# THE RELATIONSHIP BETWEEN THERAPIST DIFFERENTIATION OF SELF AND VICARIOUS TRAUMATIZATION

by

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*To my grandparents for saving my life,*
*and to Jeff, Sarah, Zachary, and Maximus*
*for making my life meaningful.*
*Dayenu.*

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Barbara J. Shaya

ABSTRACT

THE RELATIONSHIP BETWEEN THERAPIST DIFFERENTIATION OF SELF AND VICARIOUS TRAUMATIZATION

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The objective of this study was to explore the relationship between Bowen's Family Systems Theory (1978) concept of differentiation of self and therapist vicarious traumatization (Pearlman and Saakvitne, 1995). The results indicated a strong negative correlation between differentiation of self and vicarious traumatization. The more strongly differentiated the self of the therapist, the lower their level of vicarious traumatization. Due to the ubiquitous nature of trauma, it is expected that even therapists who consider themselves generalists will encounter detailed descriptions of their client's traumatic experiences. Not all therapists will respond to this exposure with the same level of intensity. This study explored several therapist factors and their potential impact on the relationship between differentiation of self and vicarious traumatization. A mediation analysis was conducted with therapist personal therapy history, work experience, trauma-specific training, and satisfaction with professional support. Each of these factors were found to have significant correlations to both differentiation of self and vicarious traumatization. However, none of these variables significantly influenced (mediated) the relationship between differentiation of self and vicarious traumatization. Therapist

personal history of trauma was examined as a potential moderating variable and the results found that while therapist personal trauma history is positively correlated with higher levels of vicarious traumatization, the level of personal trauma history did not moderate the relationship between differentiation of self and vicarious traumatization. Theoretical and practical implications are discussed, as well as implications for future research.

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**Vicarious Traumatization (VT):** Derived from Constructivist Self-Development Theory (McCann & Pearlman, 1990b; Pearlman & Saakvitne, 1995); describes the negative transformation of the way a therapist experiences self, others, and the world as the result of empathic engagement with, and the cumulative exposure to, the traumatic experiences of their clients

**Differentiation of Self (DOS):** Derived from Bowen Family Systems Theory (1978); refers to an individual's ability to maintain a sense of self and identity through a balance of emotions and intellect within intense or intimate relationships.

**Personal Trauma History (PTH):** The extent of the therapist's personal exposure to traumatic events both during childhood and in adulthood.

**Personal Therapy History (THPY):** The aggregate (estimated) number of years the therapist has spent in personal therapy.

**Work Experience (WE):** The number of years, post-licensure, of professional experience providing individual and/or group therapy directly to clients.

**Trauma-Specific Training (TT):** A measure of the extent of trauma-specific training received including graduate coursework, lectures, workshops, seminars and other continuing education received.

**Professional Support (SUPP):** A measure of the therapist's satisfaction with the quantity and quality of overall professional support including supervision, peer consultation, and availability of necessary resources.

# Chapter One

## Introduction

During the past several decades there has been increased awareness of the ubiquitous nature of trauma, which ranges from large-scale collective traumas (e.g., natural disasters, wars, and global pandemics), to intergenerational household dysfunction, to individual relational trauma (Benjet et al., 2015; Kilpatrick et al., 2013; SAMHSA, 2014). The negative impacts of traumatic experiences are well-researched, especially the traumatic experiences that occur during childhood developmental years (Anda et al., 2006; Benjet et al., 2015, Felitti et al., 1998; Finkelhor et al., 2013; Finkelhor et al., 2015; Turner & Lloyd, 1995). While not all individuals who have endured traumatic experiences develop a diagnosable disorder, such as posttraumatic stress disorder (PTSD), a variety of other physical and mental health issues may lead individuals who have experienced trauma to seek psychotherapy (Anda et al., 2006; Benjet et al., 2015; Kessler & Merikangas, 2004; Kilpatrick et al., 2003; Mosley-Johnson et al., 2018; Sledjeski et al., 2008).

As the fields of counseling, social work, psychology, and psychiatry have deepened their knowledge about the long-term effects of trauma, it has been increasingly recognized that even secondary exposure to traumatic experiences may lead to negative mental and physical health outcomes (Devilly et al., 2009; Figley, 1995; McCann & Pearlman, 1990b; Pearlman & Mac Ian, 1995; Pearlman & Saakvitne, 1995). In fact, the 5th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5, American Psychiatric Association, 2013) expanded the diagnostic criteria for PTSD to include both direct exposure to trauma and secondary exposure, including hearing the

details of another person's traumatic experiences through the course of one's professional duties.

Many professionals—such as firefighters, law enforcement, and frontline medical workers—endure repeated exposure to the traumatic experiences of others, which may result in secondary traumatic stress symptoms. However, mental health counselors, social workers, psychologists and psychiatrists (hereinafter collectively referred to as *therapists*) are unique in that they develop ongoing, therapeutic relationships with their clients through empathic engagement. Over time, repeatedly hearing the details of clients' traumatic experiences can take a psychological toll on therapists that may result in burnout, compassion fatigue (CF), secondary traumatic stress (STS) or vicarious traumatization (VT) (Branson, 2019; Figley, 1995; Gaboury & Kimber, 2022; McCann & Pearlman, 1990b; Pearlman & Saakvitne, 1995). This dissertation explores the factors that contribute to the development of VT in therapists who work with traumatized clients, especially in relation to therapists' differentiation of self and history of trauma.

## Personal and Professional Significance of the Study

"It is not unusual for personal experience or trauma to motivate the need for deeper knowledge" (Deblasio, 2022, p. 357). This statement explains my intrinsic motivation to live a life of personal reflection and healing, and my choice to use my experience and self-knowledge to help others achieve their own version of self-understanding and peace. My parents divorced in 1962 when I was an infant and my siblings were 2 and 3 years old. Neither of my parents were deemed fit to raise us by the Family Court system, and we were slated for foster care. Fortunately, my paternal grandparents stepped in, welcoming us into their home while legal custody remained with

the Court. Despite my grandparents' best efforts, they were unable to shield me from the effects of my parents' failures. Rife with mental illness, chronic alcoholism, verbal, emotional and physical abuse, life was chaotic and unpredictable. When I was 14, my father died a tragic death from alcoholism. By the time I graduated high school, I had also lost both great-grandparents (who spent every Sunday and holiday with us), a beloved aunt, and the grandfather who raised me. My siblings reacted to the instability in our lives by dropping out of high school, abusing alcohol and drugs, suicide attempts, and ultimately becoming estranged from the family. At 18 years old, I was raped by a man who an uncle offered me to as a gift. This led me to fulfill my family legacy by escaping into substance abuse. At age 21, I married my first college boyfriend who was also an alcoholic and was violent. When his violence turned toward me, I divorced him. I was 26 years old and knew I needed help. I wanted something different, something *more*, something healthy. I did not know what *healthy* was, only that I was not it. I was confused and curious, hypervigilant and distrusting, determined and driven. I embarked on a very long journey - that continues to this day - to understand myself, my family, and why people make the choices they do.

By the time I pursued a mid-life career change and entered the masters of counseling program at Oakland University, I had been on the client-side of the therapeutic relationship countless times with a variety of therapists. I had thoroughly explored my history, excavating the roots of my discontent. I was living a life of sobriety and recovery. I had remarried and given birth to three, now adult, children. It was time to give back, to make use of my history to help others. I have dedicated my professional counseling career to working with, and for, survivors of domestic violence, sexual

assault, and sexual abuse. More and more, my continuing education pursuits have focused on specialized advanced trauma-specific lectures, workshops, and courses. Pursuing a doctoral degree in counselor education was a logical next step as I strive to find spaces where I can contribute to the field of trauma psychotherapy, and more specifically, to educating and developing other trauma-informed professionals. One aspect of developing trauma-informed therapists is to impart the importance of self-knowledge, self-reflection, and self-care as critical to professional identity and longevity.

Dr. Richard Chefetz (personal communication, July 18, 2023), who hosts a weekly online consultation group for clinicians that specialize in complex trauma and dissociation, often states that no matter what, in the end the therapist must survive the treatment. He explains that therapists, especially newer ones, are susceptible to compromising their own well-being in an effort to meet the needs of their clients. This often has a major impact on the therapist's mental and physical health and reduces the therapist's ability to be effectively and empathically engaged with their clients. Therefore, the therapist must take care to manage their own well-being through reflective analysis of their self in relation to their clients, with a keen eye toward maintaining appropriate boundaries and processing countertransference and other emotional and psychological reactions with trusted colleagues and supervisors. An apt analogy is the familiar airline pre-take-off instruction to secure your own oxygen mask first before assisting others. The above adage is especially true for therapists who work with clients with histories of trauma. My study will contribute to the knowledge base about the factors that contribute to therapists' experience of trauma. The findings will hopefully

help therapists who work with traumatized clients to understand their reactions to their clients' trauma and to better manage their own sense of well-being.

## Background and Foundation for the Study

Trauma is shockingly prevalent, and exposure to trauma can have a substantial, life-altering impact. Benjet et al. (2015) conducted a global study and found that 70% of over 68,000 adults surveyed had experienced at least one traumatic event, with over 30% endorsing exposure to four or more traumatic events in their lifetime. Kilpatrick et al. (2013) conducted a similar study of 3,000 participants in the United States that resulted in over 90% of respondents endorsing at least one traumatic event in their lifetime and over 30% endorsing multiple traumatic events. It was found that the cumulative effect of repeated exposure to traumatic events negatively impacted both physical and mental health, especially when initial exposure occurs during childhood when one's sense of self is in development (Benjet et al., 2015; Felitti et al., 1998; Turner & Lloyd, 1995). The connection between traumatic experiences in childhood and their long-term impact on risk for disease, mortality, and consumption of healthcare resources in adulthood was investigated by Felitti et al. (1998). They found a significant correlation between the number of adverse childhood experiences (ACEs) and later health risk factors for the leading causes of death in adults. Later researchers both validated and expanded the Felitti et al., findings to include the impact of ACEs on increased likelihood of risky lifestyle behaviors and decreased psychological well-being and life satisfaction (Afifi et al., 2020; Anda et al., 2006; Felitti et al., 1998; Finkelhor et al., 2015; Karatekin & Hill, 2019; Mersky et al., 2021; Negriff, 2020).

It is reasonable, based on the above stated prevalence of exposure to traumatic experiences, to assume that even those clients who present for therapy for non-trauma related issues may eventually disclose a history of traumatic events as therapy progresses. With the publication of the DSM-5 (American Psychiatric Association, 2013), it is now accepted that secondary exposure to the details of traumatic events experienced by others may cause stress symptoms similar to those resulting from direct exposure to trauma. Therapists who work with traumatized clients are exposed to the details of their clients' traumatic experiences frequently. It is the confrontation, through client stories, with the depth of human cruelty that takes a toll on therapists. These therapists may experience a range of stress responses including burnout, compassion fatigue (CF), secondary traumatic stress, and vicarious traumatization (VT) (Devilley et al., 2009; Figley, 1995; Gaboury & Kimber, 2022; Pearlman & Saakvitne, 1995). The negative response to ongoing exposure to client trauma is considered both natural and expected for therapists who work with traumatized clients (Figley, 1995; Pearlman & Saakvitne, 1995). Further, it is the unique empathic nature of the ongoing therapeutic relationship that creates the risk for therapists to develop VT (McCann & Pearlman, 1990b; Pearlman & Mac Ian, 1995; Pearlman & Saakvitne, 1995).

The therapeutic relationship, and the role of empathy within the therapeutic relationships, has evolved since the days of Freud, when the therapist generally remained silent, to the contemporary dialogic encounter between therapist and client (Frie, 2000). Theorists such as Binswager, Satir, and Rogers have been influential in shifting the nature of the therapeutic dyad to a more relational, empathic engagement between therapist and client (Frie, 2000; Rogers, 1957; Rogers, 1975; Satir, 1987; Sleater &

Scheiner, 2019). Binswager believed that client growth and healing is dependent upon both therapist and client bringing their authentic selves to a reciprocal relationship where "personal boundaries are respected and individual difference is recognized" (Frie, 2000, p.123). Rogers' client-centered counseling approach was based on the therapist *being with* the client, bringing their authentic self to the therapeutic dyad with empathic understanding (Rogers, 1957). Satir (1987) highlighted the connection between the therapist's self-awareness and their ability to be empathically present with clients. Sleater and Scheiner (2019) researched the impact of therapist use of self within therapy sessions on the effectiveness of therapy. They found the most effective therapists are those who are deeply attuned to their own thoughts and feelings thus enabling them to empathically engage with the internal states of their clients. Therefore, it is evident that the self of the therapist plays an important role in psychotherapy. The therapist must know their self deeply, be fully present and empathically engaged with the client, be able to access their own internal states and distinguish between their self-states and the client states, and be open to hearing the details of their clients' lives and struggles. The impact on the therapist of this emotional labor is significant, particularly when the client is reporting their traumatic experiences.

In this regard, McCann and Pearlman (1990a, 1990b, 1992) developed the Constructivist Self-Development Theory (CSDT) as a means of conceptualizing the psychological impact of traumatic experiences on the development of self. They later extended CSDT to address the specific impact on therapists who work with traumatized populations, and described the negative psychological effects on the therapist as *vicarious traumatization* (VT). While the literature has shown much overlap in the use of the terms

burnout, CF, STS, VT and their meanings (Branson, 2019; Figley, 1995; Gaboury & Kimber, 2022; McCann & Pearlman, 1990b; Pearlman & Saakvitne, 1995), the term VT was conceptualized by Pearlman and Mac Ian (1995) as a distinct and separate construct from the others. VT describes the cumulative, pervasive, and likely permanent changes in a therapist's way of viewing the world and others as the result of continued exposure to the traumatic experiences of their clients (Pearlman & Mac Ian, 1995; McCann & Pearlman, 1990b; Pearlman & Saakvitne, 1995). Halevi and Idisis (2018) investigated the relationship between therapist VT and another developmental model: Murray Bowen's family systems theory (Bowen, 1978).

Bowen's theory is largely based on the concept of *differentiation of self* (DOS), which describes the ability to maintain a strong sense of self while engaging with others, especially within intimate and emotional relationships (Bowen, 1978; Titelman, 2014). Bowen proposed that DOS is developed during childhood within one's family of origin and that one's level of DOS remains relatively constant into adulthood. However, other researchers found that DOS can be strengthened through psychotherapy (Johnson et al., 2003; Messina et al., 2018).

Interestingly, Halevi and Idisis (2018) found that DOS was significantly negatively correlated with therapist level of VT. This finding makes theoretical sense. That is, the more differentiated the self of the therapist, the more likely the therapist will be able to maintain the psychological boundaries necessary to protect them from being vicariously traumatized by the client's report of their traumatic experiences. However, Halevi and Idisis (2018) did not include the impact of therapist personal trauma history or several other variables in their study that may have an impact on therapist level of VT. As

such, there is a need to know whether other, potentially relevant variables might mediate the relationship between DOS and VT.

Therefore, my study will investigate the relationship between DOS and therapist VT. However, my contribution to the literature is to investigate additional variables, which may mediate the relationship between DOS and therapist VT, that were not investigated by Halevi and Idisis (2018). These variables include the personal trauma history of the therapist and other factors, such as therapist personal history of therapy, work experience, trauma training and supervisory/peer support. My findings will contribute to a richer conceptual understanding of the relationship between DOS and therapist VT and also, hopefully, result in practical recommendations for therapists who work with clients that suffer from the impact of trauma.

Chapter three presents the research purpose and study design in detail. This study used a non-experimental, quantitative survey research design to address the following research questions:

1. What is the relationship between therapist *differentiation of self* (DOS) and *vicarious traumatization* (VT)?

2. Does therapist *personal therapy history* (THPY), *work experience* (WE), *trauma training* (TT) and/or *professional support* (SUPP) mediate the relationship between DOS and VT?

3. What is the relationship between therapist *personal trauma history* (PTH) and *vicarious traumatization* (VT)?

4. Does PTH moderate the relationship between DOS and VT?

5. Does PTH moderate the mediating effects that THPY, WE, TT, and/or SUPP have on the relationship between DOS and VT?

Data analysis was conducted using IBM SPSS version 27. I used a combination of bivariate correlation and multiple regression to examine the research questions and their related hypotheses as outlined in chapter three.

My goal is that the results from this study will add to the literature base regarding the aspects of a therapist's self and experiences that are associated with vicarious traumatization. As a result, I hope to provide recommendations for therapist education that creates awareness of vicarious traumatization and skills to offset the emotional labor of working with traumatized populations.

## Definition of Key Variables

**Vicarious Traumatization (VT):** Derived from Constructivist Self-Development Theory (McCann & Pearlman, 1990b; Pearlman & Saakvitne, 1995); describes the negative transformation of the way a therapist experiences self, others, and the world as the result of empathic engagement with, and the cumulative exposure to, the traumatic experiences of their clients

**Differentiation of Self (DOS):** Derived from Bowen Family Systems Theory (1978); refers to an individual's ability to maintain a sense of self and identity through a balance of emotions and intellect within intense or intimate relationships.

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**Professional Support (SUPP):** A measure of the therapist's satisfaction with the quantity and quality of overall professional support including supervision, peer consultation, and availability of necessary resources.

## Chapter Two

## Literature Review

A general population survey conducted across six continents, 24 countries and over 68,000 adult participants found that over 70% of respondents reported experiencing a traumatic event in their lifetime; over 30% of respondents experienced four or more traumatic events (Benjet et al., 2015). The Substance Abuse and Mental Health Services Association (SAMHSA) recognizes the public health issues that arise from the ubiquitous nature of trauma. In July, 2014 SAMHSA published guidelines for a working concept of trauma: "Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life-threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being" (p.7).

While not all therapists are expected to become specialists in trauma, it is reasonable to assume (based on the above statistics) that even therapists who work in generalized clinical settings will regularly encounter clients who have histories of trauma. Engaging in counseling with clients who have histories of trauma may have negative psychological consequences for counselors. Indeed, as evidence of the widespread recognition that traumatic stress symptoms can develop from exposure to traumatized individuals and not just from direct exposure to traumatic events, the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 2013), or DSM-5, has updated its criteria for Post-Traumatic Stress Disorder (PTSD) to include "experiencing repeated or extreme exposure to aversive details of the traumatic events" (p. 271).

Therefore, repeatedly bearing witness to the details of others' struggles and traumatic experiences undoubtedly takes a toll on therapists. There is a rich literature that explores the concepts of burnout (Devilly et al., 2009), compassion fatigue (CF; Figley, 1995), secondary traumatic stress (STS; Devilly et al., 2009; Figley, 1995), and vicarious trauma (VT; McCann & Pearlman, 2014; Pearlman & Mac Ian, 1995) related to therapists who work with traumatized populations. Figley (1995, pp. 15-16) cited several reasons therapists who work with traumatized clients on a regular basis are more susceptible to adverse reactions to trauma than other professionals who are also chronically exposed to trauma-inducing stressors, such as firefighters or medical personnel. Most importantly, therapists understand their clients' traumatic experiences through the empathic process. By emotionally putting themselves in the position of their clients through empathy, therapists run a greater risk of having an adverse reaction to trauma than professionals who do not rely on empathy when helping traumatized individuals (Pearlman & Mac Ian, 1995; Pearlman & Saakvitne, 1995).

Pearlman and Mac Ian (1995) elaborate on Figley's ideas using the term *vicarious traumatization* (VT) to describe changes experienced in a therapist's enduring ways of experiencing self, others, and the world due to the cumulative effects of helping clients over time. However, just as we know that not all individuals respond to traumatic experiences with the same intensity, not all therapists experience the stress of working with traumatized clients with equal disruption. One of the factors that has been shown to contribute to the variation in the reaction of therapists who have been exposed to trauma is therapist differentiation of self (Halevi & Idisis, 2018). In this regard, Murray Bowen (1978) developed his family systems theory largely based on the concept of

*differentiation of self (*DOS), which describes an individual's ability to maintain an emotional balance between a sense of self and a sense of togetherness with others.

