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Vicarious Traumatization: A Guide to Recognizing, Responding to, and Preventing a Serious Consequence of Providing Mental Health Care in Jails, Prisons, and Community Corrections

by Maria Masotta*

Abstract

Clinical staff, correctional officers, administrators, and medical personnel working in correctional mental health settings are at heightened risk for vicarious, or secondary, traumatization. Empathic engagement with inmates' traumatization can threaten one's sense of safety, hope, integrity, competence and purpose. Neither uniforms nor professional degrees provide insulation from this syndrome. Vicarious traumatization is under-recognized. It may result from a one-time encounter with an inmate or a cumulative exposure to inmates' traumas over years of working in correctional facilities. It is more likely to occur and persist when staff work in demanding, high-stress environments and when staff are routinely re-exposed to triggers that may resemble the primary trauma. Jails and prisons are just such environments. Limited resources; physical plant challenges; crowding; the responsibility to maintain safety and security in the face of continuous risks to staff and inmates; and exposure to violent inmate behaviors are among the stressors. Indeed, jails and prisons raise the risk for staff to be affected by both primary and secondary traumatization. Recognizing and addressing signs of vicarious traumatization is key to maintaining professional boundaries and effective treatment with inmates; to providing colleagues with appropriate support to minimize burn-out; and to extending the longevity of a career to which many staff are passionately committed. Prevention and intervention tools to reduce the impact of vicarious traumatization in our workforce are presented and discussed.

Key Words: Trauma, vicarious traumatization, primary and secondary traumatization, clinicians, prisons, jails, caseloads, supervision, training

Providing clinical care in jails, prisons, community corrections, and other criminal justice settings is challenging. At the beginning of each work day, all employees, regardless of discipline, leave their personal cell phones in the car or a locker; each person and what little property one is approved to bring in to the facility are searched. In some facilities, employees are not allowed to bring in food or water. Astute staff will leave their personal identities at the door. They refrain from displaying pictures on desks or in their offices. They do not discuss hobbies, weekend activities, friends, families, likes or dislikes in public areas. They keep the personal private to avoid having an inmate learn something revealing.

Working in correctional environments comes with risks. There's the obvious threat of physical harm from workplace assaults or exposure to infectious disease. There's the frequent physical and emotional discomfort of working in such an environment. And then there's the less obvious, insidious risk that the

*Maria Masotta, PsyD., is a Senior Clinical Operations Specialist with MHM 1593 Spring Hill Rd,, Suite 600, Vienna, VA 22182, (774) 277-2591, (e-mail) mmasotta@mhm-services.com. The author thanks her MHM colleagues Jane Haddad, PsyD, Vice President, Clinical Operations; Sharen Barboza, PhD, Director of Clinical Operations; and John Wilson, PhD, Senior Clinical Operations Specialist, for their insights in the preparation of this article.

clinical work will negatively impact who one is. This destructive force can erode one's view of the world, of other people, and of oneself. It can infiltrate one's identity, personal relationships, core values and sense of efficacy.

These challenges are unavoidable and therefore critical to understand. Despite and in some cases because of them, professionals continue to provide clinical services in multiple correctional environments. For many, the decision to pursue correctional mental health was a calling. For others, it was an interesting opportunity worth exploring. But for all, it can be challenging, interesting, rewarding work—work that can only be sustained by a professional passion and dedication in the face of adversity and competing demands.

Before reading further, take a minute and answer the following:

How often do you dream about work, lose sleep over work or have difficulty falling or staying asleep, or have what a colleague calls "work-mares"?

Ever been faced with memories of an inmate's conversation or something you observed at work?

Ever been shaken by something you just can't seem to shake?

Ever felt really traumatized?

Do you find that you lock doors more than you used to?

How has your employment in a correctional environment or criminal justice system changed the way you do things after hearing about something that an inmate experienced or hearing about their crime?

What is trauma?

To fully grasp the concept of vicarious traumatization, we must briefly review the concept of trauma. Trauma can occur when an individual has either "experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others" and "the person's response involved intense fear, helplessness, or horror." (APA, 2000, p. 467) Events such as experiencing or witnessing emotional, physical or sexual abuse or assault, an extremely painful or frightening medical procedure, catastrophic injuries or illnesses, having been mugged, domestic violence, burglary and combat can be traumatic.

