In addition, 62% (n = 51) of mental health professionals reported their caseload consisted of 60% or more of trauma clients. Of the participants, almost 32% (n = 22) noted the caseload of 30 to 59% of trauma clients, while only 6% (n = 5) of participants indicated working with less than 30% of trauma clients.

Measures

The Trauma Attachment and Belief Scale (TABS; Pearlman, 2003) and the Counselor Self-Estimate Inventory (COSE; Larson et al., 1992) were used for this study. Prior to the use of both measurements, permission for use was granted by the authors and/or publishers of the instruments.

Trauma and Attachment Belief Scale. The Trauma and Attachment Belief Scale (TABS) is based on CSDT and measures disruptions in cognitive schemas and beliefs sensitive to the effects of trauma (Pearlman, 2003). The TABS consists of 84 items and has scales measuring (a) self-safety, (b) other-safety, (c) self-trust, (d) other-trust, (e) self-esteem, (f) other-esteem, (g) self-intimacy, (h) other-intimacy, (i) self-control, and (j) other-control. An acceptable Cronbach's alpha of .60 to .87 on subscales and an overall .96 is reported for the total TABS score (Aidman & Garro, 2005; Pearlman, 2003).

Content, convergent, and criterion validity was established by Pearlman (2003). Trauma survivors' statements were utilized to establish content validity and criterion validity was determined by examining differences in TABS scores by known groups; convergent validity was proven by comparing the TABS to the Maslach Burnout Inventory. Pearlman also indicated earlier versions of the TABS have shown to predict levels of vicarious trauma in counselors. Additionally, Briere and Spinazzola (2005) commented that the TABS is unique in that it predicts the self in relation to interactions and relationships with others. Factorial validity was established through the use of a non-clinical sample that yielded theoretical support and trauma histories yielding higher scores on the TABS (Pearlman, 2003).

Counseling Self-Estimate Inventory. The Counseling Self-Estimate Inventory (COSE) is proposed to be the most adequate and most often used instrument to measure counselor self-efficacy (Larson & Daniels, 1998). It is comprised of 37 items and is based

on five factors. Factors include (a) microskills, (b) attending to the counseling process, (c) dealing with difficult client behaviors, (d) behaving in a culturally competent manner, and (e) being aware of one's own cultural values. Cronbach's alpha on the subscales is acceptable, with values ranging from .62 to .88 and .93 overall (Larson et al., 1992). Larson et al. (1992) indicated that convergent and criterion validity was determined as a result of the total scores correlating with measures of problem-solving behavior, state and trait anxiety, satisfaction with practicum performance, outcome expectations in a mock interview, and observer-rated counseling performance.

Procedure

After determining interested organizations, hospitals, and community agencies, potential participants were e-mailed a description of the study and a link to the online survey via surveymonkey.com. Informed consent was obtained prior to participation, which included notification that participation was voluntary and they could drop out at any time. Participants were asked to complete a demographic section, which included professional credential(s), years of experience, and perceived preparedness via graduate program, the Trauma Attachment and Belief Scale, and the Counselor Self-Estimate Inventory. Of the 102 surveys that were returned, only the 82 completed surveys were included in data analysis. SPSS Statistics V22.0 was utilized to analyze demographic questions, total TABS scores, and total COSE scores.

Results

Multiple regression analysis was used to examine the extent to which vicarious trauma, percentage of trauma clients, and years of experience were related to self-efficacy. Self-efficacy was defined as the total score on the COSE, and vicarious trauma was defined as the total score on the TABS.

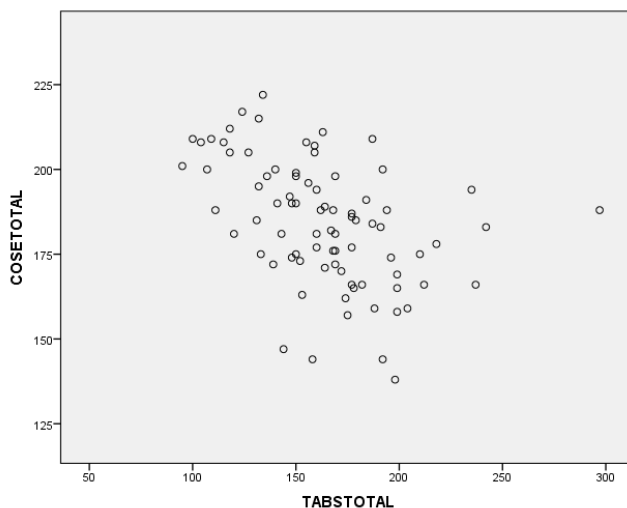


Figure 1. The relationship between vicarious trauma and counselor self-efficacy.