Halevi and Idisis (2018) studied VT of therapists through the lens of Murray Bowen's DOS. The study found that levels of DOS were predictive of the degree of VT in therapists who work with traumatized populations. This finding makes conceptual sense. If the self of the therapist is poorly differentiated, the psychological boundary between the traumatized client and the therapist will be fragile, thereby challenging the therapist's capacity to engage the self-protective boundaries that may prevent them from being negatively impacted by the trauma. The traumatic material could more easily flood the therapist's psyche resulting in VT, which may persist beyond the counseling session. In contrast, therapists who have developed a strongly differentiated self may have the ability to employ greater psychological safeguards to protect themselves from the emotionally distressing elements of the client's traumatic experiences.

However, there are several questions that remain unanswered by the Halevi and Idisis (2018) study. First, given the restricted sample size of their study, it is unknown whether the negative correlation between DOS and VT is generalizable or simply a sampling artifact. Second, it needs to be determined whether the two-dimensional, four-subscale construct of DOS includes aspects that are unnecessary in terms of measuring a differentiated self (Drake et al., 2015; Jankowski & Hooper, 2012; Skowron & Friedlander, 1998; Skowron & Schmitt, 2003). Third, Halevi and Idisis (2018) did not offer any findings regarding the self-oriented versus other-oriented subscales of the VT construct. Fourth, while Halevi and Idisis found that DOS is inversely and significantly correlated with VT, they only examined a limited number of variables as possible

contributors to this relationship; there are multiple additional variables that are potentially relevant to this correlation that need to be explored. In particular, therapist personal trauma history (PTH) is an important variable to explore regarding the relationship between VT and DOS. This dissertation attempts to build upon Halevi and Idisis' (2018) study by answering these remaining questions. The answers will provide important empirical and conceptual insights into the relationship between VT and DOS.

This chapter describes the foundation and rationale for the proposed research study. First, I discuss the historical evolution and tensions in the mental health community regarding the recognition of the prevalence and impact of traumatic experiences. Then, the heightened negative impact of traumatic experiences that occur during the developmental years are discussed. After providing an overview of trauma, I narrow the discussion to vicarious traumatization. Specifically, I discuss the impact of traumatized clients on therapists and the reasons that the therapeutic relationship provides fertile ground for the development of vicarious traumatization. After a discussion of vicarious traumatization, I narrow the discussion to the theories and variables that constitute this study. Specifically, I provide an overview of Constructivist Self-Development Theory and Murray Bowen's concept of Differentiation of Self. With this theoretical foundation in place, I discuss the specific factors that will be investigated as potential mediating and moderating variables in the relationship between differentiation of self and vicarious traumatization.

## History of the Study of Psychological Trauma

The topic of trauma has received increased attention within mental health professions in recent decades as researchers and professionals strive to research,

understand, and develop effective treatment for those impacted by traumatic events. There are multiple types of traumatic events ranging from natural disasters and unintentional accidents to various forms of interpersonal violence. For instance, certain oppressed groups have been victims of trauma throughout the history of the United States. This historical trauma includes the slaughter of indigenous tribes (History.com Editors, 2019a); the trafficking, enslavement, and torture of Africans (*The Story of Violence in America*, 2022); the internment of individuals of Japanese descent (History.com Editors, 2009); and the support and promotion of the eugenics movement, which resulted in the Holocaust (National Human Genome Research Institute, 2021). Although it is important to acknowledge, a review of the historical trauma of oppressed groups is beyond the scope of this paper. Instead, my focus is on the struggle in the mental health community to understand the impact that traumatic experiences have on individuals' mental and physical health. Starting with the late 1800's and early 1900's debates about *hysteria*, I then move to a discussion of WWI and WWII debates concerning *shell shock.* Next, I discuss the Vietnam war and women's liberation movement and that era's impact on achieving recognition of *posttraumatic stress disorder* in the *Diagnostic and Statistical Manual III*. An overview of the sociopolitical environment of the 1980's and 1990's provides a foundation for the discussion of Satanic panic, daycare abuse scandals, allegations of childhood sexual abuse against parents, and the memory wars, which ushered in necessary conversations regarding the nature of traumatic memory.

The study of psychological trauma has not been continuous. Judith Herman (1992) in her seminal work, *Trauma and Recovery*, stated the study of psychological

trauma throughout the 20th century is one of "episodic amnesia" (p. 7). These periods of forgetting are not due to a lack of interest, but rather societal and political forces that work to suppress the realities of human evil. Abram Kardiner, who treated veterans of World War I, stated in his 1947 book titled, *War Stress and Neurotic Illness*, that "it is a deplorable fact that each investigator who undertakes to study [traumatic neuroses] considers it his sacred obligation to start from scratch and work at the problem as if no one had ever done anything with it before" (Kardiner & Spiegel, 1947 as cited by Van Der Kolk, 2000, p. 12).

What is it about the study of psychological trauma that is so resisted? Herman (1992) argued that the study of psychological trauma forces us to confront the deep capacity for evil and cruelty in human nature; and further, to acknowledge human vulnerability. If we wish to investigate, for example, the psychological consequences of soldiers returning from war, we must also examine the human consciousness and justifications that led to the decision to engage in war and killing in the first place. Also, there may be political or cultural circumstances that impact such an investigation. An important historical example of the tendency to ignore and deny the traumatic origins of psychological disorders is the late nineteenth-century debates on the etiology of hysteria.

**Hysteria**

Jean-Martin Charcot, the 19th century French neurologist, first proposed the idea that *hysteria* was a separate and distinct diagnosis (Van der Kolk, 2014; Young, 1997). Prior to Charcot's work at the French asylum, Salpetriere, hysteria was deemed to be a female affliction and was placed on a continuum with epilepsy known as *hystero-epilepsy* (Faber, 1997; Herman, 1992). The key features of hysteria included nightmares, memory

disturbance, dissociative states, identity disturbance and physical complaints, such as exhaustion, nausea, sensory loss, seizures, convulsions and paralysis (Dayan & Olliac, 2010; Faber, 1997; Herman, 1992). Through careful observation of a wide range of patients, Charcot claimed in 1880 that the symptoms of hysteria were psychological in nature (Faber, 1997; Herman, 1992; Young, 1997). Disinterested in the inner lives of his patients, Charcot left the "why" of this psychological disturbance to his students, Pierre Janet and Sigmund Freud, both of whom went beyond Charcot's observation of symptoms to employ talk therapy with hysterical patients (Herman, 1992; Young, 1997). "For a brief decade men of science listened to women with a devotion and a respect unparalleled before or since" (Herman, 1992, pp. 11-12).

In the late 19th century, Janet and Freud independently reached the conclusion that symptoms of hysteria were the manifestation of emotional reactions to traumatic events. Further, Janet and Freud found that these symptoms could be lessened or eliminated once the traumatic events were brought into consciousness and put into words through psychoanalysis (Herman, 1992; Young, 1997).

Freud extended his study of hysteria to the exploration of the sexuality of his predominantly female clients. In 1896 Freud presented his paper, *The Aetiology of Hysteria*, outlining his seduction theory to the Viennese Society for Psychiatry and Neurology (McOmber, 1996). Based on 18 case studies, Freud stated, "...at the bottom of every case of hysteria there are one or more occurrences of premature sexual experience" (Herman, 1992, p. 13). Freud explored with his patients the origin of their hysterical symptoms and found repeated stories of incest, sexual assault and sexual abuse. The social and political climate in Europe at the time was averse to recognizing the extent of

the sexual oppression and abuse of women and children, an idea that was finding its voice among the early feminist movement in Europe (Herman, 1992). Freud retreated from his seduction theory, joining his colleagues in denying that sexual exploitation was actually occurring within the affluent populations he treated. Freud subordinated, but did not completely abandon, his original position (i.e., seduction theory) and made the new claim that the traumatic events his patients reported were merely fantasies and wishes, not actual childhood events (Freud, 1962; Herman, 1992; Young, 1997).

Freud's retraction of his initial seduction theory of hysteria (i.e. hysteria caused by early sexual trauma) is consistent with Herman's (1992) argument about why some hypotheses about the causes of psychological trauma are resisted. To consider the possibility that widespread sexual abuse of vulnerable children occurs is to confront the deep capacity for evil and cruelty in human nature. The theory that traumatic events may be a cause of the symptoms noted in hysterical patients was set aside and ignored for decades until it was revisited by Abram Kardiner during World War II (Herman, 1992; McOmber, 1996; Van der Kolk, 2000). But first, a brief recognition of the impact of trauma occurred during World War I.

**Combat-Related Trauma: World Wars**

Prior to World War I (WWI), soldiers suffering physical and mental breakdowns due to the stress of war were viewed with derision, deemed to be of inferior moral character and unable to withstand the pressures of war (Fueshko, 2016; Herman, 1992). A variety of labels were used to describe these men (e.g., *irritable heart, compensation neurosis, war neurosis, Effort Syndrome,* and *soldier's heart*), which drew public scorn and added an element of shame to men who were already suffering (Fueshko, 2016;

Herman, 1992; Kucmin e al., 2016; Young, 1997). It was during WWI that the illusion of the glory of battle and the heroic view of the courageous warrior gave way to the realities of the catastrophic loss of lives throughout the prolonged war. “Under conditions of unremitting exposure to the horrors of trench warfare, men began to break down in shocking numbers…many soldiers began to act like hysterical women” (Herman, 1992, p. 20). Roughly 40 percent of British casualties were mental breakdowns (Fueshko, 2016).

Searching for a way to deflect from the psychological toll suffered, the medical diagnosis of *shell shock* was created to denote the negative effects on the nervous system derived primarily from the concussive effects of exposure to explosions at close range. Dr. Charles Myers, a British psychologist, was tasked with examining cases of shell shock during WWI. Myers noted that symptoms of shell shock also appeared in soldiers who had not been exposed to combat and that many had lingering symptoms well after the end of the war (Fueshko, 2016; Herman, 1992; Young, 1997). “The emotional stress of prolonged exposure to violent death was sufficient to produce a neurotic syndrome resembling hysteria in men” (Herman, 1992, p.20). The reality of the effects of prolonged exposure were demoralizing and, risking loss of public support, the military chose to suppress Myers’ findings and fostered further focus on the moral character of those who suffered, labeling them as malingerers and cowards (Fueshko, 2016; Herman, 1992). Once again, the study of the nature of psychological trauma was largely abandoned.

Indeed, treatment for shell shock following WWI matched the victim-blaming spin ascribed to the condition. Soldiers who were hospitalized for shell shock after WWI were treated with threats, punishment, and even electroshock therapy (Herman, 1992;

Macleod, 2018; Young, 1997). Despite this victim-blaming view of shell shock, some in the psychiatric community continued to argue that the symptoms of shell shock were a "bona fide psychiatric condition that could occur in soldiers of high moral character" (Herman, 1992, p. 21).

The arrival of World War II (WWII) created renewed interest in the psychological toll of warfare on soldiers within the medical community (Herman, 1992; van der Kolk, 2014). It was finally recognized that *any* soldier could break down under extreme conditions and the extent and inevitability of psychiatric casualties is directly related to the duration and severity of combat exposure. Focused on identifying protective factors against acute breakdowns, American psychiatrists found that the strongest protection could be found in the emotional attachments among and between soldiers. Therefore, new treatment approaches were designed to minimize the time a soldier spent away from his fighting unit (Herman, 1992).

Two aspects are worth highlighting from the World War II era. First, the power of relationships to heal psychological trauma; and second, the birth of brief evidenced-based treatment approaches (Herman, 1992; Young, 1997; Van der Kolk, 2014). The cathartic nature of unburdening oneself of the details of traumatic memories was accomplished through hypnosis and the use of sodium amytal on veterans. The treatments offered seemingly swift relief and soldiers were quickly returned to duty. The warnings by several psychiatric professionals that catharsis of memories through medically-induced means was incomplete without also integrating those memories into consciousness were ignored. The long-term psychological effects of combat trauma were not addressed until after the Vietnam war (Herman 1992; van der Kolk, 2014).

## Vietnam War and the War Against Women

There were two significant activist movements that occurred during the 1970's in the United States that prompted a renewed interest in the psychological consequences of trauma: the antiwar movement and the women's liberation movement (Herman, 1992). The prolonged nature of the Vietnam War created a swelling of public antiwar sentiment that villainized returning veterans who were suffering extensively from the psychological trauma of committing (what a significant proportion of the public viewed as) war crimes within an unjust war. With nowhere to turn but to each other, veterans formed support groups that served to provide a safe place for discussing their psychological wounds and to raise public awareness of the negative effects of the war. Hundreds of these support groups were formed, thereby prompting political pressure to institute a legal mandate for new treatment programs within the Veterans Administration called Operation Outreach (Andreasen, 2010; Herman, 1992). "The moral legitimacy of the anti-war movement and the national experience of defeat in a discredited war had made it possible to recognize psychological trauma as a lasting and inevitable legacy of war" (Herman, 1992, p. 27). This recognition paved the way for scientific research and for the eventual inclusion (in 1980) of a new diagnosis within the anxiety disorders category of the psychiatric community's diagnostic manual (American Psychiatric Association, 1980) called *post-traumatic stress disorder* (PTSD) (Andreasen, 2010; Herman, 1992).

While Vietnam veterans were gathering to raise awareness about the atrocities of the war in Vietnam, the women's liberation movement was fighting its own battle to demonstrate that "the most common post-traumatic disorders are those not of men in war but of women in civilian life" (Herman, 1992). Almost a century earlier, Freud had

recognized and then discarded the reality that violence is a routine aspect of the sexual and domestic lives of women. Consciousness-raising groups were created similar to those the Vietnam veterans had established, with the goals of raising public awareness of trauma related to women and initiating related social reforms. The subsequent explosion of research in the subject of sexual assault yielded alarming results: sexual violence against women and children was pervasive with one in four women reporting they had been raped, and one in three women reporting they had been sexually abused in childhood (Russell, 1984). As an illustration of the way that trauma to women was being reconsidered in light of these findings, one of the responses from the women's movement was that rape should be redefined as a method of political control that enforced the subordination of women through terror (Brownmiller, 1975; Card, 2002; Card, 2010; Herman, 1992). As Susan Brownmiller stated:

> Man's discovery that his genitalia could serve as a weapon to generate fear must rank as one of the most important discoveries of prehistoric times, along with the use of fire and the first crude stone ax…It is nothing more or less than a conscious process of intimidation by which *all* men keep *all women* in a state of fear (Brownmiller, 1975, pp. 14-15).

As trauma to women continued to receive increased attention, Holmstrom & Burgess (1975), a sociologist and psychiatric nurse respectively, made an important contribution by studying the psychological effects of rape. These researchers observed a pattern of symptoms among rape victims that they called *rape trauma syndrome.* The identification of this syndrome subsequently led to research into the psychological impact of other forms of violence, such as domestic battery and the sexual abuse of children. The symptoms found in the survivors of sexual and physical violence mirrored the symptoms of combat trauma and the condition that was previously called hysteria. It was only after

public recognition of the frequent and predictable reactions to trauma due to the organized efforts of Vietnam war veterans that it became clear that the psychological impact of sexual violence on women had essentially the same impact on women as trauma from war did on soldiers (Herman, 1992). Indeed, when the third edition of the DSM (American Psychiatric Association, 1980) included the diagnosis of PTSD, it recognized there is a psychological reaction to trauma that is common among a variety of stressors including combat, death camps, industrial accidents, natural disasters, and sexual and interpersonal violence. This recognition opened the door for countless survivors of sexual abuse, domestic violence and rape to step forward and disclose their abuse.

Building upon the momentum of the civil rights era of the 1960's, the women's liberation movement succeeded in finally, after many decades, getting the Equal Rights Amendment (ERA) decidedly approved by both houses of Congress in 1972, leaving the final ratification to the States (Blakemore, 2019). Though the ERA has still not achieved full passage, the 1970's marked the implementation of the Title IX of Education amendment prohibiting discrimination in education based on sex and the Roe v. Wade decision, which protected a woman's legal right to an abortion (History.com Editors, 2019). At the same time, increasing numbers of women entered the workforce, which prompted an increase in childcare options. These childcare options were supported by the grassroots activism of the National Organization for Women (NOW), the implementation of government programs (e.g., Aid to Dependent Children for low-income families), and tax incentives to middle and upper-income families (Michel, 2011). Additionally, during this period the women's movement established hundreds of rape crisis centers throughout

the United States that offered emotional support as well as legal and practical assistance to rape victims (Herman, 1992). “The initial focus on the rape of adults led inevitably to a rediscovery of the sexual abuse of children” (Herman, 1992, p. 31). As focus turned toward the abuse of children, the nation looked for a monster to blame. In the 1980’s that monster was Satan himself.

**Satanic Panic and the Daycare Abuse Scandals**

Tensions rose in the 1980’s as the United States was faced with an economic recession and women, both by choice and by necessity, joined the labor force in increasing numbers (Bromley, 1991; Richardson et al., 2009; Yuhas, 2021). At the same time, Yuhas (2021) stated the religious right’s focus on the nuclear family and the public’s emergence from decades of denial of the extent of sexual abuse, especially that of children, provided fertile ground for a moral panic. In the 1970’s, Christian fundamentalism became a powerful social and political force that viewed Satan as the personification of evil within society (De Young, 2008; Richardson, 1997). The establishment of the Church of Satan by Anton LaVey was seen as proof by Christian fundamentalists that Satan was alive and active in the United States, further strengthening the dichotomous ideology of good versus evil (Richardson, 1997; Richardson et al., 2009). In 1981, a book was published in Canada that fueled the rise of Satanism as the root of social problems in the United States. The “Satanic Panic” that arose in the 1980’s later spread to other westernized countries around the world fueled in large part by the changing media landscape and its tendency to sensationalize provocative stories (Bromley, 1991; Richardson, 1997; Richardson et al., 2009)

The publication of the book, *Michelle Remembers* (Smith & Pazder, 1981), influenced public perception and fueled controversy and debate surrounding child abuse during the 1980s. *Michelle Remembers* was a memoir written by Michelle Smith and her psychotherapist-turned-husband, Lawrence Pazder. The book chronicled Pazder's treatment of Smith's depression post-miscarriage and contained graphic descriptions of Smith's childhood abuse by a cult of Satanists of which Smith's mother was a member (Richardson, 1997; Richardson et al., 2009; Smith & Pazder, 1981; Yuhas; 2021). The book was later discredited, but not before being popularized through media articles and interviews that reached a wide audience. Law enforcement and child welfare agencies joined forces and dedicated resources to addressing the issue of what they believed was widespread satanic ritual abuse of children (De Young, 2008; Richardson, 1997; Richardson et al., 2009). Yuhas (2021) stated that some of these law enforcement and child welfare agencies adopted the book as a pseudo-training manual, while the book also provided the public a villain outside of the home.

Like Freud and his contemporaries in their day (Herman, 1992; Young, 1997), there was resistance to the notion that the home might be a source of abuse to children; so, parents looked for blame outside of the home. Daycare centers and schools were scrutinized. This scrutiny served the dual purpose of addressing the issue of sexual abuse of children while also highlighting the conservative view that the demise of the traditional family values of stay-at-home motherhood was the root cause of child harm. The convergence of these cultural currents created the foundation for events that involved the competing interests of the medical, legal, psychiatric and journalism fields. The most notable manifestation of this is the McMartin Preschool Case.

In 1983, a mother accused a teacher at the McMartin Preschool in Manhattan Beach, California of sexually molesting her 2 ½ year old child. What followed was a 7-year, $15 million trial that yielded many lessons in how not to manage child sexual abuse cases. The case played out in the media, fueled by a public fascination with satanism, serial killers, and child abductions (Bottoms & Davis, 1997; Garven et al., 1998). Ultimately, the investigative techniques used by Kee McFarlane, the director of Child International Institute and an unlicensed social worker, to determine that sexual molestation had occurred at McMartin Preschool were criticized as highly suggestive and coercive. Garven et al., (1998) cautioned that the "full package" of investigative techniques used in the McMartin Preschool were extreme and "should not be viewed as typical of the practice in most child protection and law enforcement agencies…In our experience, a few social workers and police sometimes use such techniques, with tragic results for children, adults, and even entire communities" (p. 355). Schreiber et al. (2006) conducted an analysis comparing the McMartin investigative techniques with interviews by Child Protective Service (CPS) workers of children who had allegedly been sexually abused. The study confirmed the high suggestibility of the investigative techniques in the McMartin Preschool case. (Brewin, 2020; Cheit, 1998; Cheit, 2014; Crook & McEwen, 2019; Dallam, 2001; Lamb, 2017; Loftus et al., 1994; Loftus & Pickrell, 1995; Otgaar et al., 2019; Otgaar et al., 2021). The McMartin Preschool Trial has been characterized as a modern day witch hunt that resulted in *hundreds* of baseless child sexual and ritual abuse cases against daycare centers and workers (Cheit, 2014; De Young, 2008; Nathan & Snedeker, 1995). This view has been accepted as conventional wisdom and found its way

into many textbooks. However, a closer examination of the evidence yields a different conclusion.