Let's connect this to working in the correctional environment: Have you ever learned about an unexpected inmate or peer death at work via suicide or following an assault? (Examples can include correctional officer suicide, inmate suicide, and inmate-on-inmate murder.) Have you ever heard about an inmate or colleague being seriously harmed in the criminal justice system? (This can include an inmate assault on staff or inmate-on-inmate assaults using weapons necessitating urgent medical care.) Have your family members or colleagues ever been threatened by an inmate? Have you ever listened to an inmate disclose traumatic experiences or report on details of a traumatic crime?

Trauma History among Inmates

Histories of trauma, and often multiple traumas, are pervasive among inmate populations. Based on a sample of over 7500 male and female inmates, Wolf and Shi (2009) found that inmates have experienced high incidences of trauma. For male inmates, a history physical abuse ranged between 43% and 66%; a history of sexual abuse ranged between 7% and 26%; and emotional abuse ranged between 35% and 53%. For female inmates, a history physical abuse ranged between 38% and 77%; a history of sexual abuse ranged between 31% and 65%; and emotional abuse ranged between 36% and 59%.

Traumatization and Vicarious Traumatization

Healthcare clinicians working in the criminal justice system can be exposed to trauma either directly or vicariously. Direct exposure includes witnessing a use of force, witnessing or responding to self-injurious or suicidal behaviors, and being threatened or assaulted. Vicarious exposure to trauma can occur when hearing details of violent crimes, learning of inmates' trauma in the community or prison and witnessing an inmate re-live or re-enact a trauma. Clinicians may experience horror, terror or revulsion in reaction to these aversive experiences. These emotions can lead to intense and potentially chronic stress reactions, including chronic anger. Similarly, facing antisocial behavior on a daily basis can lead

to distrust and hardened anger which may then grow into contempt or disengagement.

Vicarious Traumatization (VT) was first identified by McCann and Pearlman (1990) and was later expanded on by Pearlman and Mac Ian as "the transformation that occurs within the therapist (or other trauma worker) as a result of empathic engagement with the clients' trauma experiences and their sequelae." (Pearlman and Mac Ian, 1995, p. 558). Conditions that can give rise to VT include, "listening to graphic descriptions of horrific events, bearing witness to people's cruelty to one another, and witnessing and participating in traumatic re-enactments," (Pearlman and Mac Ian, 1995, p. 558). In correctional healthcare clinicians, VT can result in the alteration of one's views of themselves, the world and others (Pearlman and Mac Ian, 1995). This can occur after hearing an inmate's disclosure of traumatic events, regardless of whether these events occurred prior to incarceration or during their current incarceration. This can also occur after the clinician witnesses an inmate assault or a forced move.

Direct and vicarious traumatization are conceptually overlapping processes. According to the DSM-IV, direct traumatization includes not only threats or actual injury to oneself, but also exposure to threats or actual injury to others. Vicarious traumatization may include hearing about trauma that occurred to third parties in the past, bearing witness to the impact of that trauma in the present, or witnessing traumatic events that are occurring to others. How direct or indirect the traumatization is depends, at least in part, on how familiar the staff member is with the trauma victim. Because treatment requires empathic engagement and empathic engagement can lead to identification with a victim, VT may be indistinguishable from direct traumatization. How much is direct and how much is vicarious can largely be a matter of perspective. It should be no surprise that the signs and symptoms of VT are similar to those of Posttraumatic Stress Disorder.

Mental health personnel, whether they be psychiatrists, psychologists, masters or bachelor level clinicians, are all likely to experience vicarious exposure at some point during their career. Some healthcare providers may be exposed to any one of these experiences or any variety of them several times a day. VT can also result in disruptions in spirituality and one's ability to tolerate strong emotions (Neumann and Gamble, 1995) as well as disruptions to our schemas (cognitive frameworks or mental representations) about safety, trust, intimacy, and control (McCann and Pearlman, 1990). Pearlman and Mac Ian (1995) suggest that VT can occur after years of chronic exposure. The cumulative nature of the work can lead to PTSD-like symptoms that persist for months or years after providing trauma treatment (McCann and Pearlman, 1990). Given the intensity of correctional environments, the authors also suggest that VT can develop after one incident. Not surprisingly, "Secure and prison settings were consistently related to higher level of distress." (Moulden and Fireston, 2007, p. 78)