Counselor self-efficacy scores and standardized residuals were normally distributed ($SW(82) = .986, p = .515$). Scatterplots were analyzed and no curvilinear relationships between the criterion variable and predictor variables or heteroscedascity

were evident. There was a statistically significant relationship between counselor self-efficacy, vicarious trauma, percentage of trauma clients, and years of experience ($F(3, 78), = 7.307, p = .000$). A moderate effect size was noted with approximately 22% of the variance accounted for in the model ($R^2 = .219$). The only statistically significant predictor of self-efficacy was vicarious trauma ($r = -.488, p = .000$). This relationship is illustrated in Figure 1. Neither the percentage of trauma clients ($r = -.095, p = .198$) nor years of experience ($r = .115, p = .151$) affected self-efficacy. While not anticipated, the data also revealed there was a statistically significant relationship between the percentage of trauma clients and vicarious trauma ($r = .261, p = .009$).

A descriptive analysis was utilized to determine mental health professionals' perceived preparedness via graduate training. Of the participants, almost two-thirds ($n = 51$) indicated they were not prepared to work with trauma clients by their graduate programs. Table 1 depicts the percentage of trauma clients and the participants' beliefs related to preparedness for trauma counseling.

Table 1.

Preparedness Based on Percentage of Trauma Clients

Variable	Prepared	Not Prepared	N
Less than 30%	1	4	5
30% to 59%	12	14	26
60% or more	18	33	51
Total	31	51	82

Discussion

This study examined the relationship between vicarious trauma and self-efficacy among mental health professionals who work with trauma clients. More specifically, it evaluated whether vicarious trauma can affect a mental health professional's level of self-efficacy. Mental health professionals who participated in this study were separated by years of counseling experience and percentage of trauma clients. These categories were later utilized to evaluate mental health professionals' levels of self-efficacy with respect to the level of vicarious traumatization.

Findings suggested that mental health professionals with higher levels of vicarious trauma are more likely to have lower levels of self-efficacy. It was noted that 20% of the variance was accounted for in this model and as levels of vicarious trauma increased, levels of self-efficacy decreased. Thus, it could be suggested that self-efficacy may be influenced not only by the level of vicarious trauma, but also by other factors. This finding suggests further support for CSDT (McCann & Pearlman, 1992) and Pack's (2013) findings in that vicarious trauma impacts counselors in different ways based on variables such as past experiences, training and education, personality, and existing self-care strategies. As C. H. Bell and Robinson (2013) indicated, it should not be assumed that mental health professionals are emotionally prepared to work with trauma clients because they know "how to" work with them.

In evaluating the data further, it was found that while the level of vicarious trauma had an effect on the mental health professionals level of self-efficacy, the percentage of trauma clients was not a significant predictor. However, upon further investigation, it was discovered that the percentage of trauma clients did influence higher scores for vicarious trauma.

Mental health professionals who had a caseload of 60% or more of trauma clients had the lowest levels of self-efficacy despite their years of experience. Thus, in working with trauma clients, a high caseload could increase risk for developing vicarious trauma, which in turn could influence self-efficacy. As Thompson, Amatea, and Thompson (2014) suggested, only examining mental health professionals' years of experience may be an imprecise method of evaluation; therefore, the specific types of clients and work responsibilities should also be taken into account. With this in mind, professionals who have higher levels of vicarious trauma may bring negative effects to the counseling relationship as a result of lower levels of self-efficacy.

It is important to discuss the perceived preparedness of mental health professionals due to Enns et al. (1997) and others' (Neumann & Gamble, 1995; Pearlman & Mac Ian, 1995; Pearlman & Saakvitne, 1995) suggestion that training and education may also influence self-efficacy and vicarious trauma. Overall, 62% of the mental health professionals surveyed indicated they were not prepared by their graduate institutions to do this type of work, however it is unknown as to what they felt was lacking in their training. While graduate institutions do have the responsibility of providing general knowledge regarding counseling skills, application, and its uses, additional education efforts should focus on the 80% of other factors which influence self-efficacy but were not accounted for in the findings.

Implications for Ethical Practice

In working with counselors of traumatized clients, counselor educators and counselor supervisors should be aware of the emotional risks that may be involved. To explore the implications that working with trauma clients has on the field of counseling, suggestions for counselor educators and supervisors, along with the individual trauma counselor, are provided.

For counselor educators and supervisors. Education and building a trauma counselor's level of self-efficacy is significantly impacted in the classroom during graduate studies. C. H. Bell and Robinson (2013) and Acker (2010) noted that counselor educators need to ensure that beginning mental health professionals are equipped to handle real life working conditions. This knowledge not only includes learning the necessary counseling skills but also the attitudes and clinical aspects required to work with trauma clients. Additionally, counselor educators and graduate programs should systematically integrate knowledge of vicarious trauma and how working with large numbers of trauma clients could potentially impact counselor self-efficacy and possibly the ability to provide effective counseling services. Because vicarious trauma can alter cognitive schemas, which in turn could lead to the use of ineffective counseling practices, educating current and future counselors about self-care and counselor well-being is of utmost importance in assisting counselors in normalizing their experiences (Pack, 2013). It is suggested that counselor educators begin preparing counselors in training at the beginning of their graduate program on not only vicarious trauma and self-efficacy but on

topics which could have various influences. These topics include that of self-care, the regular use of personal counseling, working through the trainees' own difficulties and trauma material, methods of increasing personal self-awareness, incorporating openness and mindfulness, advocating for the self, and most importantly, encouraging students to find their own individual way of effectively coping with stressful situations.