Over a 15-year period, Cheit (2014) conducted a meticulous analysis of original case files, trial transcripts, media reporting, and other documentation from not only the McMartin Preschool Case, but also dozens of other cases that formed the foundation for the witch-hunt narrative. Cheit, a Professor of Public Policy and Political Science at Brown University, "accomplishes well what he set out to do: assess the actual records from the cases and make independent assessments about the nature and quality of the evidence in them" (Lamb, 2017). Cheit's investigation revealed numerous missteps in both investigative and interviewing techniques, prosecutorial overreach, and miscarriages of justice that may have fueled the witch-hunt narrative. However, Cheit also dismissed the extreme claims put forth in the witch-hunt narrative that there were hundreds of cases where innocent individuals were accused and sometimes convicted of crimes with no evidence or factual basis (Cheit, 2014; Lamb, 2017). As Lamb (2017) stated, "The thoroughness of his research only serves to add weight to his conclusions that in nearly all the cases he examined, there was serious, substantial evidence of sexual abuse, which could not ethically be ignored by prosecutors" (p. 950).

Cheit (2014) states that the McMartin Preschool case was not the first case of allegations of child sexual abuse in daycare centers, though it is often cited as such. In fact, there were several cases which predated McMartin that prove the phenomenon of child abuse in daycare centers was real. Cheit recounts eight separate cases, spanning the years 1979-1983, where perpetrators were either convicted or pled guilty to dozens of counts of child sexual abuse (see Cheit, 2014 pages 153-155 and related footnotes).

These cases involved proven elements which were, in post-McMartin 'witch-hunt' cases, considered too fantastical to be true including: tying children up with medical gauze and forcing objects into their mouths, the use of handcuffs, locking children in wooden boxes, sodomy, and being lured to the basement of a church where children were sexually abused. Cheit continued his exploration to review the dozens of cases listed by Nathan and Snedeker (1995) as evidence of a "nationwide epidemic" of false accusations of alleged Satanic ritual abuse and found that the mere inclusion of certain elements (i.e., activities that took place in a basement, the mention of Barbie dolls) could result in a case being tagged as having "ritualistic elements" (Cheit, 2014). Sadly, these facts were lost in the provocative narrative of widespread Satanic ritual abuse that was popularized and sensationalized by the media, parents, and overly-ambitious child welfare workers, therapists, prosecutors, and law enforcement officers who were anxiously navigating the nascent days of child sexual abuse allegations. It is clear that the notion that the most serious threat facing the nation's children during the 1980's was the existence of widespread, well-organized Satanic ritual abuse cults operating in daycare settings was overstated (Cheit, 2014; De Young, 2008). A nationwide study conducted by the National Center on Child Abuse and Neglect (NCCAN) concluded there was no hard evidence for intergenerational satanic cults that sexually abuse children. However, the study did find evidence of lone perpetrators or couples whose abuse of children involved Satanic themes or ritualistic elements (Cheit, 2014; National Center on Child Abuse and Neglect, 1995). The NCCAN study found convincing evidence that religion-related abuse (e.g., beating the devil out of a child, abuse by clergy) was more common than Satanic abuse. "Our research leads us to believe that there are many more children being abused in the name

of God than in the name of Satan" (National Center on Child Abuse and Neglect, 1995, p. 15).

The legacy of the Satanic Panic era witch hunt narrative is a lingering sentiment that children are highly suggestible and their claims of abuse are not credible. The exaggerated claims of ritualistic abuse promulgated by the media, anxious parents, overly-enthusiastic law enforcement, ill-trained therapists, and fundamentalist religious and political stakeholders overshadowed the real epidemic of child sexual abuse cases. Even so, the seeds of two ideas were planted in public awareness: that false memories of sexual abuse can be easily implanted in children due to their high suggestibility; and that therapists actively seek to implant those memories (Brewin, 2020; Cheit, 1998; Cheit, 2014; Crook & McEwen, 2019; Dallam, 2001; Lamb, 2017; Loftus et al., 1994; Loftus & Pickrell, 1995; Otgaar et al., 2019; Otgaar et al., 2021).

**Child Sexual Abuse Allegations Against Parents**

In the context of the fallout from the daycare abuse cases, the nation struggled to determine the actual prevalence of child sexual abuse. The Department of Health and Human Services led the data collection effort, and legislation to facilitate this data collection was passed. The Child Abuse Prevention, Adoption, and Family Services Act of 1988 (U.S. Department of Health and Human Services, National Center on Child Abuse and Neglect, 1992) required the establishment of a national database of child maltreatment statistics. The initial years of data collection uncovered inconsistencies in the way data was collected, categorized and reported among States as well as differing statutes of limitations for crimes committed against children. However, evidence of child abuse was overwhelming and family members appeared to be the main perpetrators

(Bottoms & Davis, 1997; U.S. Department of Health and Human Services, 1992). Despite the recognition of abuse of children within the family, victims were unable to seek justice through the courts during the 1980's due to the expiration of the statutes of limitations.

In 1988, the lobbying efforts of Patti Barton, who alleged sexual abuse by her father during her childhood, and her husband Kelvin Barton, led to a revision of the Washington State code of law. A new law was passed that allowed adults to sue their alleged perpetrators for abusing them as children. The law provided a three-year window based on "either *delayed discovery* or *delayed recognition of the harm* caused by the abuse" (Crook, 2022, p. 54). By 1992, fourteen additional states had established similar laws (Crook, 2022; Loftus, 1993; National Conference of State Legislatures, 2017). These laws opened the doors for civil actions against incest perpetrators, but only for victims who claimed to have just recently remembered their abuse (Brown et al., 1999; Crook & McEwen, 2019; Dallam, 2001). It was this vague aspect of the laws - *delayed discovery or delayed recognition of the harm caused by the abuse* - that fueled the intense debates about traumatic memory.

**Memory Wars**

"Traumatized people simultaneously remember too little and too much" (Van der Kolk, 2014, p. 181). It was Pierre Janet (1904) who first put forward the idea that there are significant differences between ordinary memory and traumatic memory. Janet coined the term *dissociation* to describe the discontinuity of memory that occurs following a traumatic experience. The specific mechanisms through which disruptions to memory occur (as listed in the criterion for stress-related disorders, dissociative disorders, and

personality disorders in the DSM-III and subsequent editions; American Psychiatric Association, 1980; American Psychiatric Association, 1994; American Psychiatric Association, 2013), continue to be researched and debated to the present day (Janet, 1904; Scalabrini et al., 2020; Van der Kolk & Van der Hart, 1990). Those debates became heated in the 1990's during what were known as the memory wars. This period also reignited the idea that therapists use coercive techniques to convince suggestible clients that they are victims of abuse.

The name most often associated with the memory wars is Elizabeth Loftus, a University of Washington psychology professor. Dr. Loftus, a memory researcher, was previously hired by the father of Patti Barton as an expert witness in his defense against his daughter's sexual abuse allegations. Though Loftus' testimony did not prevail and Patti Barton won her lawsuit in 1990, Loftus became a frequent expert witness for the defense in similar sexual abuse trials. As more states allowed for delayed discovery of child sexual abuse, more individuals, including celebrities, stepped forward with their own recovered memories. Loftus proposed alternative explanations to the media stating to a Washington Post reporter that "an overly zealous psychologist could unwittingly use his or her influence over a vulnerable patient to plant the seeds of a 'memory' that is actually a fantasy" (Crook & McEwen, 2019, p. 8). The word "implanted" was featured increasingly in news headlines, thereby creating a legal defense and a shift in public sentiment toward a new victim: accused parents who were the victims of false memories implanted by therapists. Loftus joined forces with aggrieved parents to form a foundation to expose false allegations of abuse.

In March, 1992 the False Memory Syndrome Foundation (FMSF) was formed by parents who claimed to have been falsely accused of child sexual abuse by their now-adult children. The syndrome upon which the foundation was named, False Memory Syndrome (FMS), was described by the foundation as "a widespread social phenomenon where misguided therapists cause patients to invent memories of sexual abuse" that was occuring at epidemic levels (Dallam, 2001, p. 10). Though professing to be a scientific organization, early activities of the foundation were focused on influencing the legal system and the public through a media campaign (Crook & McEwen, 2019; Dallam, 2001; *False Memory Syndrome Foundation*, n.d.; Schuman & Galvez, 1996). Indeed, a review of FMSF newsletters show a concerted effort to solicit anecdotal stories from FMSF member families and other non-peer reviewed mainstream articles to include in press packets to be sent to newspapers, news stations, and talk shows. Further, third-hand accounts of therapists "suggesting" child sexual abuse were cited in the newsletters with a call-to-action for members to "make noise," actively encouraging members to report to legal and ethical authorities their beliefs that therapists were practicing improperly. They even included a sample letter to write to governing bodies with a statement that "This (accusation) is absolutely not true" (*False Memory Syndrome Foundation*, n.d.).

Loftus, a founding Board Member of the FMSF, pursued research to support this new implanted memory defense. Loftus modeled her study off an assignment completed for extra credit points by a student, James Coan, in her undergraduate Cognitive Psychology class (Coan, 1997; Loftus & Pickrell, 1995). Coan stated,

> Memory distortion, as many readers know, is Dr. Loftus's particular area of interest, and so this portion of the class was particularly engaging. At some point,

> she introduced the controversy regarding repressed memory. She noted that it would be extremely interesting, and important to the repression debate, if it were possible to get somebody to remember an entire event that had never happened. She further pointed out that to make it even more relevant to the debate, the falsely remembered event should be mildly traumatic. Dr. Loftus felt that being made to believe that one had been lost in a shopping mall as a child might be an appropriately traumatic thing to get people to erroneously believe. Following this, she offered extra credit points (5, I believe) toward our final grades in the class for designing and piloting a method of making somebody believe they had been lost in a shopping mall (Coan, 1997, p. 273).

Coan created an 'experiment' involving his mother, sister, and brother. He told his family that he was replicating a study about "remembering events from one's past of having been treated kindly. The study I cited was, of course, invented" (p. 273). He created three identical booklets, one for each family member, that included four stories - three true and one false. The false story was about Chris, his brother, being lost in a mall at age 5, and an older man who found him and returned him to his family. The three subjects were asked to write about each of the four events in their respective booklets, for six consecutive days.

> Though my brother was the subject of the false memory. I didn't target him specifically as the person most likely to remember it. I'd hoped that they'd all remember it, but wouldn't have been surprised if none of them had. As it turned out, my sister filled out her booklet incorrectly, so I had to throw that one out. My mother didn't remember anything. (She noted that this caused her some guilt, but I think she'll be okay.) My brother, however, remembered a remarkable lot about the fictional story, including some details that hadn't been suggested. Extra credit points for me (Coan, 1997, p. 274).

Coan reported that Loftus asked him to interview his brother on tape about the various memories. Chris provided more details about being lost, the old man, and his mother's reaction when reunited. Eventually, Coan told Chris that one of the stories was made up and asked him to identify which one it was. Chris could not (Coan, 1997). Loftus used Coan's recorded interview with Chris in conference presentations as proof of her

implanted memory theory, and she invited Coan to complete his Honors Project by recreating his study in her laboratory under her mentorship. The resulting 'Lost in the Mall' study (Loftus & Pickrell, 1995) has been widely cited by a diverse range of proponents and critics within the academic, psychology, and legal fields.

In the Lost in the Mall study (Loftus & Pickrell, 1995), 24 subjects were asked to recall events that were supplied by a close relative. Participants were recruited as pairs of either parent-child or siblings over the age of 18. The older member of each pair was required to be knowledgeable about the younger member's childhood experiences. For each pair, the older relative provided stories about events from the subject's childhood. Similar to Coan's original study, booklets were given to each subject with four stories including the three true stories and the researcher-created subject-specific false event about getting lost. In all cases, the false story included these elements: the subject was lost in a mall or large department store for an extended period of time, the subject cried, the subject was found by an elderly woman and reunited with their family. To make the false story plausible, older relatives were asked to provide information about where the family would have shopped when the subject was 5 years old, which family members usually went along on shopping trips, what stores the subject would be interested in, and verification that the subject had not, in fact, been lost in a mall at age 5. Subjects were given the booklets and asked to read the events their relatives had provided, then to write what they remembered about the events. After completing the booklets, subjects were scheduled for two interviews; the first interview was 1-2 weeks after completion of the booklet, and the second interview was 1-2 weeks after the first interview. Each interview began by reminding the subject of the four events and asking them to recall as much

information as they could. They were asked to rate the clarity of their memories for each event on a scale of 1 - 10 with "10" indicating extremely clear. They were also asked to rate their confidence level on a scale of 1 - 5 (5 = extremely confident) that, if given more time, they would be able to remember more details about the events. After the first interview, subjects were asked to "think about the events and try to remember more details for the next interview" (Loftus & Pickrell, 1995, p. 722). The second interview was similar and at the end of the session, a debriefing was provided which informed subjects that the researchers were attempting to implant a false memory and asked subjects to identify which of the four memories was false.

The results of the study showed that subjects remembered something about 49 of the 72 (68%) true events. Six subjects (25%) remembered the false event either partially or fully, while 75% of the subjects consistently maintained they had no recollection of the false event. Additionally, the average clarity ratings for the false events were lower (2.8 in the first interview and 3.6 in the second) than for the true events (6.3 in both first and second interviews). Confidence ratings followed a similar pattern with lower confidence in the false memories than the true memories. For both categories, confidence ratings *decreased* from the first to the second interview. After debriefing, 19 subjects correctly identified the false event while the remaining 5 subjects identified one of the three true events as the false one (Loftus & Pickrell, 1995). Loftus concluded that "These findings reveal that people can be led to believe that entire events happened to them after suggestions to that effect" (p. 723). Loftus and others used these findings as proof of an idea that Loftus had debuted four years earlier in 1991 to Washington Post reporter, Tracy Thompson: "An overly zealous psychologist could unwittingly use his or her

influence over a vulnerable patient to plant the seeds of a ‘memory’ that is actually a fantasy” (Crook & McEwen, 2019, p. 8). The amount of damage done by Loftus’ claims purporting the existence of epidemic levels of FMS as the result of unscrupulous therapists, without any evidence, was substantial. Trauma and traumatic memory researchers and trauma therapists were left scrambling to correct the record, a daunting task given the FMSF media campaign had successfully skewed public perception of the issue.

Critics of both Loftus theory of implanted false memory and her Lost in the Mall study abound (Becker-Blease & Freyd, 2016; Blizard & Shaw, 2019; Brand & McEwen, 2016; Brewin, 2020; Brewin & Andrews, 2016; Brown, 1996; Cheit, 1998; Cheit, 1999; Cheit, 2014; Crook, 2022; Crook & McEwen, 2019; Dallam, 2001; Freyd, 2003; Hovdestad & Kristiansen, 1996; Kendall, 2021; Lamb, 2017a; Lamb, 2017b; Romano, 2021; Schuman & Galvez, 1996; Yuhas, 2021). Loftus and the FMSF widely publicized, through an active media campaign, her theory of implanted memory as fact, without any scientific evidence, prior to conducting the Lost in the Mall study. By the time the Lost in the Mall study was published (Loftus & Pickrell, 1995), the media and legal system were already citing the ideas Loftus and the FMSF put forth as indisputably true. This is arguably not an acceptable approach to scientific research. Nor is the *file drawer effect*, where studies with insignificant findings are not published (Becker-Blease & Freyd, 2016). Yet, when the first 6 subjects in the Lost in the Mall study correctly identified the created false memory, Loftus and Pickrell (1995) dropped them from the study. Two detailed reviews of the Lost in the Mall study were conducted in 2019 that concluded that despite the reported 5 of 24 subjects having false memories implanted, all 24 subjects

actually correctly identified the false story before the study had completed (Blizzard & Shaw, 2019; Crook & McEwen, 2019).

A full analysis of the debates as to the outcome of the Lost in the Mall study and its application to the specific instance of delayed recovery of childhood abuse memories is beyond the scope of this dissertation; however, it is important to note the impact this era, and Loftus' involvement in propagating the idea of false memories, had on the study of psychological trauma. During the 1990's as the nation attempted to address the history of child sexual abuse within the family, competing political, social, and legal agendas overtook the discourse in a way that threatened the psychotherapy profession (Brewin, 2020; Cheit, 1998; Crook & McEwen, 2019; Dallam, 2001; Lamb, 2017; Loftus et al., 1994; Loftus & Pickrell, 1995; Otgaar et al., 2019; Otgaar et al., 2021).

Despite the FMSF statements to the contrary, there was ample evidence of amnesia and delayed memories in people who experienced trauma, including combat veterans, sexual assault survivors, and Holocaust survivors (Quirk & DePrince, 1996). Consider the following examples specifically related to childhood sexual abuse. Briere & Conte (1993) surveyed 450 subjects reporting histories of childhood sexual abuse. Of these, 267 subjects (59%) identified some period of their lives before age 18 when they had no memory of their abuse. Factors that impacted the likelihood for amnesia of events included the severity and length of abuse as well as the age of onset. Feldman-Summers & Pope (1994) surveyed 330 APA-member psychologists, randomly selected, and found that of the 24% who reported a history of childhood abuse, 40% also reported a period of forgetting. A variety of sources were reported as catalysts for remembering. Only 8% of those who had forgotten and later recalled abuse indicated therapy as the only source of

recall, and of those, 37.5% had external corroboration of the abuse.

In another study, Herman & Schatzow (1987) surveyed 53 incest survivors who were active in group and individual therapy. All 53 had been sexually abused by family members, primarily fathers or step-fathers, and to a lesser degree by brothers, uncles, grandfathers or mothers. Sixty-four percent had less than full recall of their abuse with 28% experiencing severe memory deficits of their abuse. A full 75% of these participants were able to obtain corroboration of their abuse either by the perpetrator himself or from another family member.

Perhaps the most intriguing of examples is the study by Williams (1994) of 206 women who had, as children, been treated for childhood sexual abuse with forensic evidence collected and documented at a community hospital. Seventeen years later, 129 of these women were located and interviewed (without knowing the purpose of the interviews) regarding their childhood experiences, including their experiences with sex. Over one-third (38%) of the women did not report their childhood sexual abuse to the researchers. Williams concluded that "having no recall of child sexual abuse is a common occurrence for adult women with documented histories of such abuse" (p. 1174). These four studies demonstrate that evidence did exist that supported the common experience among childhood sexual abuse survivors of either partial or full amnesia of traumatic experiences followed by later recovery of those memories through a variety of mechanisms. So it is unlikely that therapists were - as charged by Loftus - imposing false memories upon clients.

From an historical perspective, Schuman and Galvez (1996) stated the timing of the FMS movement (10-15 years into the increased recognition of childhood sexual

abuse) was not a coincidence. They viewed its arrival as a response to the increased recognition of abuse at the hands of parents, clergy, coaches and other trusted individuals that threatened the patriarchal hegemonic norms. As further support for their argument, they also stated that it was not coincidence that the 'incompetent' therapists most targeted by the FMSF were marriage and family counselors and social workers, professionals more likely to be women, than clinical psychologists and psychiatrists, who were more likely to be men. Schuman and Galvez (1996) viewed the fact that psychoanalytic theories (i.e. repression) and techniques (i.e. hypnosis), long accepted, were suddenly being attacked as they were purportedly used with female clients that were in therapy for recovered memories of childhood trauma. Becker-Blease and Freyd (2016) echo this focus on gender politics stating that most perpetrators of child sexual abuse are men (DePrince et al., 2002). By casting allegations of sexual abuse as "false memories" and the accusors as suffering from "false memory syndrome," the FMSF recreated the sociopolitical circumstances surrounding the debates on *hysteria* that caused Freud to retreat from his infantile seduction theory. Further, the memory wars reconstituted the general denial of the etiology and prevalence of psychological trauma and its detrimental impact, especially concerning the traumatic experiences of women and children.