VT does not develop for every clinician who treats trauma survivor clients (Moulden and Firestone, 2007). For example, some clinical staff working with a client with a sexual trauma history may not be impacted at all, while another clinician with a similar client may experience symptoms indicative of PTSD. These symptoms may include intrusive memories of the client's disclosures; avoidance of films that show explicit sexual violence; and hypervigilance, such as checking that doors are locked (Sommer, 2008). Clinicians who provide treatment to sexual offenders may experience symptoms consistent with VT such as, "intrusion, avoidance, and hyperarousal." More specifically, they may experience "intrusive thoughts, avoidance behaviors (e.g. alcohol abuse), suspiciousness or self and others, hypervigilance, and various psychological correlates (e.g., depression, anxiety, and irritability/frustration." (Moulden and Firestone, 2007, p. 68)

Consider a colleague's response when asked how working in the criminal justice system impacted him: "Since working with this population, I am hypervigilant (bordering on paranoid) about protecting my personal/family identity. I don't use social networking sites, my home address and phone numbers are unlisted. I try to make it very difficult for people to track me down online."

Another colleague reported,

> I have a few things that I notice affect me. The first being not trusting of any strangers initially or thinking that everyone has an ulterior motive when meeting me which involves taking advantage of me somehow. Second, I sometimes forget that criminal behavior is not normal and that most people don't do things that inmates have done.

> I find myself, at times, surprised when people actually hold their tempers in situations or haven't been to jail at some point in their lives. I tend to forget that there are people who do use substances in safety without tearing apart their lives or hurting others. My work has made me more cynical about how much social programs actually help people. It sometimes feels like everyone abuses welfare, SSI [social security], or several other programs meant to help people. I know that this is not true, but working with so many people who do abuse the system wears on me.

These experiences exemplify the impact that working in the criminal justice system has on the clinicians' view of self, others and the world. Similar to how PTSD can be explained to a trauma survivor as the body's normal reaction to an abnormal, terrible experience, VT is a normal reaction to the stressful and sometimes traumatizing work of treating trauma survivors (McCann and Pearlman, 1990). Thus, VT is not a reflection of "pathology in the therapist, nor intentionally inflicted on the part of the survivor client." (Pearlman and Mac Ian, 1995, p. 558) It can best be conceptualized as an "occupational hazard for those who work with trauma survivors." (Pearlman and Mac Ian, 1995, p. 558) The authors opine that, given the high incidences of trauma in the inmate population, VT is without a doubt an occupational hazard of providing healthcare in the criminal justice system.

Focusing on clinical staff treating both sexual assault victims and offenders, Moulden and Firestone (2007) provide data on the presence of VT as an occupational hazard. More than 50% of clinicians providing treatment to either a sex offender or victim experience intrusive, avoidant and/or hyperarousal symptoms in the clinical range. Similar to the clinician's comments on hypervigilance above, 33% of clinicians providing sex offender treatment experience hypervigilance regarding safety. Specifically, they tend to report being mistrustful of others, particularly adults who have contact with children. This is highlighted by a colleague summarizing how similar professional work impacted her,

> I think the biggest impact for me was working with pedophiles and hearing about the sexualization of children. I found for a time that I found myself sexualizing children's behavior, and/or seeing sexuality in normal parenting behavior of others (e.g. seeing a dad carrying his daughter with his hand on her bottom and sexualizing that contact). I was bothered by the fact that my mind was going there, making healthy interactions and behaviors into something sexual. I lost my sense of the innocence of adult-child relationships. I was suspicious of school teachers and sports coaches; seeing them and wondering what their motives were for spending so much time with children. That piece remains; the removal of innocence about relationships. I think I've heard about every possible relationship having involved abuse or exploitation that nothing remains pure anymore. Every relationship is potentially abusive. I don't like thinking like that, but that's where I'm at.

In a sample of female clinicians, Schauben and Frazier (1995) found that the higher the number of trauma victims on the clinician's caseload, the more the clinicians reported PTSD symptoms and disturbances in their beliefs or schemas, and the more they self-identified as experiencing VT. Clinicians providing treatment to those impacted by trauma may experience PTSD symptoms themselves (McCann and Pearlman, 1990; Kassam-Adams (1994) as cited in Pearlman and Mac Ian, 1995).

Moulden and Firestone (2007) summarize the literature and find that that there are higher incidents of VT in clinical staff employed in secure settings, such as a prison or secure hospital unit, when compared to clinical staff working in outpatient or community units. Clinicians in secure settings experienced increased emotional exhaustion and increased depersonalization. Staff in secure settings also experienced decreased feelings of accomplishment. It was opined that elevated levels of VT could be the result of dangerousness of the environment and clientele, as well was the isolated work environment (Moulden and Firestone, 2007).