Furthermore, this study indicates the importance for counselor educators and supervisors to help counselor trainees become aware of how the desire (or perceived need) to assist large numbers of trauma clients could hold not only negative consequences for the counselor but also for the client. While this study revealed 20% of self-efficacy is accounted for due to vicarious trauma, it is undetermined what the other factors are specifically.

For the trauma counselor. Pearlman and Saakkvitne (1995) suggested that being self-aware and looking out for one's own personal needs should be viewed as a primary method of maintaining levels of self-efficacy both personally and professionally. Ethically speaking, it is imperative that mental health professionals assess whether they are capable of treating clients (C. H. Bell & Robinson, 2013). The American Counseling Association's *Code of Ethics* (2014) acknowledges this importance, as unaware counselors may be putting their clients at risk for harm or further victimization. Additionally, mental health professionals should remember that when vicarious trauma occurs, cognitive schemes are modified; thus, a counselor may not be able to make clear judgments in regard to potential ethical dilemmas and gray areas. Such ethical dilemmas include that of self-disclosure, issues of countertransference, client-counselor boundaries, confidentiality, treatment plans and decisions, forcing personal values and belief systems on clients, the use of ineffective counseling tools or modalities, etc. (C. H. Bell & Robinson, 2013; Enns et al., 1997). As the process of developing vicarious trauma suggests, gradual changes in a mental health professional's cognitive schemas could serve as a warning for the counselor. If attended to, recognition of the warning signs may allow the counselor to identify when their own treatment is needed to address deficits. Of course, failure to address personal issues on the part of the counselor can allow such baggage to eventually emerge in the counseling sessions with clients.

Mental health professionals who work in an agency setting may be faced with dilemmas involving pressures to see more and more trauma clients. Because the findings of this study suggest a significant relationship between percentage of trauma clients and levels of vicarious trauma, in situations such as these it is vital that self-care efforts occur more frequently and that a supportive counselor supervisor or administrator is present. While burnout was not addressed in this study, previous research suggests mental health professionals who have more years of experience in the field are less prone to burnout (Thompson et al., 2014), this trend does not hold true for vicarious trauma. As the findings suggest, the years of experience in the field is not a significant predictor in regard to vicarious trauma, but rather, what really matters is the number of trauma clients a mental health professional counsels. Because lower self-efficacy levels are more prevalent in mental health professionals with higher levels of vicarious trauma, which in turn is related to having a higher percentage trauma clients, supervisors and administrators should be aware of these risks and work to assist the counselor in monitoring/balancing their caseload. While not addressed in the study, this balance in caseload in the beginning stages of work in the mental health field or specific setting can

also act as an initial organizational intervention to protect individuals from the first stage of burnout as well (Acker, 2010; Morse, Salyers, Rollins, Monroe-DeVita, & Pfahler, 2012).

Limitations

Because the sample is relatively small in comparison with the number of the mental health professionals who work with trauma and mainly consists of licensed professional counselors, this study should be replicated and expanded to demonstrate reliability of answers. Furthermore, as a result of the underrepresentation of specific other types of mental health professionals, an adequate comparison between levels of training could not be conducted.

The retrospective information gained regarding the effectiveness of the participants' training may be inaccurate as a result of additional experiences gained post-graduation through continuing education efforts. Additionally, because a mental health professional's cognitive processes may have been altered as a result of vicarious trauma, participant's perceptions of training may not be completely accurate.

Conclusions

There appears to be a strong relationship between vicarious trauma and the self-efficacy of mental health professionals who work with traumatized clients. Even though there was not a statistically significant relationship between trauma caseload and self-efficacy, there may be an indirect relationship between the level of vicarious trauma and trauma caseload. Mental health professionals, counselor educators, and employers of mental health professionals should be aware that years of clinical experience *does not* have an influence on the counselors' levels of self-efficacy, but in fact the levels of vicarious trauma has a significant influence. Thus, supervisors should utilize caution when establishing or building upon counselor caseloads due to the increased risks of high levels of vicarious trauma and encourage continuous self-care practices. Because vicarious trauma creates cognitive distortions and changes in core belief systems within the counselor (Pearlman & Mac Ian, 1995), counselors need to be cognizant of the risk working with large numbers of trauma clients carries. Counselor educators and mental health professionals should remember it is the provider's and supervisor's responsibility to ensure that trauma clients are receiving competent treatment. As this study suggests, it is also their responsibility to monitor the caseload and amount of exposure a trauma mental health professional receives in an effort to ensure that effective services are provided. Counselor educators should be mindful that graduate training has a significant influence on levels of preparedness by teaching the "how to" of working with clients and has the potential to assist future counselors in learning "how to" effectively cope with trauma material that clients present.

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Note: This paper is part of the annual VISTAS project sponsored by the American Counseling Association. Find more information on the project at: <http://www.counseling.org/knowledge-center/vistas>