In 1993, as a result of the intense debates over the issues of childhood memories, the APA established a working group to review current scientific literature and to identify future research and training needs regarding the evaluation of memories of childhood abuse. The APA Working Group on Investigation of Memories of Childhood Abuse first met in August, 1993 and presented their final report to the APA Board of Directors on February 14, 1996 (American Psychological Association, 1998a). The group was

composed of six individuals, three of whom were research psychologists and three who were researcher-clinicians. The summary report (American Psychological Association, 1998b) acknowledged the vast differences of opinion between the two groups, encouraging both sides to recognize the value of bridging knowledge rather than balkanizing or prioritizing political agendas. However, both the researchers and researcher-clinicians did agree that gaps exist in scientific knowledge about the mechanisms and processes that lead to both accurate and inaccurate memories of childhood abuse. Further, "Controversies regarding adult recollections should not be allowed to obscure the fact that child sexual abuse is a complex and pervasive problem in America that has historically gone unacknowledged" (p. 933).

**Traumatic Memory**

Brewin and Andrews (2016) conducted a systematic review of existing research on creating false memories. They highlighted the difficulty distinguishing *remembering* (a full recollective experience of the original event including sensory images) from *knowing* (a feeling of familiarity without retrieving context) in laboratory experiments of memory. They cited three elements needed to accept the truth of a reported autobiographical memory: belief that the event was personally experienced, sensory imagery accompanying the memory of the event, and confidence in the memory of the event and its plausibility. Plausibility is reliant upon one's knowledge of self and beliefs and whether there is an alternative explanation. The Lost in the Mall study (Loftus & Pickrell, 1995) incorporated repetition of the created memory along with instructions to participants to think about the memory in between sessions and attempt to expand upon what is remembered about the event. As a result, participants who were designated as

partially recalling events were merely repeating what they had been told, exhibiting *knowing* rather than *remembering.* Brewin and Andrews (2016) concluded that while a small minority of individuals might develop false memories in laboratory conditions, those memories may contain both true and false elements. Further, studies have shown that repeated attempts to remember, whether directed or not, "have been shown to lead to the recovery of true autobiographical memories, as well as to false memories containing true elements" (p. 20). Brewin and Andrews stated that susceptibility to false memory creation is lower than previously suggested and therefore, it cannot be concluded that false memories of childhood events are common or that they are easy to suggest or implant. Loftus herself conceded that false memory production in an experimental paradigm does not prove that an individual is susceptible to false memories in other situations, such as a therapeutic setting (Patihis et al., 2018). "The best assumption for practitioners is that clients, whatever their personality and even if they claim to possess exceptional memory, may be vulnerable to memory distortions" (p. 158). Brewin (2021) stated "The general conclusion, which still holds today, was that recovered memories may be true, false, or a mixture of the two" (p. 443). Indeed, since 1980 the DSM has consistently included within the PTSD and dissociative disorders categories the existence of memory distortions (American Psychiatric Association, 1980; American Psychiatric Association, 1987; American Psychiatric Association, 1994; American Psychiatric Association, 2013).

**DSM-III and Beyond**

As a result of the accumulated efforts of many clinicians and advocates over the prior century, Posttraumatic Stress Disorder (PTSD) was added to the third edition of the

DSM (American Psychiatric Association, 1980). Included in the Anxiety Disorders category, PTSD was defined as "the development of characteristic symptoms following a psychologically traumatic event that is generally outside the range of usual human experience. The characteristic symptoms involve re-experiencing the traumatic event; numbing of responsiveness to, or reduced involvement with, the external world; and a variety of autonomic, dysphoric, or cognitive symptoms" (p. 236) including impaired memory. A separate DSM category, Dissociative Disorders, also included memory disturbance as a symptom. The Dissociative Disorders category described *psychogenic amnesia* of varying lengths and the possibility that PTSD may also be present. The publication of DSM-III-R (American Psychiatric Association, 1987) criterion for PTSD included the addition of avoidance symptoms in diagnostic criteria and a requirement that overall PTSD symptom duration must exceed one month. Although the DSM-III and III-R recognized PTSD as originating from a variety of stressors–including combat, death camps, industrial accidents, natural disasters, and sexual and interpersonal violence–many clinicians who specialized in working with traumatized populations were dissatisfied with the resulting diagnosis and called for an expansion and reconceptualization of trauma diagnoses (Friedman, 2013; Herman, 1992; Van der Kolk et al., 2005;Van der Kolk, 2014). As a result, within a year of the publication of DSM-III-R a task force was appointed to begin work on the next revision, which was also prompted by the expected release of the World Health Organization's 10th edition of the International Classification of Diseases (ICD, World Health Organization, 1992). The ICD provides a classification system used internationally for collecting data for health

services research and the resulting statistics on disease are used in primary, secondary and tertiary care (World Health Organisation, 2022).

When the American Psychiatric Association was in the process of revising the DSM for publication of the DSM-IV, Judith Herman (Friedman, 2013; Herman, 1992) proposed a diagnosis called Complex PTSD (CPTSD). Her proposed criteria for CPTSD included the existing PTSD criterion and added other symptoms that often present after prolonged trauma (i.e. alterations in consciousness, self-perception, relations with others, and systems of meaning). Many of these symptoms currently reside in other categories of the DSM, such as Dissociative Identity Disorder, Borderline Personality Disorder and Somatization Disorder. Van der Kolk et al. (2005) were tasked with conducting a field trial comparing different groups of traumatized individuals and found that individuals who were abused as children suffered a quantity and intensity of post-traumatic symptoms that were rare in survivors of natural disasters. They proposed to the DSM-IV PTSD workgroup that a new trauma diagnosis be added, similar to Herman's conceptualization of Complex PTSD, but with a focus on childhood trauma called Developmental Trauma Disorder (Kilpatrick et al., 1998; Van der Kolk, 2014). Ultimately, the PTSD diagnosis remained in the Anxiety Disorders category of the DSM-IV with an expansion of the description to read:

> …the development of characteristic symptoms following exposure to an extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one's physical integrity; or witnessing an event that involves death, injury, or a threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate (p. 463).

Further, the symptoms of the new DSM-IV PTSD diagnosis required the presence of characteristics of persistent reexperiencing, avoidance, and increased arousal that causes "*clinically significant distress or impairment"* (p. 463) in important aspects of functioning. The language that the event is generally outside the range of normal human experience was dropped. The Dissociative Disorders category remained separate from PTSD with the renaming of psychogenic amnesia to *dissociative amnesia.* Dissociative amnesia is described as "a retrospectively reported gap or series of gaps in recall for aspects of the individual's life history. These gaps are usually related to traumatic or extremely stressful events" (p. 520). Neither of the proposed diagnoses–Complex PTSD or Developmental Trauma Disorder–were included in the DSM-IV, leaving clinicians and researchers who specialized in traumatized populations still dissatisfied with the status of recognizing the full psychological impact of trauma (Herman, 1992; Van der Kolk et al., 2005; Van der Kolk, 2014).

After extensive review of the research, the DSM-5 workgroup determined that PTSD no longer fit within the anxiety disorders category. A decision was made to create a new chapter, *Trauma and Stress-Related Disorders*, which included only diagnoses that had an onset or worsening of symptoms following exposure to a traumatic or stressful event. The diagnosis of PTSD was moved to this category with several changes. The requirement that a person's response to a traumatic or stressful event involved fear, helplessness, or horror was removed due to the recognition that many individuals exposed to traumatic or stressful events deny experiencing these intense emotional reactions in the immediacy of the event (American Psychiatric Association, 2013; Friedman, 2013). The DSM-5 PTSD criteria was expanded to include indirect exposure

to the details of traumatic events, such as the indirect exposure experienced by professionals who learn about the details as part of their everyday duties (indirect exposure is discussed further in a later section of this chapter). Avoidance and arousal symptoms remained in the DSM-5 PTSD criterion and two new criteria were added: 1) negative alterations in cognitions and mood (i.e. inability to remember an important aspect of the event, persistent negative beliefs and distorted cognitions about self, alterations in emotional states), and 2) marked alterations in arousal and reactivity (hypervigilance, disturbance in concentration or sleep, self-destructive behavior) (American Psychiatric Association, 2013). In all versions of the PTSD diagnostic criteria, beginning with DSM-III and through the current DSM-5, there is a specifier for "delayed expression" whereby full diagnostic criteria is not met until at least 6 months after the traumatic event (American Psychiatric Association, 1980; American Psychiatric Association, 1987; American Psychiatric Association, 1994; American Psychiatric Association, 2013).

Dissociative Disorders remained a separate category in the DSM-5 because a) none of the dissociative disorders require prior exposure to a traumatic or stressful event, and b) the relationship between traumatic exposure and dissociative disorders required further investigation according to the DSM-5 workgroup (Friedman, 2013). However, a dissociative subtype was added to the PTSD diagnosis based on research regarding differing treatment requirements for individuals with PTSD who also had dissociative symptoms, specifically depersonalization and derealization (Friedman, 2013; Lanius et al., 2012; Stein et al., 2013). While Complex PTSD, per se, was not added to the DSM-5, Friedman (2013) stated that "changes in PTSD criteria as well as the addition of the new

dissociative subtype provide a new opportunity for considering complex PTSD that was not available in DSM-IV" (p. 554).

> Adding this subtype will encourage much needed research into the epidemiology, etiology, neurobiology, diagnosis, phenomenology, and treatment response of the dissociative subtype. Additional research with a wider variety of trauma types and severity is needed to deepen our understanding of the environmental and genetic contributions for this subtype and to test whether the dissociation-childhood sexual abuse link is confirmed. More research is also needed to clarify which individual and trauma variables make individuals more vulnerable to dissociative symptoms (Lanius et al., 2012, p. 702).

The importance of continued research into the relationship between traumatic exposure and dissociative disorders cannot be overstated as individuals with more complex presentations, such as those with PTSD dissociative subtype, do not often respond to standard cognitive-behavioral treatments (CBT) and thus require a longer, phase-oriented treatment plan (Chu, 2011; Cloitre et al., 2012; Courtois et al., 2020; Courtois & Ford, 2016; Herman, 1992; Lanius et al., 2012; Van der Kolk, 2015; Van der Kolk et al., 2005).

The above history supports the idea that the study of psychological trauma has been episodic. Over the course of the last century, there were multiple periods when professionals and the public began to become aware of the high prevalence of trauma and its psychological impact. This awareness was regularly followed by mass denial and attempts to suppress uncomfortable truths about the ubiquity of trauma and its devastating effects on those who had experienced it. Efforts to suppress evidence of abuse that has resulted in psychological trauma have included outright denial that such abuse had occurred and victim-blaming. During other periods, an oddly paradoxical form of suppression occurred whereby the exaggeration or sensationalization of traumatic

experiences ironically ended up diverting attention away from unsettling realities about actual trauma.

The reasons for this suppression of the truths about trauma were often rooted in sociopolitical agendas, which sought to maintain the hierarchy of the social, governmental, military, and political systems in power. To confront the extent and sources of trauma would have risked upending the institutional systems that often set the stage for traumatic events to occur. This suppression was particularly prominent when concerns regarding the abuse of women and children were brought to the forefront.

To confront the deep capacity for evil and cruelty in human nature is, understandably, an unsettling and worldview-changing experience. As shown above, it can also be an inconvenient challenge to the status quo because it may cause social and political repercussions that some may find untenable. During the past century, dedicated trauma researchers and clinicians have pushed back against these suppressive forces in an effort to ensure that attention remains focused on researching the psychological impact of trauma. These efforts eventually resulted in the inclusion of PTSD in the DSM-III (American Psychiatric Association, 1980) and the evolution of the concepts of both traumatic stress and dissociative disorders in subsequent editions of the DSM (American Psychiatric Association, 1987; American Psychiatric Association, 2004; American Psychiatric Association, 2013). Research into further understanding the array of psychological disorders that result from traumatic experiences is critical to the development of improved prevention and treatment approaches. The surprisingly high prevalence of trauma, which is discussed in the next section, is also an important reason that future research is needed.

## Exposure to Traumatic Events

It might be comforting to think that traumatic events are rare and extreme occurrences that affect a minority of people. However, this is not the case. As mentioned earlier, the DSM-IV removed the language within the PTSD category that described traumatic events as generally outside the range of normal human experience (American Psychiatric Association, 1994). This was a logical step because it is now known that exposure to traumatic events is "very common…and…not outside the normal range of human experience" (Benjet, et al., 2015, p. 339). Similarly, not all individuals who have been exposed to traumatic events will experience a diagnosable traumatic reaction, such as PTSD. By determining the frequency of various traumatic events and their correlations to negative outcomes, we gain insight into the myriad ways that exposure to single or multiple traumatic events manifests both psychologically and physically over the course of one's life.

The usual approach for determining the frequency of various events is through epidemiological research. For instance, Benjet et al. (2015) conducted an epidemiological study regarding the frequency of traumatic events. The study surveyed 68,894 adults spanning six continents and 24 countries from 2001 to 2012. The survey assessed 29 types of traumatic events. When a participant endorsed a specific traumatic event, they were asked about the number of times they had been exposed and the age at which they were first exposed. Over 70% of respondents reported experiencing at least one traumatic event with over 30% endorsing exposure to four or more traumatic events throughout their lifetime. Several of the traumatic events were personal in nature, such as sexual assault and interpersonal violence. Because of the personal nature of these events, the

researchers speculated that these results are an underestimate of the actual lifetime exposure to traumatic events.

The results of the Benjet et al. (2015) study clearly showed that exposure to traumatic events is common with over two-thirds of respondents reporting they had experienced at least one traumatic event. The Benjet et al. (2015) study focused on the frequency of events internationally. Other researchers have confined their study to the United States, both validating the frequency of traumatic events found by Benjet et al. (2015) and also extending their investigation to the impact these events had on participants.

Kilpatrick et al. (2013) assessed the frequency of stressful life events and the impact of these events on survey participants from the United States. The highly structured, self-administered survey was completed online by over 3,000 participants. The survey measured exposure to DSM-5 PTSD Criterion A events (i.e. direct or indirect exposure to events which threaten death, serious injury, or sexual violence) (American Psychiatric Association, 2013) through 28 questions prefaced by definitions of the types of events included. When participants provided affirmative responses to the 28 questions, three follow-up questions queried about the number of occurrences of the event, which events (if multiple events were endorsed) occurred first, and which event was considered the worst by the participant. Additionally, questions were developed to measure PTSD symptoms and their recency and severity. The study confirmed a high rate of trauma prevalence. Almost 90% of respondents reported experiencing at least one traumatic event and an alarming 53% of respondents reported being victims of interpersonal violence. Notably, the study found that over 30% of the participants experienced multiple

traumatic event types, the probability of lifetime PTSD increased with multiple event exposure, and the highest probability of developing lifetime PTSD was associated with events involving military combat or interpersonal violence. The finding about the relationship between interpersonal violence and the development of PTSD is notable as sexual assault prevalence was 29.7% (42.4% of women and 15.8% of men) and physical assault prevalence was 43.7% (44.9% of women and 42.4% of men). However, PTSD is not the only negative impact that exposure to traumatic events causes. Other researchers have found that there are other negative psychological and physical outcomes resulting from traumatic event exposure.

Using data from the National Comorbidity Survey-Replication (NCS-R) (Kessler & Merikangas, 2004), Sledjeski et al. (2008) investigated the relationship between the number of lifetime traumatic events, PTSD, and 15 chronic medical conditions. They found that individuals with PTSD were more likely to develop chronic medical conditions than those without PTSD. Furthermore, the likelihood of developing PTSD increased as a function of increased exposure to traumatic events. Exposure to any traumatic event has been shown to increase the risk of experiencing subsequent traumatic events (Benjet et al., 2015; Kilpatrick et al., 2013). The cumulative stress resulting from the repeated experience of traumatic events has been shown to impact both physical and mental health negatively, especially when initial exposure occurs during childhood when one's sense of self is developing (Benjet et al., 2015; Felitti et al., 1998; Turner & Lloyd, 1995).

Therefore, epidemiological studies sampling participants both within the United States and globally substantiate the high rates of exposure to traumatic events in these

populations and the psychological and physical health issues that result. Further, as mentioned previously, initial exposure to a traumatic event increases the risk of subsequent traumatic event exposure, and exposure to traumatic events that occur during childhood can have a particularly deleterious impact on later psychological development. In this regard, the Adverse Childhood Experiences Study (ACES) was an epidemiological investigation of the potentially traumatic events that occur during childhood which demonstrated the heightened negative impact on later development (Felitti et al., 1998; Finkelhor et al., 2015). The information ACES provided about the frequency and severity of childhood trauma is an important counter to societal attitudes about trauma because, as noted above, the public and many professionals have historically tended to minimize or outright deny the high prevalence of child abuse.

**Adverse Childhood Experiences**

In the last two decades, the field of medicine has increasingly investigated the relationship between childhood trauma and risky lifestyle behaviors in adulthood. Studies of the long-term impact of childhood trauma often examined the impact of single traumatic events on specific populations, such as females who have experienced childhood sexual abuse (Briere & Runtz, 1988; Bryant & Range, 1995; McCauley, 1997). The focus on a single type of trauma ignores the influence of multiple negative factors that can accumulate in a dysfunctional home environment. With this in mind, Felitti et al., (1998) conducted a study that examined multiple types of potentially traumatic events called adverse childhood experiences (ACEs) (i.e., potentially traumatic events that occurred in childhood within the home environment), and the relationship between these ACEs to public health issues.

Specifically, the ACE survey was conducted to examine the long-term impact of trauma during childhood, and the resulting risk for disease, mortality, utilization of healthcare resources, and factors that negatively impacted quality of life in adulthood (Felitti et al., 1998). The ACE survey consisted of 10 yes or no questions that assessed adverse experiences such as child maltreatment and household dysfunction (Anda et al., 2006; Felitti et al., 1998; Finkelhor et al., 2015). Categories of household dysfunction surveyed included potentially traumatic experiences, such as exposure to alcohol and drug abuse, mental illness, criminal behavior, physical or sexual violence to self or another, or loss of a parent to death or incarceration. The resulting ACE score (0-10) was compared to participant measures of health status, disease, and adult risk behavior. The health risk factors surveyed included items such as smoking, obesity, alcohol or drug abuse, depression, and suicide attempts. Disease conditions were obtained from the participant's documented medical history and included the leading causes of death in the United States, such as heart disease, cancer, stroke, chronic bronchitis or emphysema, and diabetes. The study found that the health risk factors for the leading causes of death in adults were significantly correlated with the number of categories ACEs experienced. Further, the study concluded that those who have endured ACEs are at increased risk of engaging in unhealthy coping mechanisms, such as smoking, drinking, illicit drug use, overeating, or risky sexual behaviors. These behaviors, in turn, predispose individuals to a variety of mental and physical health issues (Felitti et al., 1998).

While the Felitti et al. (1998) findings focused on the impact of childhood trauma on physical health, Anda et al. (2006) studied the psychological impact of childhood trauma. Anda et al. found that childhood trauma precedes numerous psychiatric disorders,

including substance abuse, depression, anxiety, PTSD, dissociative disorders, and personality disorders. Further, childhood traumatic events may disrupt one's ability to form healthy attachments in adulthood. Anda et al. concluded that when considering the consequences of traumatic events experienced in childhood, there should be equal attention given to developmental and psychiatric disorders as is given to physical health issues.

The ACE research (Felitti et al., 1998) has made important contributions to our understanding of the public health issues and costs resulting from childhood exposure to traumatic events. However, some researchers have proposed that the original ACE questionnaire is incomplete (Afifi, Salmon, et al., 2020; Briggs et al., 2021; Finkelhor et al., 2013; Finkelhor et al, 2015; Karatekin & Hill, 2018; McLennan et al., 2020). Briggs et al. called for integrating ACE findings with developmental psychopathology research and expanding beyond household dysfunction to include community and environmental level traumas and adversities. Finkelhor et al. (2015) stated "there is strong evidence that other common childhood adversities missing from this [the ACEs] list also have negative long-term developmental effects" (p.13). The common adversities that Finkelhor et al. proposed should be included in assessing ACEs are childhood bullying and peer victimization, poverty and deprivation, isolation and peer rejection, and exposure to community or collective violence (Briggs et al., 2021; Finkelhor et al., 2013; Finkelhor et al., 2015). Finkelhor et al. (2015) stated the negative psychological effects of these additional adversities can exceed those resulting from household dysfunction. As a result, Finkelhor et al. (2013; 2015) suggested revising the ACE questionnaire from 10 to 14 items to include the additional categories.