The impact of our relatively isolated, high risk environment is captured by a colleague's summary of her experience of VT:

> I was attending a training on VT and I felt overwhelmed, anxious, I wanted to leave the training. I just got really overwhelmed, uncomfortable, tearful. Sometimes after work I want to go home and stare at walls. Sometimes it's hard to interact with normal people and I get extremely irritable hearing about other people's work problems.

Note the clinician's use of the words "normal people" when referring to people who are not employed within the criminal justice system. The phrase captures the colleague's sense of alienation and separateness, and implies that those of us who work in the criminal justice system are not normal.

Protecting Clinicians

Sommer (2008) indicated that as protective factors increase, trauma symptoms decrease. Protective factors include professional experience, income and post-graduate training and supervision (Baird and Kracen, 2006). Similar to how firefighters protect themselves from the occupational hazard of getting burned when running into a burning building to put out a fire; correctional healthcare clinicians can and must protect themselves from the occupational hazards of providing treatment in criminal justice settings. There are a variety of strategies one can use:

1. Avoid professional isolation (McCann and Pearlman, 1990). This can be accomplished via the use of case conferences for high risk cases/decisions, regular multi-disciplinary team meetings for decision making and support and debriefing with colleagues after a particularly difficult interaction with an inmate.

2. Form or participate in a support group, with the focus being on normalizing the helpers' experience and providing a safe haven for clinicians to talk without the fear of being judged (McCann and Pearlman, 1990).

3. Pursue holistic self-care (Harrison and Westwood, 2009), which includes physical, mental, emotional, spiritual, and aesthetic domains. Talk with colleagues, interviewees and supervisees about the importance of self-care, which can "never be emphasized enough." (Neumann and Gamble, 2009, p. 345) Display literature regarding self-care and lead by example. Support and encourage time off.

4. Maintain a supportive work environment (McCann and Pearlman, 1990). Respond to mistakes from novice clinicians in a "non-shaming manner" and teach and support novice clinicians to tolerate uncertainties of treatment (Neumann and Gamble, 2009, p. 345). Recognize staff's hard work. Clinicians can find support at workshops and on listservs (Moulden and Firestone, 2007).

5. Provide supervision (Pearlman and Mac Ian, 1995) regardless of licensure status. In addition to reviewing interventions/techniques, allow time to discuss personal feelings about or the impact of the work on the staff.

6. Learn about VT and share information with colleagues and supervisees.

7. Teach mindfulness (Harrison and Westwood, 2009) or relaxation skills to colleagues and supervisees. Encourage the use of relaxation skills (at the start of a meeting, before/after a supervisee talks about a challenging case).

8. Journal, whether for cathartic or inspirational purposes.

9. Encourage reflective reading and self awareness.

Recognizing VT

Just as a firefighter who is adequately prepared with enough gear and oxygen to run into a burning building can still get burned, correctional healthcare clinicians with several protective factors and few risk factors may still experience VT. Examples of signs and symptoms that are indicative of VT are behavioral changes in relation to interactions with an inmate or work responsibilities, intrusion of inmates' stories or imagery into clinician's life, burn-out, feeling overwhelmed, withdrawal from inmates or colleagues, impaired self-care, numbing, flooding, denial, PTSD symptoms, nausea, headaches, sleep disturbances, difficulty trusting others, feelings of horror, hypervigilance related to keeping self and loved ones safe, exhaustion, and sexual difficulties (McCann and Pearlman, 1990; Moulden and Firestone, 2007; Neuman and Gamble, 1995; and Sommer, 2008).

If a clinician experiences VT, re-visit the use of preventative strategies above. Additionally, increase supervision and/or encourage personal therapy depending on the nature of the distress. In supervision, discuss the use of health coping strategies, such as:

1. Balancing personal and professional lives (McCann and Pearlman, 1990). The infamous phrases, "Take time to smell the roses" and "All work and no play" refer to this ever-important philosophy.

2. Maintaining personal boundaries. In addition to maintaining healthy boundaries when interacting with clients, healthy boundaries include limiting work during evening and weekend hours (McCann and Pearlman, 1990).