Numerous studies have been conducted that validate the original findings (Felitti et al., 1998) while also using exploratory factor analysis to examine the effects of specific ACEs and clusters of ACEs (Afifi et al., 2020; Karatekin & Hill, 2019; Mersky et al., 2021; Negriff, 2020). Afifi et al. (2020) suggested expanding the ACEs questionnaire to 16 items separated into two constructs: child maltreatment and peer victimization (physical abuse, sexual abuse, emotional abuse, emotional neglect, physical neglect, exposure to intimate partner violence, spanking, and peer victimization) and household dysfunction (household substance abuse, household mental health problems, household gambling problems, parental separation or divorce, parental trouble with police, child protective services or foster care engagement, poverty, and neighborhood safety). This construct-related view of ACEs begins to address the idea proposed by some researchers that not all ACEs have equal negative effects on physical and psychological well-being, even as it is continually affirmed that the greater number of ACEs experienced by any one individual increases the likelihood of later physical and psychological challenges (Briggs et al., 2021; Negriff, 2020). Negriff (2020) indicated that maltreatment items have more significant impact on internalizing symptoms and mental health problems, while household dysfunction more strongly predicts externalizing behaviors which may result in physical health maladies. Mersky et al. (2016) explored a 17-item ACE survey designed to strengthen the cross-cultural validity of the measure and found that ACEs are more prevalent in low-income households. They confirmed the two-factor model based on the original 10 ACEs, however, with the additional 7 items they found a more nuanced four-factor model emerged. The four factors were interpersonal victimization (physical abuse, sexual abuse, emotional abuse, domestic violence, bullying and violent crime,

household substance abuse, and household mental health problems), neglect (emotional neglect and physical neglect), extreme poverty (frequent family financial problems, food insecurity, and homelessness), and family loss and separation (incarceration, prolonged parent absence, and divorce/separation, along with household substance abuse).

It is important to note that these studies were conducted to deepen the knowledge of what is considered a childhood adverse experience and to explore the possibility that certain types of experiences may have a stronger predictive value for future physical and psychological health issues than others. However, the ACE is not considered a diagnostic assessment and there is no predetermined score, or combination of events, which determine negative outcomes in adulthood (Afifi et al., 2020; Anda et al., 2006; Felitti et al., 1998; Finkelhor et al., 2015; Karatekin & Hill, 2019; Mersky et al., 2021; Negriff, 2020). The original ACE research (Felitti et al., 1998) was influential in the recognition of the extent to which traumatic experiences occur during childhood. The above studies, building upon the original, investigated outcomes that meet diagnostic criteria for psychological and physical disorders; however, exposure to ACEs can produce impaired well-being at subclinical levels that may also prompt individuals to seek help.

Exposure to ACEs can also produce psychological suffering that does not meet the full diagnostic criteria for PTSD or other DSM-5 disorders. Mosley-Johnson et al. (2018) conducted an analysis using data collected by Midlife Development in the United States (MIDUS), a longitudinal study spanning the years 1995-2014 with over 6,000 individuals who participated in phone interviews and online questionnaires. Their goal was to expand the understanding of the long-term effects of ACEs beyond chronic disease and poor mental health. They found that higher ACE scores were associated with

reduced social well-being, psychological well-being, and life satisfaction. Therefore, even when ACEs do not result in formal psychiatric disorders, these experiences often still have a negative impact on well-being.

The above discussion demonstrates the high rates of exposure to traumatic events in general population studies and the heightened medical, psychological and developmental risks associated with ACEs. As noted from the research discussed above, exposure to trauma may manifest in myriad ways. Therefore, it may not be apparent to therapists that particular clients have a history of trauma when they first present for mental health treatment. As such, many clients who report general psychological issues, such as anxiety, depression, adjustment challenges, or relationship difficulties, may eventually disclose a history of traumatic events as treatment progresses. Therefore, given the high prevalence of trauma, it is reasonable to conclude that most therapists will regularly be exposed to recollections of client traumatic events whether or not they deem themselves to be trauma therapists. Such secondary exposure to client trauma may cause therapists to experience a range of stress responses including burnout, compassion fatigue, secondary traumatic stress, and vicarious traumatization (Devilley et al., 2009; Figley, 1995; Gaboury & Kimber, 2022; Pearlman & Saakvitne, 1995). This range of potential responses to secondary traumatic exposure is explored next.

**Secondary Exposure to Traumatic Events**

The job of bearing witness to the details of others' struggles and traumatic experiences takes a toll on therapists. These effects have been alternately described as burnout (Devilly et al., 2009), compassion fatigue (CF; Figley, 1995), secondary traumatic stress (STS; Devilly et al., 2009; Figley, 1995), and vicarious traumatization

(VT; McCann & Pearlman, 1990a; Pearlman & Mac Ian, 1995). In the academic and professional communities, there is a lack of agreement about the meaning of these concepts and whether they are distinct or intersecting (Devilly et al., 2009; Gaboury & Kimber, 2022;). To address the question of whether these are, in fact, distinct constructs, Jenkins and Baird (2002) examined the relationship between burnout, CF, STS and VT. The term *burnout* was initially used to describe the emotional toll on human service workers whose work required intense involvement with other people's problems. Burnout manifests as emotional exhaustion, depersonalization, and reduced self-efficacy as the result of chronic over-extension of self. Jenkins and Baird found a moderate overlap of burnout with CF/STS and VT. Later researchers have found burnout is significantly negatively correlated with age and experience, with less-experienced therapists reporting higher levels of burnout than older, more-experienced therapists (Cook et al., 2020; Hiles Howard et al., 2015).

Charles Figley (1995) studied the unique phenomenon of burnout among counselors for over four decades. He initially described the phenomenon as a type of secondary victimization which, among therapists who work with traumatized populations, manifested as depression, anxiety, sleeplessness, and other symptoms like those suffered by individuals who have directly experienced trauma. Figley's research aimed to expand the DSM-III (American Psychiatric Association, 1987) and DSM-IV (American Psychiatric Association, 1994) descriptions of Post-Traumatic Stress Disorder (PTSD) to include the impact on those who are confronted with the pain and suffering of others. His recommendation was to keep the PTSD criterion as is and to add the category of Secondary Traumatic Stress Disorder with criteria that paralleled PTSD criteria. Figley

defined secondary traumatic stress as the natural consequence that results from helping or wanting to help traumatized persons. Figley later proposed the terms *compassion stress* and *compassion fatigue* (CF) to describe the cost of caring to those who treat traumatized populations more accurately. Further, Figley believed compassion fatigue to be a friendlier, more digestible label to describe the manifestations of therapists' duty-related experiences. However, Jenkins and Baird (2002) found that compassion fatigue invites misinterpretation from the standpoint of content validity as the majority of items on the Compassion Fatigue Scale (17/23) measure trauma symptoms and experiences more in line with PTSD rather than measuring either compassion or fatigue. Nonetheless, Figley made clear the need to distinguish primary and secondary exposure to traumatic stress and to adjust diagnostic categories and criteria accordingly. While not producing a new category as suggested by Figley, the American Psychiatric Association (2013) did modify diagnostic criteria for PTSD to include secondary exposure.

The Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 2013), or DSM-5, updated its criteria for PTSD to include "indirect exposure to aversive details of the trauma, usually in the course of professional duties" (p.271) to reflect the recognition that traumatic stress symptoms can develop from exposure to the recollections of traumatized individuals and not just from direct exposure to the traumatic event itself. This adjustment to Criterion A qualifiers subsumes Figley's (1995) conceptualization of STS as being composed of intrusion, avoidance, and arousal symptoms. The DSM-5 also added a fourth symptom cluster, negative alteration in cognition and affect, to the diagnostic criteria for PTSD. This category includes negative thoughts and assumptions about oneself or the world which McCann and Pearlman

(1990) have attempted to distinguish with their conceptualization of VT. Mordeno et al. (2017) noted that the DSM-5 PTSD criteria do not address the unique nature of the interactive relationship between the traumatized client and the therapist whose role is to create an empathic and healing environment while vicariously witnessing the client's traumatic experiences. The unique nature of the therapeutic relationship and the role of the therapist within the relationship will be explored next.

## The Role of the Therapist in the Therapeutic Relationship

This section reviews the history of various conceptualizations of the therapeutic relationship with particular attention to the role of the therapist from the perspectives of Freud, Binswager, Rogers, and Satir. I also discuss the emergence of therapist empathy as a significant element of the therapist's contribution to the therapeutic relationship. Then, I provide an overview of the role that therapist empathy plays in the development of *vicarious traumatization*.

In psychotherapy, all roads lead back to Freud. Considered the father of talk therapy, Freud's version of psychotherapy was mostly monologic with the client speaking while the therapist was separate and mostly silent (Mitchell & Black, 1995). The self of the therapist remained largely absent to avoid contaminating the understanding of the client's self as it emerged in psychoanalysis (Mitchell & Black, 1995). Freud viewed interpersonal relations as instinctually oriented; other people were merely objects in one's innate drive to gratify their needs (Freud, 1962). In this "I-It" (Frie, 2000, p. 118) orientation, Freud viewed the therapist as an object onto which the client projected their needs and wishes, rather than a self in its own right (Frie, 2000; Mitchell & Black, 1995).

In contrast to Freud, Binswager proposed a dialogic form of psychotherapy. Binswager was influenced by Buber's philosophy of dialogue. Buber argued that individuals cannot be fully understood apart from their relationships with other individuals (Buber, 1923). Further, Buber stated that "authentic selfhood can only be comprehended in terms of the reciprocity of I and Thou" (Frie, 2000, p. 118).

Binswanger incorporated Buber's dialogic nature of human existence into his own conceptualization of self-realization within a loving and reciprocal I-Thou relationship (Frie, 2000). It is through this I-Thou relationship of openness, immediacy, and mutuality between therapist and client that growth and change can occur. Binswanger argued that within the I-Thou relationship "each partner has the need to recognize the other as both distinct from, and similar to, himself or herself" (p. 120). In this regard, Frie stated:

> It is important to note that in Binswanger's conception of the I-Thou or interpersonal love relation, the other person is *not* simply a means to an end, but a *participant* in the process of self-realization. When the other person is described simply as an object for self-reflection or as the means to self-discovery, the relationship is drained of attachment, intimacy, and engagement. When applied to the therapeutic relationship, this insight suggests that therapist and patient meet face-to-face and come to know each other as two interacting human beings. If this is not the case, then the self, though placed in a context of a relationship, is defined only in terms of separation. Indeed, where classical psychoanalysis stresses separation and autonomy from the other, the emphasis in the existential-interpersonal approach I am outlining is on deepening our understanding of our continuing relationship to others. (p. 121)

Binswanger argued that Freud's view of objectification did not account for the role of interpersonal relations in the development of the client's self (Frie, 2000). Binswanger was interested in how individuals construct their worldview through their interactions with the social environment. He believed the purpose of psychotherapy was to recognize and liberate clients from distorted ways of relating to the world and to others

around them. Binswanger believed this purpose can only be achieved through an I-Thou relationship between the therapist and the client, a state of being-with-one-another in an authentic, reciprocal relationship (Frie, 2000). Through mutual interaction, the I-Thou relationship enhances self-realization and avoids distancing or fusion, if "personal boundaries are respected and individual difference is recognized" (Frie, 2000, p. 123).

In the 1950's, Rogers created the theoretical framework for his client-centered counseling approach (Rogers, 1957). Rogers' conceptualization moved the therapeutic dynamic from one where the therapist *does* something to the client to the therapist simply *being* present with the client. Virtually all counseling and other psychotherapy students are taught the necessary and sufficient conditions for effective therapeutic change as initially described by Rogers (1957). Among these conditions, Rogers stated, "The therapist experiences an empathic understanding of the client's internal frame of reference and endeavors to communicate this experience to the client" (Rogers, 1957). Rogers' discussion of empathic understanding focused on its' impact on the client. He described empathy as:

> To sense the client's private world as if it were your own, but without ever losing the "as if" quality—this is empathy, and this seems essential to therapy. To sense the client's anger, fear, or confusion as if it were your own, yet without your own anger, fear, or confusion getting bound up in it… (Rogers, 1957, p. 243).

Rogers viewed various techniques, including his client-centered technique of reflective listening, as providing a mechanism through which the essential conditions of unconditional positive regard and empathic understanding were achieved. Rogers did not propose a way to operationalize empathy, leaving others to grapple with doing so. McIntyre and Samstag (2021) stated that "despite the importance of therapeutic empathy,

there is confusion about what exactly it is, given the myriad ways it has been described and measured" (p. 127). Because, in the Rogerian view, utilization of empathy is one of the primary functions of the therapist, being precise about what empathy means is vital to understanding the role of the therapist self in therapy. McIntyre and Samstag's (2021) attempt to formulate a construct of therapeutic empathy is discussed next.

McIntyre and Samstag (2021) performed an integrative review of 28 articles published between 2016 and 2021. Beginning with Rogers' (1975) person-centered approach, they summarized the theories that contributed to a definition of therapeutic empathy as an *empathic dialectic* (McIntyre & Samstag, 2021, p.127). McIntyre and Samstag described empathic dialectic as the therapist's capacity to emotionally resonate with the internal states of clients, to recognize and repair relational ruptures, and to effectively mentalize and coregulate both their own and their clients' emotional states. McIntyre and Samstag highlight the significance of the "as if" condition stated by Rogers (1957; 1975). The ability of therapists to recognize the separation between themselves and their clients to avoid over-identification requires the therapist to be attuned to their own emotional states and to continually check in with their clients as to the accuracy of their felt sense. "It requires the therapist to set themselves aside and be secure enough to know they will not get lost in the world of another; that they can return to their own whenever they'd like" (McIntyre and Samstag, 2021, p. 128). Furthermore, they found that the therapist's level of secure attachment predicts their capacity for attunement and effective emotional regulation within the therapeutic dyad and, conversely, therapists with insecure attachment styles are less able to be empathically attuned without becoming dysregulated, negatively impacting therapeutic effectiveness. They conclude that

therapists-in-training should be advised to address their own psychological issues in personal therapy to gain greater self-awareness and enable a more effective and empathic therapeutic alliance.

The connection between self-awareness and the ability to be more empathically present with clients is described well by therapist and theorist, Virginia Satir (1987):

> When I am in touch with myself, my feelings, my thoughts, with what I see and hear, I am growing toward becoming a more integrated self. I am more congruent, I am more "whole," and I am able to make greater contact with the other person (p. 25).

Satir viewed the therapist's awareness and use of self as an intentional and integral part of the therapeutic process and that the presence of the self of the therapist occurs regardless of treatment approach or philosophy. Satir (1987) pleaded, "Can we accept as a given that the self of the therapist is an essential factor in the therapeutic process?" (p. 26). As such, Satir viewed the therapist's continuous journey toward self-understanding and growth as both essential to their ability to maintain congruence during therapeutic relationships and as a means of avoiding burnout. Satir considered the therapist self as the instrument through which therapeutic change may occur and defined self as "how complete one is as a person, how well one cares for oneself, how well one is tuned in to oneself, and how competent one is at one's craft" (p. 25).

In support of Satir's view of self in the therapy process, Sleater and Scheiner (2019) determined the use of self by the therapist predicts successful therapeutic outcomes. Sleater and Scheiner researched therapist's use of self and its impact on the effectiveness of therapy. Sleater and Scheiner highlighted three approaches to therapist use of self: the instrumental approach, the authentic approach, and the transpersonal

approach. The instrumental approach uses techniques “on” the client. The therapist views what they do as more important than who they are. The authentic approach is a more personal, humanistic approach whereby the therapist brings their authentic personality into the relationship. The transpersonal approach requires a deeper presence where the therapist and client create an intersubjective experience unique to them. This is achieved through the therapist’s mindful presence and embodied empathy. The therapist utilizes their bodily awareness to momentarily live in the client’s experience while remaining conscious that the experience belongs to the client. It is this transpersonal approach that was so aptly described by Satir (1987). According to Sleater & Scheiner (2019), this deepened therapeutic framework, described by Rogers as the “as if” quality of empathy (Rogers, 1957), cannot be taught through technique but rather must be acquired through time and experience (Sleater & Scheiner, 2019).

According to the above theorists and researchers, the expression of empathic attunement from a highly self-aware therapist is a key component to effective therapeutic outcomes. It is evident from the above discussion that effective therapists are finely attuned to their own thoughts and feelings, which enables them to recognize the internal experiential states of their clients. This is especially true when working with traumatized clients. McCann and Pearlman (1992) stated that most traumatized clients want and need to experience an empathic, warm relationship with a responsive therapist who actively and openly builds an alliance with the client.

The above discussion highlighted the impact the therapist’s empathically present self has on the therapeutic relationship. As noted earlier, the therapist’s sense of self also influences the therapist’s experience of secondary exposure to the traumatic experiences

of their clients. McCann and Pearlman (1992) stated that the therapist must possess the capacity to tolerate intense emotions and painful memories without either overreacting or withdrawing. Even for therapists who possess a high level of self-awareness, the emotional labor required to maintain that balance may exact a toll on their professional and personal lives. However, just as not all individuals respond to traumatic experiences in the same way, therapists respond to working with traumatized clients in unique ways. In the next section, I discuss the theoretical framework developed by McCann and Pearlman (1990) and later expanded for use in understanding the varying response by therapists to cumulative secondary exposure to client traumatic experiences (Pearlman & Saakvitne, 1995).

## Vicarious Traumatization

As discussed previously, the cumulative effects of trauma, especially those traumatic events which occur during one's developmental years, cause and exacerbate long-term physical and psychological health issues. It is further recognized that not all individuals experience and respond similarly to traumatic events (Anda, et al., 2005; Briggs, et al., 2021; Felitti, et al., 1998; Finkelhor et al., 2013; Finkelhor et al., 2015; Mosely-Johnson et al., 2018). McCann et al. (1988) studied individual differences in response to traumatic events based on the unique meaning attributed to the event. They determined that it is critical to understand the unique inner world of each trauma survivor's beliefs, thoughts, and feelings as these are what shape the individual's response to trauma. Through their extensive work with adult survivors of childhood sexual abuse at The Traumatic Stress Institute, McCann and Pearlman (1990) identified the need for a heuristic model that integrated the literature on trauma and individual

psychological development. They were curious why some individuals respond to traumatic experiences negatively, while others are able to process and resolve their traumatic experiences in a way that maintains or returns them to health and functionality. Building upon the McCann et al (1988) study, McCann and Pearlman (1990) created the Constructivist Self-Development Theory (CSDT), which focuses on the intersection between the individual and the traumatic event and its impact on the self in development. While CSDT was initially developed as a way to conceptualize differential responses to traumatic events by clients, McCann and Pearlman discovered that the therapists working with these clients were also potentially traumatized through the clients' retelling of their traumatic experiences. McCann and Pearlman were prompted to coin the term *vicarious traumatization* to describe the therapist's unique experience of working with traumatized clients, and forthwith expanded their research to include the effects of trauma work on therapists (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995).