3. Maintaining realistic expectations while in doing this type of work (McCann and Pearlman, 1990). Many who are attracted to this work are perfectionists working in an imperfect system with bottomless pits/wells/requests and a never-ending 'to-do' list. Support the clinician in reminding them that they are human and only capable of completing what is humanly possible without adverse affects on one's personal life, emotional and physical health, relationships and ultimately one's professional work.

4. Allowing the experience of emotional reactions (McCann and Pearlman, 1990). Again, clinicians are humans, not robots. If something is scary, allowing oneself to feel and express that emotion in privacy or in trustworthy company is necessary.

5. Seeking out non-victim related activities. If clinicians want to volunteer, they should avoid doing so in a domestic violence shelter where the exposure to trauma experiences prevails. Instead, they should consider repairing a hiking trail or working at an animal shelter.

6. Being aware of unresolved issues that may be impacted (McCann and Pearlman, 1990).

7. Maintaining a sense of humor.

As clinicians tell their clients, healthy coping strategies take time and are not a quick fix. Many times, when stressed individuals are drawn to unhealthy coping strategies, such as drugs, alcohol, denial and disengaging from friends, family, colleagues or enjoyable hobbies and activities. While these strategies provide immediate relief or numb the symptomatology, they can be associated with higher symptoms of VT (Schauben and Frazier, 1995) and have long term consequences. Conversely, those who used active coping, planning, sought emotional or instrumental support (talking with family friends or consulting with colleagues) and used humor experienced less VT (Schauben and Frazier, 1995).

This article began with a reference to the challenges of working in the criminal justice system that are faced on a daily basis because clinicians are passionate about the work. To maintain this passion, it is essential to maintain optimism and hopefulness about the clientele, colleagues and the system itself; often in the face of conflicting or contradictory information and experiences. Clinicians should identify and talk about the positive aspect of the work they do, with colleagues, families and friends. One of the most impressive things about working in corrections is the strength of the inmate population, despite, for many of them, a life of hardship, poverty and abuse. Recognizing and cherishing human resilience is powerful. When asked about the impact of working in corrections, a colleague eloquently reflected,

> I'd like to think that overall I've become a more sympathetic person having worked with this population twice in my lifetime. In working here you get to see the people behind the crime instead of just their crimes. It's hard for the people on the outside to be compassionate and understanding unless you work, like we do, with the inmates and see the tormented, tortured, wounded souls they are and a good many of them have never really known happiness since childhood. I find it very sad and it makes me grateful for what I've been blessed with
> despite my own hardships. Working here has also personally made me a stronger person all the way around, I think.

This perception reflects the view that "maintaining optimism and hopefulness in the face of tragedy is an essential component to making our work with victims possible." (McCann and Pearlman, 1990, pp. 146-147) Furthermore, it is recommended that practitioners "acknowledge and confirm the many positive experiences in our work as well as the positive impacts this has had on ourselves and our lives. It is important to remind ourselves and others that this work has enriched our lives in countless ways." (McCann and Pearlman, 1990. p. 147)

This article has covered a fair amount of what clinicians

as individuals can do either to minimize the likelihood of VT occurring or of ways to manage it, if it is experienced. There are also systemic response strategies that can be implemented when feasible:

1. Provide training in trauma therapy focusing on "a solid theoretical foundation that includes an understanding of the effect of psychological trauma, a relational perspective, and attention to countertransference and vicarious traumatization." (Pearlman and Mac Ian, 1995, p. 564) This training may be particularly apt for novice healthcare providers or those transitioning from community to correctional healthcare. This can be done during the orientation phase of employment and/or the employee can be encouraged to attend trainings in the community. Advocate for agency reimbursement for continuing education.

2. Use a trauma-informed treatment approach. It would be a mistake to conclude that since many of the inmates in the criminal justice system have a trauma history, taking the trauma into account during treatment could exacerbate their distress. While we want to avoid re-traumatizing the individual, ignoring the trauma eventually results in more distress for the inmate. Using a trauma-informed treatment approach takes the trauma into account while providing support and teaching the inmate healthy coping skills so he or she learn to manage symptoms. When the clinician structures the session to focus on skills, safety, and current functioning, the clinician can acknowledge the inmate's trauma history without being exposed to a vivid, graphic account of it.