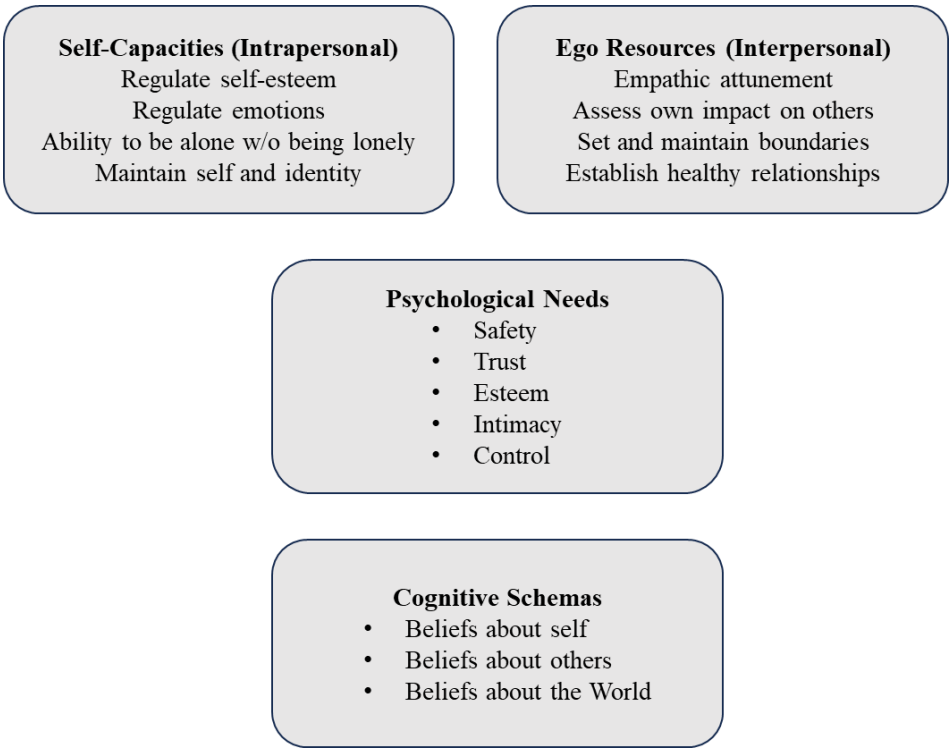
**Constructivist Self-Development Theory**

CSDT posits that individuals possess an inherent capacity to actively create their personal realities and worldviews as they interact with their environment, and that one's reaction to trauma is a complex interaction between life experiences and the developing self. McCann and Pearlman (1990) view the self as the psychological foundation of an individual, their identity and their inner life. CSDT describes the self as being composed of four aspects: *self-capacities* which regulate self-esteem, *ego resources* which regulate interactions with others, *psychological needs* which motivate behavior, and *cognitive schemas* which organize one's experience of self and the world (McCann et al., 1988;

McCann and Pearlman, 1990a; McCann & Pearlman, 1990b; McCann & Pearlman, 1992).

**Figure 2.1**

*Constructivist Self Development Theory View of the Self*




McCann and Pearlman (1990a) define *self-capacities* as internal aspects that help an individual maintain a consistent sense of self through the ability to tolerate and regulate strong emotions. These include the ability to be alone without feeling lonely, to self-soothe, and to take in criticism without a loss of esteem. Another important self-construct, *ego resources*, are defined as the conscious abilities one constructively uses to engage with the world and others. Ego resources include one's capacity for self-reflection, critical thinking, personal growth, and empathy. Ego resources also include skills necessary for self-protection, such as the ability to set and maintain appropriate

boundaries, establish emotionally mature relationships, and accurately assess the consequences of one's own, or others', actions.

*Psychological needs* are those internal drives that motivate behavior and form the basis upon which relationships with others are built. CSDT conceptualizes psychological needs from a developmental perspective because they continue to develop throughout one's life. When a traumatic event occurs, there is a potential for disruption to the development of self. Furthermore, when a traumatic event occurs during the critical developmental periods when identity is being formed (e.g. childhood and young adulthood), the disruptions to one's sense of self are more likely to cause pervasive changes (McCann & Pearlman, 1990a; McCann & Pearlman, 1992; Pearlman & Saakvitne, 1995). CSDT focuses on five psychological needs that are most disrupted by trauma: *safety, trust, esteem, intimacy* and *control.* These needs combine with one's self-capacities and ego resources to create *cognitive schemas*, both conscious and unconscious, relative to the beliefs and expectations one has about self and others (McCann et al., 1988; McCann & Pearlman, 1990a; Pearlman & Saakvitne, 1995). The following fictional example illustrates the interaction between self and event:

> Sasha, age 13, is the only child of two working parents. Sasha's father suffers from persistent depression which is exacerbated by heavy alcohol use. He fluctuates between periods of quiet withdrawal where he ignores Sasha and bouts of anger during which he is highly critical. Sasha's mother pressures Sasha to "not upset" her father and demands perfect performance in academics and extracurricular activities. During her father's bouts of anger, Sasha's mother sends Sasha to her room to not make things worse. Sasha, alone and confused, lacks the ability to calm the churning she feels in her gut. She feels bad about herself and her inability to help her father feel happy. Sasha has not yet been taught how to develop *self-capacities*. She also lacks the *ego resources* necessary to ask for help from her parents, having received the message that her feelings and needs are unwelcome. Sasha's *psychological needs* are not being met. The result is that Sasha has constructed *cognitive schemas* that she is bad and blames herself for the

> stress her parents experience. She believes she deserves to be banished to her room and that she is unworthy of love, even from her parents. One day Sasha's father kills himself. Sasha, lacking a foundation of self or the familial support needed to endure the grief, reacts by becoming further entrenched in her negative beliefs of worthlessness and self-blame. These *negative cognitive schemas,* if not addressed through therapeutic intervention, will continue to impair Sasha's relationship with both herself and others in the future.

McCann et al. (1988) present CSDT as a heuristic model intended to help therapists and researchers better understand the unique responses of individuals to traumatic experiences. The model is intended to be used as a framework for assessment and intervention, a way to understand individual differences in response to trauma. CSDT has also been used to understand the contributions of the self of the therapist to the therapeutic process (Pearlman & Saakvitne, 1995).

As psychotherapy, and especially trauma therapy, has shifted away from reliance on a medical model to a relational model, the significance of the self of the therapist has concomitantly been given greater emphasis. Pearlman and Saakvitne (1995) state that the therapeutic relationship is shaped by what the therapist brings to it, "specifically our personal history, feelings, attitudes, defenses, unconscious processes, conscious reactions, and behaviors, all of which will inform and be reflected in our countertransference" (pp. 15-16). It is because of this shift toward the relational aspects of therapy, and the importance of the therapist within the relationship, that McCann and Pearlman (1990b) noted the need to extend the application of CSDT to include therapists. Pearlman and Saakvitne adapted the CSDT model to address the long-term effects of working with traumatized populations on the therapist. They named the enduring and lasting effects of this work *vicarious traumatization* (VT). To understand the distinct phenomenon of VT,

we must distinguish it from the previously discussed related constructs: burnout, compassion fatigue, and secondary traumatic stress.

**Defining Vicarious Traumatization**

Building upon the foundation of CSDT, McCann and Pearlman (1990b) originated the term *vicarious traumatization* (VT) to describe the negative impact that working with traumatized populations may have on therapists over time. McCann and Pearlman view VT as distinct from burnout, which posits that the therapist is distressed due to external events, and *compassion fatigue* (CF), which attributes the source of distress to the therapist's exhausting emotional labor and unresolved psychological conflicts (Branson, 2019; Gaboury & Kimber, 2022; McCann & Pearlman, 1990b; Pearlman & Saakvitne, 1995). Jenkins and Baird (2002) validated this distinction by comparing instruments that measure CF/STS and VT, and concluded that "neither measure is reduceable [sic] to the other" (p. 431). Schauben and Frazier (1995) also validated McCann and Pearlman's (1990b) and Pearlman and Saakvitne's (1995) hypothesis that VT is a distinct and separate construct from burnout. VT is a distinct construct because CSDT (the theory VT originated from) views the therapist's response to working with traumatized clients as the result of *both* the external situation and their unique cognitive schemas and psychological needs. They further state:

> …we understand the effects on therapists as pervasive, that is, potentially affecting all realms of the therapist's life; cumulative, in that each client's story can reinforce the therapist's gradually changing schemas; and likely permanent, even if worked through completely (p. 136).

McCann and Pearlman (1990b) posit three conditions within the therapeutic dyad that result in VT. First, the therapist is empathically engaged with, and exposed to, the

client's detailed descriptions of traumatic experiences. Second, the therapist is empathically engaged with, and exposed to, the reality of human evil and cruelty as described by their clients. Third, the therapist participates in reenactments of the client's original trauma through the process of transference and countertransference during counseling sessions. These conditions differentiate VT from burnout, CF, and STS. Similar to Figley's (1995) assertion that CF and STS are the natural result of therapeutic engagement, Pearlman and Saakvitne (1995) view VT as an inevitable consequence for therapists who work with traumatized clients over time. Therefore, Pearlman and Saakvitne conclude that it is impossible to work with traumatized populations without experiencing significant shifts in one's view of self, others, and the world.

CSDT was developed to understand the unique inner world of a trauma survivor's beliefs, thoughts, and feelings and how they shape the individual's response to trauma. While initially created as a way to conceptualize differential responses to traumatic events by clients, McCann and Pearlman (1990) extended CSDT to address the impact on therapists who work with traumatized clients and labeled the therapists' response as *vicarious traumatization.* Just as a client's sense of self shapes their response to trauma, the therapist's sense of self can influence the therapist's experience of secondary exposure to the traumatic experiences of their clients. Therefore, the self of the therapist plays an important role in the therapist's ability to process the traumatic experiences of their clients. The next section describes the consequences to the therapist both personally and professionally when overwhelmed by the cumulative exposure to their clients' traumatic experiences.

## Consequences to the Therapist of Vicarious Traumatization

Therapists are often drawn to the mental health field for personal reasons. Therapists who themselves have a trauma history "may carry both a higher tolerance for painful feelings and a greater capacity for empathy," (Pearlman & Saakvitne, 1995, p. 285) which can increase their vulnerability to VT. While Pearlman and Saakvitne (1995) originally conceptualized VT within the specific domain of therapists who work with sexual abuse survivors, VT is a consequence of work with a wide range of traumatized populations, including survivors of combat-related exposure, interpersonal violence, law enforcement, and other frontline workers (Pearlman & Mac Ian, 1995). Clients who are chronically suicidal can be particularly stressful to work with as the therapist psychologically absorbs, session after session, the client's despair and hopelessness, which exacts a toll on the therapist (Pearlman & Saakvitne, 1995; Pearlman & Mac Ian, 1995). Recently, therapists have had an influx of clients who have been traumatized by the COVID-19 pandemic. The risk of VT in therapists increased during the pandemic because of this surge of traumatized clients and because of the psychological vulnerability of therapists who also suffered from COVID-19-related distress (Aafjes-van Doorn et al., 2020).

The empathic process through which therapists understand their clients' traumatic experiences results in the transformation of the way the therapist experiences self, others, and the world (Gaboury & Kimber, 2022; McCann & Pearlman, 1990b; Pearlman & Mac Ian, 1995; Pearlman & Saakvitne, 1995; VanDeusen & Way, 2006; Way et al., 2007; Williams et al., 2012). VT permeates every aspect of the therapist's inner world and relationships. This transformation does not occur as the result of any one session or client

relationship, but rather as the cumulative effect of many clients over time (Gaboury & Kimber, 2022; McCann & Pearlman, 1990b; Pearlman & Mac Ian, 1995; Pearlman & Saakvitne, 1995; Williams et al., 2012). While working with trauma can ultimately be rewarding for therapists, VT describes the negative effect on the therapist that may result. Therapist's receive their clients' traumatic experiences through the sensory system. As therapists work with clients to process the details of traumatic events, they are exposed to specific descriptions of images, sounds, smells, and bodily sensations that the empathic therapist may experience viscerally (Pearlman & Mac Ian, 1995; Pearlman & Saakvitne, 1995). Some of these experiences may trigger aspects of the therapist's own history of trauma (Gaboury & Kimber, 2022; McCann & Pearlman, 1990b; Pearlman & Mac Ian, 1995; Pearlman & Saakvitne, 1995; VanDeusen & Way, 2006; Way et al., 2007; Williams et al., 2012). While therapists often strive to separate their own feelings from those the client describes during the session, these sensory triggers may carry over into the therapist's personal life, resulting in an increased aversion or startle response to certain images, sounds, or smells (Adams & Riggs, 2008; Pearlman & Saakvitne, 1995). Therapists may experience symptoms of anxiety, depression, and PTSD similar to those experienced by their clients, albeit, at subclinical levels. The effects of working with traumatized clients are unique to each therapist and may impact multiple aspects of the therapist's life, both personally and professionally. In addition, aspects of the therapist's self may also be negatively affected as the result of working with traumatized clients (Gaboury & Kimber, 2022; McCann & Pearlman, 1990a; McCann and Pearlman, 1990b; Pearlman & Saakvitne, 1995; Williams et al., 2012). These aspects of self are discussed next.

VT causes “profound disruptions in the therapist’s basic sense of identity, world view, and spirituality” (Pearlman & Saakvitne, 1995, p. 280). These disruptions can be deeply unsettling, and it is imperative that therapists take the time to thoroughly process these experiences (Gaboury & Kimber, 2022; McCann & Pearlman, 1990a; McCann and Pearlman, 1990b; Pearlman & Saakvitne, 1995; Williams et al., 2012). VT can cause a therapist to rethink their basic beliefs about their self-worth, role, and overall identity, unseating long-standing beliefs about the self. Hearing the horrific stories of abuse inflicted upon clients can stir up feelings within the therapist of anger and hatred toward the client’s abuser to the point of eliciting fantasies of revenge or harm to the abuser. These fantasies can create psychological distress and conflicts in a therapist’s sense of self because therapists often identify as kind, compassionate helpers. Working with survivors of trauma heightens the therapist’s awareness of their own vulnerability to abuse or capacity for exploiting others. The empathic experience of their client’s helplessness extrapolates to the therapist’s own sense of powerlessness to help their clients. The impact, left unprocessed, can overwhelm the therapist’s ability to manage even minor aspects of their personal lives. The therapist may even question why they are doing this work in the first place (Gaboury & Kimber, 2022; McCann & Pearlman, 1990a; McCann and Pearlman, 1990b; Pearlman & Saakvitne, 1995; Williams et al., 2012).

In addition to an altered sense of identity, VT may impact a therapist's worldview (McCann & Pearlman, 1990b; Pearlman & Sakvitne, 1995; Way et al., 2007; Williams et al., 2012). One’s worldview consists of multiple schemas about how and why things happen, values, principles, and life philosophies. Working with trauma survivors

challenges many therapists' long-standing views of human nature and causes them to question the extent of the human capacity for evil. In response, therapists can become suspicious of others, wondering if everyone they meet is a survivor or a perpetrator. When therapists who suffer from VT observe even minor interpersonal transgressions this can create a hypervigilant and fearful response in the therapist, who may wonder if even worse transgressions may occur later in private. The therapist who has suffered from VT may begin to doubt their own healing impact in a world that they now may perceive as overwhelmingly cruel. The overgeneralization of negative expectancies leads to a general cynicism about the world, or worse:

> These shifts reflect a profound loss of optimism, hope, and companionship with humanity, and an emotional constriction that can infuse and severely narrow one's life. A therapist may experience a loss of emotional spontaneity, generosity, and vulnerability that will deeply affect both (their) intimate relationships and personal spirituality (Pearlman & Saakvine, 1995, p. 286).

Pearlman and Saakvitne (1995) view spirituality as the experience of joy, love, hope, faith, gratitude, creativity, forgiveness, and a sense of wonder. A disruption to the therapist's spirituality is considered the tell-tale symptom of VT and is particularly damaging to the therapist both personally and professionally. Through empathically connecting with their clients' sense of groundlessness and meaninglessness, therapists may disconnect from their own sense of purpose and meaningfulness. Therapists may become emotionally numb as a way of protecting themselves and find it increasingly difficult to internalize a source of hope for themselves, their loved ones, and their clients. The profound disruptions to the therapist's basic sense of self and others cause shifts in their psychological needs as evidenced by altered cognitive schemas regarding safety,

trust, esteem, intimacy and control. I discuss these psychological needs in more detail next.

***Psychological Needs***

CSDT identified five universal psychological needs believed to be most vulnerable to disruption by traumatic life experiences. These include *safety, trust, esteem, intimacy, and control* (McCann et al., 1988; McCann & Pearlman, 1990a; McCann & Pearlman, 1990b; Pearlman & Saakvitne, 1995). These five psychological needs are used as the basis for measuring levels of VT by assessing both self-oriented (intrapersonal) and other-oriented (interpersonal) cognitive schemas within each of the five psychological need categories (Pearlman, 2003). A brief description of each follows.

The continuous exposure by therapists to the reality of the lack of *safety* experienced by their clients can disrupt the therapist's own schemas regarding the safety of self and the safety of others. The impact of this exposure on therapists may be the loss of their own sense of safety and security. Therapists may experience increased hypervigilance related to self and loved ones, nightmares, anxiety, and avoidance of people and places that elicit a fearful response (Adams & Riggs, 2008; Pearlman, 2003; Pearlman & Saakvitne, 1995; Williams et al., 2012).

Therapists may also experience altered schemas regarding *trust*, both trust of self and trust in others. Therapists who lack *trust* in self become self-critical and avoid sharing their thoughts and opinions for fear they will be criticized. They may begin to distrust their instincts with clients. A lack of trust in others leads a therapist to avoid reaching out to colleagues or supervisors, leading to feelings of professional isolation. They may withdraw from social situations and community engagement, leading to

personal isolation as well (Pearlman, 2003; Pearlman & Saakvitne, 1995; Way et al., 2007; Williams et al., 2012).

A loss of self-*esteem* or esteem for others may widen a therapist's feelings of disconnection. On one hand, the therapist may lose confidence in themselves professionally, resulting in a sense that they are not helping anyone. This sense may cause them to question their competence as a trauma therapist. Loss of esteem for others can result from chronic exposure to client stories of others who have treated clients cruelly, selfishly or neglectfully. The therapist may generalize their loss of confidence in the goodness of humans or become angry with people who are not sensitive to, or working toward, social reform (Pearlman, 2003; Pearlman & Saakvitne, 1995; Way et al., 2007).

*Intimacy* needs are impacted by VT and may result in emotional numbing that serves as a protective mechanism against exposure to stories of human cruelty. As therapists avoid painful feelings that arise in their work with traumatized clients, they may also become numb to positive feelings that provide enjoyment and respite from the darkness. As a result, therapists may lose access to their creative and playful self. This loss may negatively impact their personal relationships and can also impact their ability to be empathically present with clients (Pearlman, 2003; Pearlman & Saakvitne, 1995; Way et al., 2007; Williams et al., 2012).

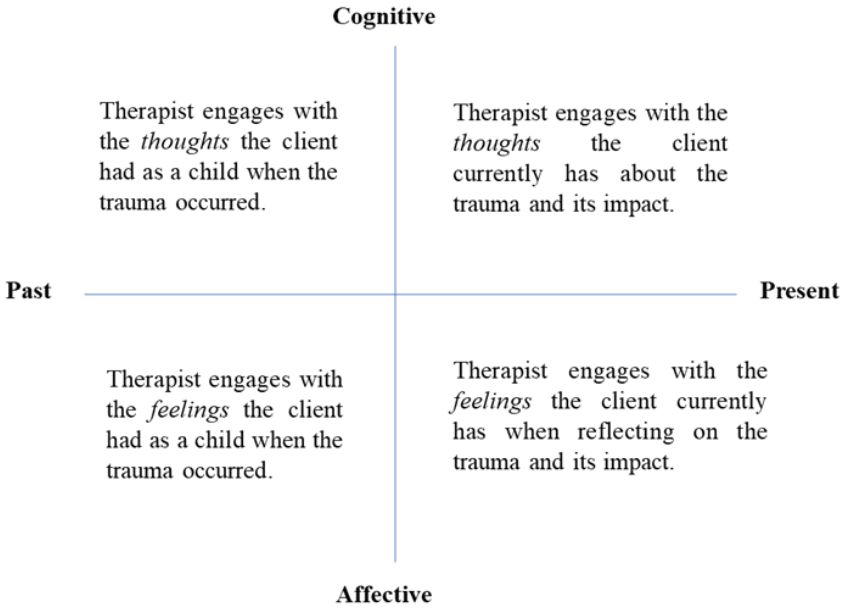
Exposure to client stories of traumatic experiences may impact the therapist's sense of *control.* Therapists who work with trauma survivors are regularly exposed to the powerlessness and helplessness their clients felt and may continue to feel. Unable to effect meaningful external change, therapists may begin to feel helpless and powerless

themselves. Therapists may find themselves questioning whether change or healing is possible. The psychological need for other-oriented control may manifest in an attempt to be overly directive with others or, if not possible, to withdraw to a sufficiently small world that one can control (Pearlman & Saakvitne, 1995).

The above discussion shows the intense emotional burden of working with traumatized populations and the potentially high psychological cost to the therapist both in terms of self-oriented and other-oriented needs. Pearlman and Saakvitne (1995) consider the ability to engage empathically with clients one of the most valuable skills a therapist can possess, and yet it is this very empathic engagement that puts therapists at risk for VT (Gaboury & Kimber, 2022; McCann & Pearlman, 1990a; McCann and Pearlman, 1990b; Pearlman & Saakvitne, 1995; VanDeusen et al., 2006; Way et al., 2007; Williams et al., 2012). Pearlman and Saakvitne (1995) describe the relationship between empathy and VT as the interaction between two types of empathy, *cognitive empathy* and *affective empathy*, and two time periods, *past* and *present.* Figure 2 shows the relationship between type of empathy and time frame, resulting in four realms of empathic engagement between the therapist and client.

**Figure 2.2**

*Four Realms of Empathic Engagement Between Therapist and Client*




While all four realms of empathic engagement create a risk to the therapist of developing VT, it is the *past-affective* realm of empathic engagement in which therapists are the most vulnerable to VT. This realm presents when a client is sharing a traumatic experience that happened during their childhood. In this realm, the therapist is connected to, and engages with the feelings of terror, anger, helplessness, and powerlessness that their client experienced as a child being abused. This affects therapists at a deep level and can change one's fundamental experience of self, others, and the world. Yet, it is exactly this past-affective empathic connection that is necessary for a trauma survivor to heal (Pearlman and Saakvitne, 1995). "It is only through the therapist's empathic connection, that the client herself can come to connect with and understand the truth of her experience in its developmental context" (Pearlman and Saakvitne, 1995, p. 297).

The above discussion demonstrates that effective therapists, especially where traumatized clients are concerned, possess a high level of self-awareness and a capacity for being empathically attuned to clients during therapy sessions. This therapeutic presence exposes the therapist to the reality of human evil and cruelty as clients describe and process their traumatic experiences with the therapist. As a result, the therapist may find their own sense of self, beliefs about others, and beliefs about the world challenged or disrupted, which leaves them vulnerable to VT. However, not all therapists will develop VT under these circumstances. While CSDT provides a framework to explain why some therapists are affected negatively by their work, there are additional factors that have been suggested as contributing to the development of VT. I discuss some of these factors that may contribute to the development of VT in the next section.

**Factors Which May Contribute to Vicarious Traumatization**

As stated previously, VT does not occur due to any single client session or relationship but rather from the cumulative effect over both time and multiple clients. CSDT contends that it is the interaction of specific therapist characteristics with elements of trauma work over time that predicts a therapist's vulnerability to VT (Pearlman & Mac Ian (1995). Therapist characteristics that have been examined with respect to their impact on VT include professional training and experience, professional work environment and support, and personal trauma history and therapy (Adams & Riggs, 2008; Branson, 2019; Butler et al., 2017; Courtois and Gold, 2009; DelTosta et al., 2019; Gaboury & Kimber, 2022; Halevi & Idisis, 2018; Neumann & Gamble, 1995; Pearlman & Mac Ian,1995; Shannon et al., 2014; Schauben & Frazier, 1995; VanDeusen & Way, 2006; Way et al., 2007; Williams et al., 2012).

### *Professional Training and Experience*

Courtois and Gold (2009) issued a call to action for all mental health professions to include trauma-specific training in their graduate curricula. They stated that therapists who have not been adequately educated and exposed to the prolific nature of trauma and its impact may have stronger negative reactions when encountering traumatized clients. Further, they stated that inadequately educated therapists may miss the presence of trauma in their clients altogether, leading to misdiagnosis and ineffective treatment (Courtois & Gold, 2009; Pearlman & Saakvitne, 1995). Related to this call to action, Adams and Riggs (2008) found a strong relationship between VT symptoms and deficits in trauma-specific training (defined as receiving minimal or no trauma-specific training). Adams and Riggs emphasized that "one-time lectures or class discussions are not enough; rather, students need substantial trauma-specific training in the context of a full semester of coursework or multiple intensive workshops in order to protect themselves against the potential negative impact of trauma counseling" (p. 32). Butler et al. (2017) stated preparing therapists-in-training to serve traumatized clients is key to hindering the negative impact of VT on the therapist. Training can provide the needed framework for processing one's own reaction to hearing the traumatic experiences of clients. They found that even within a trauma-content infused curriculum, students experienced reactivation of negative responses from their own trauma histories, albeit less so than when encountering traumatized clients in their fieldwork placements. Trauma education should include information about the effects of trauma work on therapists, tools for self-assessment of VT, and the importance of mindfulness and self-care practices as a regular

aspect of professional development (Adams & Riggs, 2008; Courtois & Gold, 2009; Foreman, 2018; Shannon et al., 2014).

The level of experience a therapist possesses is another factor that impacts VT. New and less experienced therapists have been shown to be at greater risk of VT (Adams & Riggs, 2008; Pearlman & Mac Ian, 1995). Pearlman and Mac Ian (1995) found that newer therapists (i.e., less than 2 years of work experience) had more symptoms of VT than therapists with more experience. Neumann & Gamble (1995) found that new therapists commonly experience intense preoccupation with clients, rescue fantasies, and insecurities about their own professional competence. Adams and Riggs (2008) stated that newer therapists are generally more concerned with self than clients, resulting in more countertransference issues than more experienced therapists. Newer therapists working with traumatized clients may find themselves continuously confronted with their countertransference reactions including shame, abandonment, and helplessness. They may also experience client behavior as direct attacks or criticism that may cause psychological wounds to the therapist that impacts the development of their professional identity (Neumann & Gamble, 1995). As a result of these risks to new therapists, Adams and Riggs (2008) suggested that supervisors monitor new therapists for a disrupted sense of self and symptoms of identity confusion.

Cohen & Collens (2013) conducted a metasynthesis of 20 qualitative articles and concluded that therapists with more experience report less VT because they have had the opportunity to witness not only the traumatic experiences but also the recovery process and growth of their clients. The positive psychological change observed in clients that comes from finding meaning and an increased sense of self as a result of traumatic

experiences is known as vicarious posttraumatic growth. Makadia et al. (2017) found that while therapist trainees did show higher levels of secondary traumatic stress, they did not yet exhibit symptoms of VT. This may be due to the nature of VT as cumulative over time, and that the trainees had not yet accumulated enough vicariously traumatic encounters to cause a shift in cognitive schema. Additionally, while a therapist's age is often related to the level of experience they have acquired, it is not uncommon for individuals to pursue therapy as a second, or later-in-life, profession (Tracey, 2022). Butler et al. (2017) stated that working with traumatized clients may be even more overwhelming for therapists who have limited life experience. Therefore, while newer does not necessarily mean younger when discussing therapist experience levels, newer *and* younger is a particularly vulnerable combination with respect to VT.

### *Professional Work Environment and Support*

The environment in which a therapist works may impact vulnerability to VT, particularly with respect to the therapist's caseload and access to professional support (DelTosta et al., 2019; Halevi & Idisis, 2018; Neumann & Gamble, 1995; Pearlman & Saakvitne, 1995; Williams et al., 2012). This is especially true for newer therapists who work in community mental health settings where large caseloads are considered the norm. Additionally, Schauben and Frazier (1995) found that therapists who had a higher percentage of trauma clients in their caseloads experienced higher levels of VT.

As therapists are exposed to the traumatic material of multiple clients, PTSD-like symptoms may appear that need to be processed to minimize the long-term impact that results in VT. Neumann & Gamble (1995) stated the importance of organizational support through professional development opportunities and adequate supervision, both

individually and with peers. Due to the professional and ethical mandate for confidentiality, the overt processing of distressing material must be done within a professional supervisory or peer relationship (DelTosta et al., 2019; Neumann & Gamble, 1995; Pearlman & Saakvitne, 1995). McCann and Pearlman (1990) emphasize the importance of the development of a professional network of like-minded colleagues to avoid professional isolation. Regular group case consultation provides a safe place where therapists can discuss and normalize their reactions to traumatic material. The use of individual supervision was examined by Halevi and Idisis (2018) who found that the type of supervision one receives matters. Therapists who receive supervision privately experienced less VT than those who received supervision through their workplace. Halevi and Idisis stated this may be due to the conflict involved when one's clinical supervisor is also the therapist's work superior with evaluative power that may impact the therapist's career. DelTosta et al. (2019) affirmed the importance of a strong supervisory working alliance between a new therapist and a trauma-informed supervisor. They found that a strong supervisory working alliance leads to a reduction in the new therapist's negative thoughts about self and others and consequently, decreased VT. Pearlman and Mac Ian (1995) found the combination of fewer years of work experience and not actively receiving supervision resulted in the highest levels of VT.

### *Personal Trauma History and Therapy*

One of the factors hypothesized to contribute to the development of symptoms of VT is the therapist's own history of trauma. Therefore, it is worthwhile to explore the incidence of a history of personal exposure to traumatic events among mental health therapists. It has been suggested by some researchers that pursuing a career as a mental

health therapist may be rooted in one's desire to resolve personal issues, sometimes referred to as the *wounded healer hypothesis* (Barnett, 2007; DiCaccavo, 2002; Groesbeck, 1975). Examples of unresolved issues that might lead someone to pursue a helping career are the fulfillment of intimacy needs not met in childhood, the continuation of a caretaking role learned through being parentified in a dysfunctional home environment, and experiences of early loss or deprivation (Barnett, 2007; DiCaccavo, 2002; Elliott & Guy, 1993; Nikčević et al., 2007).

To explore the extent to which therapists may have their own history of trauma, Elliott and Guy (1993) conducted a study comparing mental health professionals and non-mental health professionals to assess childhood trauma prevalence and adult psychological functioning. The study specifically addressed the following categories of trauma: physical abuse, sexual molestation, parental alcoholism, hospitalization of a parent for mental illness, and death of a parent or sibling. They found that 66.4% of mental health professionals reported experiencing at least one of these traumatic events, while only 48.8% of all non-mental health professionals reported them. They also found that mental health professionals were more likely to have sought personal therapy (78% vs. 41%), and that therapists experienced significantly less psychological distress overall than non-mental health professionals. Other researchers have confirmed the finding that therapists report higher rates of ACEs, but they do not suffer greater current psychological distress than their non-therapist counterparts who had lower rates of ACEs (Esaki & Larkin, 2013; Hiles Howard et al., 2015; Nikčević et al., 2007). Increased age, a supportive working environment, and increased compassion satisfaction are shown to be protective factors to VT (Esaki & Larkin, 2013; Hiles Howard et al., 2015). Elliott and

Guy (1993) suggested as a possible alternative explanation to the wounded healer hypothesis: that the relationship between a therapist's personal trauma history and choice of profession is the result of having overcome one's own issues. The above discussion shows that therapists have both a higher incidence of ACEs and are more likely to have pursued therapy to resolve their traumatic experiences.

Adams and Riggs (2008) studied 129 counseling graduate students and found that one-third reported a personal trauma history. They studied the influence that defense style had on VT and found that for those students with a personal trauma history, a self-sacrificing defense style significantly increased the risk of VT. They noted the importance of instructors and supervisors within graduate programs being aware of the use of immature defense styles in students resulting from the personal trauma history, and to either address the impact of the student's immature defense style on their fitness for the therapy profession directly or recommend the student pursue personal counseling.

One of the challenges to understanding the impact of a personal trauma history on a therapist's level of VT is the previously discussed conflation within the research literature of VT with burnout, compassion fatigue (CF), and secondary traumatic stress (STS) (Branson, 2019; Gaboury & Kimber, 2022). Gaboury and Kimber (2022) conducted a thorough literature review of peer-reviewed quantitative research articles published between 2000 and 2021 that studied the relationship between therapist personal trauma history and VT, CF or STS. Their search yielded just 10 peer-reviewed journal articles and, of these, only three articles measured VT using an instrument (TABS, Pearlman, 2003) specifically developed to assess VT according to the distinct definition as presented in this paper. Within these three studies, there were mixed results. Williams

et al. (2012) found that therapists with a personal trauma history were more likely than those therapists with no personal trauma history to experience VT symptoms. Way et al. (2007) found that therapists with a history of emotional neglect, specifically, showed negative disruptions to their cognitions of self-intimacy, which is one symptom of VT. However, VanDeusen and Way (2006) found no relationship between a therapist history of child sexual abuse and higher levels of VT. These few but varied results regarding the relationship between therapist personal history of trauma and VT highlights the need to conduct further research on whether personal trauma history impacts a therapist's experience of VT symptoms.

Pearlman and Mac Ian (1995) found that newer therapists who reported a history of personal sexual trauma showed higher levels of VT and other general stress symptoms, and that VT symptoms lessened as the length of time working with trauma clients increased. Pearlman and Mac Ian suggested the possibility that those therapists who were most distressed self-selected out of the field. Halevi and Idisis (2018) suggested that more experienced therapists develop skills that enable them to separate their selves (i.e., become more differentiated) more effectively from their clients' worlds and emotions. In an attempt to study the therapist's capacity to maintain a strong, self-aware, empathic presence with traumatized clients without suffering the negative impacts of VT, Halevi and Idisis (2018) explored the concept of differentiation of self. To do so, they turned to the work of Murray Bowen (1978) who developed his family systems theory largely based on the concept of *differentiation of self (*DOS), which refers to an individual's ability to maintain a sense of self and identity through balancing thoughts and emotions within intense or intimate relationships.

## Differentiation of Self: Bowen Theory

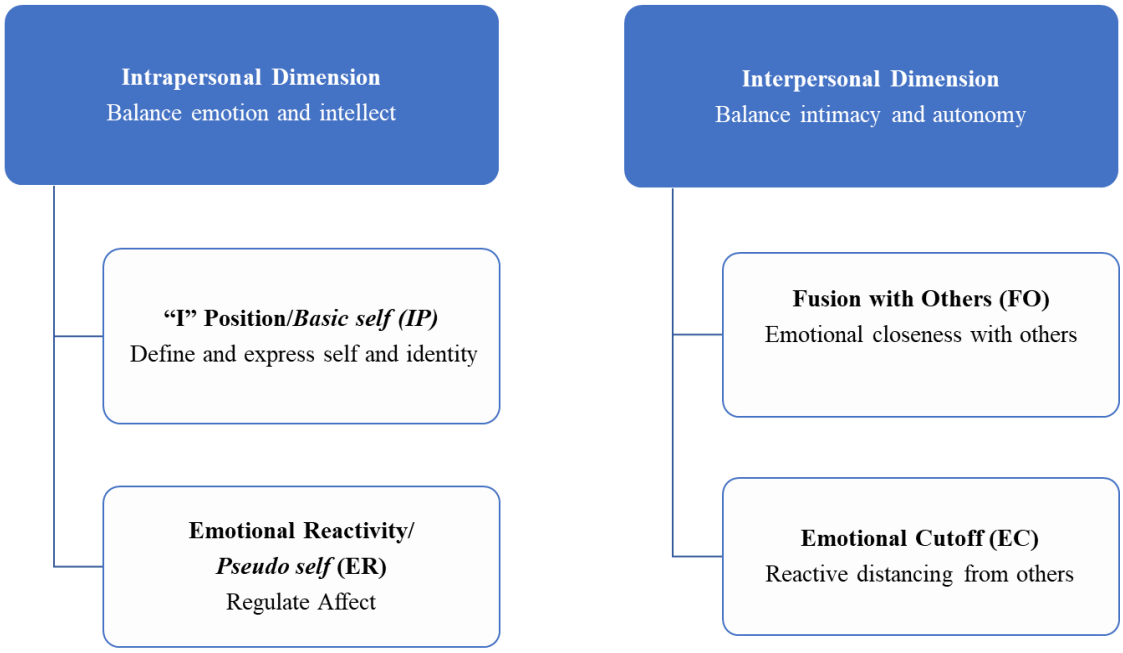
Murray Bowen's Family Systems Theory, or Bowen Theory (BT), was borne out of decades of experience working with individuals diagnosed with schizophrenia and their families. Bowen (1966) stated "The family is a system in that a change in one part of the system is followed by compensatory change in other parts of the system" (p. 351). Bowen viewed the nuclear family system as an emotional unit whereby individual family members respond to the emotional states of one another (Bowen, 1978; Titelman, 2014). Bowen's (1966) conceptualization of BT shifted over its formative years to include various concepts – the most enduring of which was the *differentiation of self* (DOS), which refers to the level of differentiation of each individual within the emotional unit. Bowen proposed that DOS was largely determined within one's family of origin during the developmental years, and that it was unchangeable once established. However, later researchers demonstrated that DOS can be improved through intentional effort within a therapeutic environment (Bowen, 1978; Kerr & Bowen, 1988; Johnson et al., 2003; Messina et al., 2018).

DOS has two dimensions as shown in Figure 3: the *intrapersonal dimension* and the *interpersonal dimension.* The ability to balance emotional and intellectual functioning is considered the *intrapersonal dimension* of DOS and refers to the ability to distinguish between one's thoughts and feelings and to choose whether to be guided by one's emotions or intellect. The ability to experience intimacy in close relationships while also maintaining one's sense of autonomy is considered the *interpersonal dimension* of DOS. DOS is the "personality variable most critical to mature development and the attainment of psychological health" (Skowron & Friedlander, 1998, p. 235). An individual who is

highly differentiated is able to maintain their sense of self while in emotional contact with others (Bowen, 1978; Kerr & Bowen, 1988; Skowron et al., 2003).

**Figure 2.3**

*Dimensions of Differentiation of Self*




Bowen viewed the intrapersonal dimension of DOS as having both a *solid self* ("I" position) and a *pseudo self* (emotional reactivity). The solid self is the beliefs, convictions, and principles by which an individual defines their self. "The solid self says, *This is who I am, what I believe, what I stand for, and what I will or will not do.*" [emphasis in original text] (Bowen, 1978, p. 365). According to Bowen, the solid self is stable and can only change slowly through considerable internal effort over time. The pseudo self is malleable and readily modified by external emotional pressures from one's family, society, or any group to which one belongs or wishes to belong. It is the pseudo

self that is emotionally reactive and conforms to the beliefs and principles of those around them, whether these are consistent with other externally generated beliefs or even one's own solid self (Bowen, 1978; Frost, 2014). It was Bowen's belief that "the level of solid self is lower, and of the pseudo-self is much higher in all of us than most are aware" (Bowen, 1978, p. 366).

The *interpersonal dimension* of DOS represents the ability to experience intimacy and togetherness with others while also maintaining a sense of autonomy. Individuals who lack a strong DOS will manifest these interpersonal aspects dysfunctionally. For instance, without a strong DOS intimacy and togetherness may devolve into fusion with others, wherein ego boundaries are slight or non-existent. Also, an individual without a strong DOS may seek autonomy through emotionally cutting off from others either through physical distance or emotionally superficial engagement (Bowen, 1978; Titelman, 2014). The interpersonal dimension of DOS describes one's ability to negotiate a) intimacy and togetherness without fusion with others, and b) a state of autonomy without resorting to emotionally cutting off from others (Bowen, 1978; Skowron et al., 2003; Titelman, 2014).

Bowen (1978) selected the term *differentiation* because he saw an analogy between the biological concept of differentiation and human relational processes. Specifically, Bowen likened the process of differentiation of self to the process of cell differentiation (Bowen, 1978; Titelman, 2014). This differentiation analogy, though, operates differently in the human and biological realms. From a biological perspective, differentiation is a genetically determined phenomenon that allows organisms to adapt to acute stressors. However, levels of psychological differentiation are not biologically

hardwired and vary widely among people. Indeed, as stressors increase in intensity, duration, and type, one's ability to adapt is dependent upon their level of DOS. Notably, it is when one experiences stressful situations in relationship to others that their level of DOS manifests itself. The "I" becomes unsettled as emotional reactivity heightens (intrapersonal) and one's tendency toward resolving stress through either fusion with others or emotionally cutting off (intrapersonal) becomes apparent (Bowen, 1978; Kerr & Bowen, 1988; Titelman, 2014).