3. Conduct supervision during regular business hours. This allows staff to obtain supervision from someone who understands the system as opposed to seeking outside supervision. It conveys that the employee is valued. Staff turnover tends to be high in correctional setting; providing supervision minimizes the potential for the clinician to leave correctional healthcare for employment in the community. When clinicians resign it creates a tremendous loss. Not only are resources depleted, but the resignation is taxing to the remaining staff who have to pick up more of the workload to cover the vacant position. Positions can remain vacant for extended periods and, even when rapidly filled, new clinicians must be oriented and trained before they can take on their own share of responsibilities.

4. Use case conferences (McCann and Pearlman, 1990). Focus on the case conceptualization and treatment needs as well as personal experiences. Specifically, discuss what the work means to the clinical staff and how staff respond to a client's painful trauma experiences.

5. Minimize dual relationships when feasible (Sommer, 2008). Some supervisees are hesitant to utilize and maximize the benefits of supervision when the site manager serves as the clinical supervisor due to concerns that discussing their insecurities, fears, or VT experiences could negatively impact evaluations of their performance. Discuss and process any concerns related to this dual supervisory relationship and change the clinical supervisor if feasible.

6. Balance the clinician's caseload (McCann and Pearlman, 1990). For example, a well balanced caseload includes clients with a variety of presenting issues such as: victims and non-victims and individuals with violent and non-violent offenses. Transfer cases that hit too close to home.

7. Support staff in using personal or vacation time.

8. Support the use of mental health care. Advocate for your employer to offer an EAP that maximizes confidentiality.

9. Provide opportunities for non-clinical work, such as presentations, research, administrative tasks (MCann and Pearlman, 1990).

10. Train supervisors and clinicians on VT. With knowledge comes power; once clinicians learn more about VT, they can learn how to protect themselves. If they experience VT they will be able to view it as a normal reaction or occupational hazard as opposed

to personal pathology. Additionally, when supervisors learn about VT they can learn to better support supervisees as well as recognize and respond to signs and symptoms.

When reviewing emergency procedures in the event of a crash landing, the flight attendant explains that passengers are not able to assist others if they do not put on their own oxygen mask first. Similarly, before treating our clients, supporting our colleagues, and supervising supervises, we must take care of ourselves. Self-awareness and self-care are as important as theoretical orientation and clinical techniques. So before running off to the next task on your list, take a minute and write down how you plan to sustain yourself and what you will do for self-care this week.

References

American Psychiatric Association. 2000. Diagnostic and statistical manual of mental disorders (4th Edition, Text Revision). Washington, DC: Author.

Baird, K. and Kracen, A.C. 2006. Vicarious traumatization and secondary traumatic stress: A research synthesis. Counseling Psychology Quarterly, (19)2, 181-188.

McCann, I.L. and Pearlman L.A. 1990. Vicarious traumitization: A framework understanding the psychological effects of working with victims. Journal of Traumatic Stress, 3, 131-149.

Harrison, R.L. and Westwood, M.J. 2009. Preventing vicarious traumatization of mental health therapists: Identifying protective factors. Psychotherapy Theory, Research, Practice, Training, 4 (2), 203-219.

Moulden, H.M. and Firestone, P. 2007. Vicarious traumatization: The impact on therapists who work with sexual offenders. Trauma, Violence, and Abuse, 8, 67-83.

Neumann, D.A. and Gamble, S.J. 2009. Issues in the professional development of psychotherapists: Countertransference, and vicarious traumatization in the new trauma therapist. Pyschotherapy, 32 (2), 341-347.

Pearlman L.A. and Mac Ian P.S. 1995. Vicarious traumatization: An empirical study of the effects of trauma work on trauma therapists: Professional Psychology: Research and Practice, 26, 558-565

Pearlman, L 1999. Self-care for trauma therapists: Ameliorating vicarious traumatization. In B.H. Stamm (Ed.), Secondary traumatic stress: Self-care issues for clinicians, researchers, and educators (2nd ed.). Lutherville, MD: Sidran Press, pp. 51-64.

Schauben LJ and Frazier P.A. 1995. Vicarious trauma: the effects on female counselors of working with sexual violence survivors. Psychology of Women Quarterly, 19, 49-64

Sommer, C.A. 2008. Vicarious traumatization, trauma-sensitive supervision and counselor preparation. Counselor Education and Supervision, 48, 61-71.

Wolff, N. and Shi, J. 2009. Victimisation and feelings of safety among male and female inmates with behavioural health problems. The Journal of Forensic Psychiatry and Psychology, 20, S56-S77.