Bowen (1978) visualized DOS as a spectrum where the low end represents the complete absence of DOS and the high end represents a fully-differentiated person. Individuals at the low end are controlled by their automatic emotional system which drives instinctual behavior. These individuals are less flexible, less adaptable, and more emotionally dependent than those higher up on the spectrum. Individuals who are poorly differentiated tend to become either emotionally fused or emotionally cut off from others when under stress. Emotionally cutoff individuals experience intimacy as profoundly threatening, while fused individuals experience separation as threatening and overwhelming (Bowen, 1978; Skowron & Friedlander, 1998; Skowron et al., 2003).

Individuals at the mid-to-high end of the DOS spectrum can balance their emotions and intellect, thereby enabling them to remain relatively autonomous, flexible, and adaptable during periods of high stress. This does not imply that high levels of DOS prevent one from experiencing dysfunction, but rather there is an ability to recover quickly when stressed. More differentiated individuals are considered by Bowen to be emotionally mature and can relate to others within the emotional realm without becoming engulfed by or enmeshed with them (Bowen, 1978, Kerr & Bowen, 1988; Skowron &

Friedlander, 1998; Skowron et al., 2003). Individuals with high levels of DOS have well-defined yet flexible boundaries which allow for emotional intimacy without fusion or the fear of being engulfed by the other. Further, highly differentiated individuals are able to maintain a strong sense of self even when their personal convictions are threatened or they are pressured by others (Bowen, 1978; Connery & Murdock, 2019; Kerr & Bowen, 1988; Skowron & Friedlander, 1998; Skowron et al., 2003).

While BT focused its initial application on the family emotional unit, Bowen viewed his theory as relevant to a variety of dyads and groups (e.g. couples, work teams, volunteer or project committees, supervisory relationships and the therapeutic dyad), which are characterized by ongoing, intense, and intimate relationships. The impact of DOS within the therapeutic dyad is informed by studies regarding the impact of DOS on romantic and marital relationships (Halevi & Idisis, 2018; Kapel Lev-Ari et al., 2020; Lampis, 2016; Lampis & Cataudella, 2019; Skowron, 2000).

Lampis and Cataudella (2019) studied the relationship between DOS and the ability to form romantic attachments. They viewed DOS as a universal developmental target, arguing that all individuals must learn how to navigate a balance between the creation of emotional attachment with significant others and the need for independence. Their view was confirmed by their findings, which demonstrated a strong relationship between emotional reactivity and anxiety in a couple's relationship. They also found that lower levels of "I"-position predict higher levels of avoidance or emotional cutoff. Previously, Skowron (2000) found that higher levels of DOS predicted greater marital adjustment. Lower levels of DOS in either person within a couple predicts marital distress, as emotional reactivity or emotional cutoff are engaged to manage anxiety in the

relationship (Bowen, 1978; Skowron, 2000). Lampis et al. (2017) examined the relationship between DOS and codependency and found that all dimensions of DOS significantly predicted codependency, especially emotional reactivity and emotional cutoff.

Kapel Lev-Ari et al. (2020) found that DOS impacted spouses of ex-prisoners of war (POWs) in that those spouses with lower levels of DOS were more vulnerable to manifesting posttraumatic stress symptoms. Specifically, they found that spouses of POWs who revealed a tendency for either emotional cut-off or fusion with others were less emotionally regulated. These spouses reported that maintaining a strong sense of self in relationships was particularly difficult to accomplish. Kapel Lev-Ari et al. suggested that POWs' heightened distress and need for support negatively impacted both their own and their spouses emotional reactivity, creating cycles of emotional fusion and cut-off that resulted in overall lower levels of DOS. The above discussion demonstrates that partners in intimate relationships impact each other's level of DOS as well as the ways that DOS manifests behaviorally.

Given that Bowen (1978) proposed that DOS is largely determined within the family of origin, what can be done in adulthood to improve one's DOS? Johnson et al. (2003) stated that adults play an active role in their differentiation process, citing Erikson's (1968) psychosocial stage of identity versus role diffusion. "An active identity search related to one's own values and choices seems essential to the differentiation process" (Johnson et al., 2003, pp. 191-192). Increasing one's level of DOS "requires self-exploration and being able to take a systemic view of one's own place in his or her emotional system" (Messina et al., 2018, p. 153).

In this regard, Johnson et al. (2003) suggested that therapists have a unique role in promoting the exploration of the source of client beliefs, thoughts, and choices. An active exploration of one's values and choices within a safe and consistent therapeutic environment enables clients to process their own search for identity. Contrary to Bowen's belief that increasing one's level of DOS can only be done through a long, concerted effort, a study by Messina et al. (2018) showed significant improvement in levels of DOS through a brief, 3-month course of therapy. The study showed increases in both dimensions of DOS, especially in the intrapersonal aspects of emotional reactivity and I-position. The study found that these improvements occurred regardless of theoretical orientation (none was prescribed by the study parameters), and they concluded that it is the therapeutic relationship that enables the productive exploration of self. Messina et al., suggested that the therapist serves as a third, more differentiated, person whose function is to model a heightened balance between emotion and intellect, thereby enabling the client to maintain a stronger I-position with significant others. Therefore, the therapist's level of DOS is instrumental in strengthening the client's DOS. Kerr and Bowen (1988) stated that when a therapist possesses a high level of DOS, they model the capacity for mature emotion regulation during periods of stress enabling their client to discover and expand their own differentiated self and reduce emotional reactivity.

Indeed, Bowen viewed the therapist's own level of DOS as a significant factor in the effectiveness of family therapy (Bowen, 1987; Kerr & Bowen, 1988). It was clear to Bowen during early conceptualizations of what would later become BT that the therapist played an important role in the process of leading family members, either individually or in combination, to higher levels of differentiation. Bowen stated therapists must

continually define their "self" to clients beginning with the initial contact where the therapist describes their boundaries and ways of approaching sessions theoretically and therapeutically. "When the family goes slowly at defining self, I begin to wonder if there is some vague ambiguous area of importance about which I failed to define myself" (Bowen, 1978, p. 177). This implies that the therapist must possess a high level of differentiation and self-awareness to best guide clients and families toward higher levels of differentiation. The relationship between DOS and other therapist variables, such as countertransference, have also been explored.

Connery and Murdock (2019) examined DOS with respect to countertransference in the therapeutic dyad. Building upon the work of Gelso and Hayes (2007) who found the therapist's coping skills, self-insight, and anxiety management are predictive of countertransference, Connery and Murdock (2019) examined the interaction between therapist DOS and client factors as determinants of the level of countertransference experienced. They stated that therapists' emotional and interpersonal awareness are critical to recognizing and understanding countertransference. Specifically, they found that therapists who were high in the I-Position dimension of intrapersonal DOS had fewer countertransference responses overall.

Other research about DOS is also related to the functioning of therapists. For instance, Skowron & Dendy (2004) examined the relationship between DOS and effortful control, defined as the ability to "suppress reactive tendencies, modulate emotion feeling, and engage in purposeful behavior" (p. 338) and found that the intrapersonal aspects of DOS were particularly important to the capacity for self-regulation and effortful control. These findings support Bowen's (1978) assertion that it is incumbent on therapists to

pursue their own therapeutic work to increase their level of DOS, improve their awareness of their countertransference reactions, and to model intentional self-regulation of emotional reactions and responses with their clients. In this respect, the adage holds true that the therapist can only take the client as far as they have gone themselves. Given the evidence of the positive relationship between high levels of DOS and psychological well-being, it is reasonable to predict that therapist DOS may be predictive of therapist vulnerability to VT (Bowen, 1978; Calatrava et al., 2022; Hainlen et al., 2015; Halevi & Idisis, 2018; Heiden-Rootes et al., 2017; Kerr & Bowen, 1988; Lambert & Friedlander, 2008; Messina et al., 2018). Next, I discuss the predicted relationship between DOS and VT.

### Vicarious Traumatization and Differentiation of Self

The proposition that there is a relationship between a therapist's vulnerability to VT and their level of DOS makes conceptual sense. VT (rooted in CSDT) provides theoretical tools to account for the negative psychological impact on therapists' beliefs about self, others, and the world after cumulative exposure to multiple clients' traumatic experiences (McCann & Pearlman, 1992; McCann & Pearlman, 1990a; McCann & Pearlman, 1990b; McCann et al., 1988; Pearlman & Saakvitne, 1995). DOS (derived from BT) refers to an individual's ability to maintain a strong sense of self especially within intense emotional relationships (Bowen, 1978; Kerr & Bowen, 1988; Titelman, 2014). Therefore, it is reasonable to predict an inverse relationship between DOS and VT. That is, if therapists have strong DOS, they will likely have the ability to erect self-protective psychological boundaries when clients present disturbing details and strong feelings about their traumatic experiences. However, if therapists have a weak DOS, they

will likely not be able to psychologically protect themselves from the influx of potentially traumatizing emotional material emanating from their clients, thereby increasing their risk of VT. Before I discuss the relationship between VT and DOS further, I first briefly review both constructs.

Regarding VT, as knowledge about the long-term effects of trauma has both expanded and deepened, it has become accepted that even secondary exposure to traumatic experiences can lead to negative mental and physical health outcomes (American Psychiatric Association, 2013; Bride, 2004; Butler et al., 2017; Devilly et al., 2009; Figley, 1995; McCann & Pearlman, 1992; McCann & Pearlman, 1990a; McCann & Pearlman, 1990b; McCann et al., 1988; Pearlman & Mac Ian, 1995; Pearlman & Saakvitne, 1995). While many professions experience secondary traumatic stress during the course of their work (e.g. emergency medical services, law enforcement, firefighters), it is the unique nature of the ongoing empathic relationship between a therapist and their clients that creates the circumstances for VT to appear (Bride, 2004; McCann & Pearlman, 1992; McCann & Pearlman, 1990a; McCann & Pearlman, 1990b; McCann et al., 1988; Pearlman & Mac Ian, 1995; Pearlman & Saakvitne, 1995). Empathic attunement from a highly self-aware therapist is a key component of effective therapeutic outcomes, especially with traumatized clients (Figley, 1995; Frie, 2000; McCann & Pearlman, 1992; McIntyre & Samstag, 2021; Mordeno et al., 2017; Pearlman & Saakvitne, 1995; Rogers, 1957; Rogers, 1974; Satir, 1987). Yet, it is this empathic attunement that places therapists at risk for developing VT because therapists continually perform the emotional labor of tolerating their clients' intense emotions and painful memories (McCann & Pearlman, 1990b; Pearlman & Saakvitne, 1995). Even for

therapists who possess a high level of self-awareness the psychological labor required to maintain emotional balance may exact a toll on their professional and personal lives.

VT is the term used to describe the potential negative consequences to therapists of cumulative secondary exposure to the details of the traumatic experiences of their clients. VT represents the pervasive and negative changes in a therapist's beliefs about self, others and the world, especially with regard to five key psychological needs (i.e. safety, esteem, intimacy, trust, and control) (McCann & Pearlman, 1992; McCann & Pearlman, 1990a; McCann & Pearlman, 1990b; McCann et al., 1988; Pearlman & Mac Ian, 199; Pearlman & Saakitne, 1995). Therapists are exposed to the details of their clients' traumatic experiences, which causes therapists to be empathically attuned to the distress, helplessness, fear, anger, confusion and other emotional and cognitive disruptions of their clients. Therapists may become overwhelmed by the human capacity for evil inherent in their clients' retelling of traumatic experiences, thereby causing therapists to lose their feelings of trust and safety with others. Further, therapists may suffer a profound loss of optimism and hope, which may lead to doubts about their ability to help clients to heal (Herman, 1992; McCann & Pearlman, 1992; McCann & Pearlman, 1990a; McCann & Pearlman, 1990b; McCann et al., 1988; Pearlman & Mac Ian, 1995).

However, just as not all individuals respond to traumatic experiences in the same way, therapists' responses to working with traumatized clients is varied. Therapist attributes that have been considered to be related to vulnerability to VT include therapist age, years of professional experience, amount of trauma-specific training received, level of professional support through supervision or peer consultation, and whether the therapist has their own history of trauma (Adams & Riggs, 2008; Branson, 2019; Butler

et al., 2017; Courtois & Gold, 2009; DelTosta et al., 2019; Figley, 1995; Gaboury & Kimber, 2022; McCann et al., 1988; McCann & Pearlman, 1990a; McCann & Pearlman, 1990b; Neumann & Gamble, 1995; Pearlman & Mac Ian, 1995; Pearlman & Saakvitne, 1995; Schauben & Frazier, 1995; Shannon et al., 2014; VanDeusen & Way, 2006; Way et al., 2007; Williams et al., 2012). Other researchers have focused on the importance of therapists possessing a strong sense of self, which allows therapists to know where the client ends and the therapist begins (Halevi & Idisis, 2018). One of the conceptual ways of describing the strength of one's sense of self is Bowen's concept of DOS (Bowen, 1978)..

DOS refers to the capacity to maintain a strong sense of self and psychological boundaries, especially when in emotionally intimate relationships with others. DOS includes the ability to achieve intimacy without becoming enmeshed or fused and the ability to maintain autonomy without emotionally disconnecting. The higher one's level of DOS, the better one is able to maintain their sense of self while in emotional contact with others (Bowen, 1978; Connery & Murdock, 2019; Halevi & Idisis, 2018; Kapel Lev-Ari et al., 2020; Kerr & Bowen, 1988; Lampis, 2016; Lampis & Cataudella, 2019; Skowron, 2000; Skowron et al., 2003; Skowron & Friedlander, 1998; Titelman, 2014). DOS is largely established during one's developmental years within their family of origin, but it has been shown that DOS can be improved within a therapeutic environment where the therapist models a heightened ability to balance emotion and intellect (Bowen, 1978; Johnson et al., 2003; Kerr & Bowen, 1988; Messina et al., 2018). This demonstration of a strong DOS, modeling effective emotion regulation, aids the client in developing a stronger sense of self and increased capacity for emotional self-regulation in

relation to significant others. Therefore, the therapist's level of DOS is critical to the effectiveness of therapy, particularly with respect to strengthening the client's relationships. The ability of the therapist to maintain a strong DOS is particularly important with traumatized clients because the therapist's empathic attunement may cause cumulative absorption of the sensory details of the client's traumatic experiences (McCann & Pearlman, 1990b; Pearlman & Mac Ian, 1995; Pearlman & Saakvitne, 1995). Therefore, it is reasonable to predict that the therapist's level of DOS will influence their vulnerability to VT. This conceptual prediction has been empirically tested by Halevi and Idisis (2018).

Halevi and Idisis (2018) conducted a study to determine if a therapist's level of DOS is correlated with VT. They predicted there would be an inverse relationship between the two variables. They surveyed 134 therapists (114 women and 20 men) who provided individual and group therapy in clinics, institutions, or private practice settings throughout Israel. The participants included psychiatrists, psychologists, psychotherapists, social workers, and clinical criminologists. Participants completed a personal background questionnaire that inquired about age, gender, education, place of work, years of experience and number of clients. They also completed the Differentiation of Self Inventory-Revised (DSI-R, Skowron & Schmitt, 2003), which measures the two dimensions of DOS (i.e. intrapersonal and interpersonal) and includes four subscales (i.e. I-position, emotional reactivity, emotional cutoff, and fusion with others). Also, participants completed the TSI Belief Scale, which is now known as the Trauma and Attachment Belief Scale (TABS, Pearlman, 2003). This instrument assesses VT by

measuring ruptures in cognitive schemas and gaps in five psychological needs (i.e. safety, esteem, intimacy, trust, and control) with regard to oneself and others.

The study confirmed the prediction that there would be an inverse relationship between DOS and VT. Specifically, they found that higher levels of DOS were correlated with lower levels of VT symptoms. An examination of the subscales of both the DOS and VT instruments showed most relationships between the subscales were negative and significant. Further, while both intrapersonal and interpersonal dimensions of DOS were strongly negatively correlated with overall level of VT, intrapersonal aspects were correlated slightly more ($r$ = -.639 vs. -.591). Additionally, Halevi and Idisis (2018) explored the impact of several moderating variables on the relationship between DOS and VT, including age, engagement in personal therapy, and type of supervision received. Of these, only being currently engaged in personal therapy was found to significantly influence VT, demonstrating that those participants who were in therapy had higher levels of VT than those who were not currently in therapy.

There are several questions that remain unanswered in the Halevi and Idisis (2018) study. First, it is unknown whether the negative correlation between DOS and VT is generalizable or simply a sampling artifact. The study was conducted in Israel with translated instruments, while the instruments (DSI-R and TABS) were developed and validated in the United States with primarily European American native-English speaking populations (Pearlman, 2003; Skowron & Friedlander, 1998; Skowron & Schmitt, 2003). The participants for my study will include mostly North American participants but will be open to therapists internationally through one of the professional organizations through which I will request participation. This will allow for a multicultural sampling.

Second, there has been research that indicates the two-dimensional, four-subscale construct of DOS may include aspects that are unnecessary in terms of measuring a differentiated self (Drake et al., 2015; Jankowski & Hooper, 2012; Skowron & Friedlander, 1998; Skowron & Schmitt, 2003). It has been suggested that the combination of one of the intrapersonal subscales (emotional reactivity) and one of the interpersonal subscales (emotional cut-off) are together sufficient to measure one's level of DOS (Jankowski & Hooper, 2012; Skowron & Friedlander, 1998; Skowron & Schmitt, 2003). I will explore various combinations of the four-subscales to determine if any of these components (subsets of the four scales) adequately explain the relationship of DOS and VT.

Third, Halevi and Idisis (2018) did not offer any findings regarding the self-oriented versus other-oriented subscales of the TABS. There are 10 subscales within the TABS, two for each of the five psychological needs (i.e. safety, esteem, intimacy, trust, control) - a self-oriented subscale and an other-oriented subscale (Pearlman, 2003). The self-oriented subscales of the TABS are designed to reflect one's level of autonomy (intrapersonal), while the other-oriented scales are related to the therapist's experience of personal connection with others (interpersonal). To test how well the self- and other-oriented scales are aligned with the intrapersonal and interpersonal dimensions of the DSI-R, I will examine if there is a relationship between the intrapersonal dimension of the DOS and the five self-oriented subscales of the TABS. I will also examine if there is a relationship between the interpersonal dimension of the DOS and the five other-oriented subscales of the TABS.

Fourth, while Halevi and Idisis found that DOS is inversely and significantly correlated with VT, they only examined a very limited number of variables as possible contributors to this relationship; there are multiple additional variables that are potentially relevant to this correlation and need to be explored. In particular, therapist personal trauma history (PTH) is an important variable to explore regarding the relationship between VT and DOS. Halevi and Idisis (2018) did not include a variable for (PTH) in their study. Given the ubiquitous nature of trauma (Benjet et al., 2015; Kilpatrick et al., 2013), the findings that therapists generally have an even higher incidence of PTH than the general population (Adams & Riggs, 2008; Elliott & Guy, 1993; Esaki & Larking, 2013; Hiles Howard et al., 2015), and the well-researched negative impacts of traumatic experiences on both physical and psychological well-being (Anda et al., 2006; Briggs et al., 2021; Felitti et al., 1998; Finkelhor et al., 2013; Finkelhor et al., 2015; Kessler & Merikangas, 2004; Kilpatrick et al., 2013; Turner & Lloyd, 1995; Van der Kolk, et al., 2005), PTH is an important variable to include in any investigation of how a therapist's level of DOS impacts their vulnerability to VT. Pearlman and Mac Ian (1995) found that therapists with a PTH had elevated levels of VT. My study will explore the influence of PTH on the relationship between DOS and VT.

Therefore, this dissertation will build upon Halevi and Idisis' (2018) study, which showed a significant inverse relationship between one's level of DOS and their level of VT. This study will contribute to the research literature in important ways. As the mental health profession becomes increasingly aware of the prevalence and potential impact of traumatic experiences on individuals, we now know that secondary exposure to traumatic experiences can also impact individuals negatively. This research will add to the

understanding of therapist vulnerability to VT and the contributions of the therapist's personal trauma history, degree of self-differentiation, and other factors to their vulnerability to VT. These results may provide valuable information regarding the training of mental health professionals. My broad research questions are as follows:

- What is the relationship between therapist differentiation of self and vicarious traumatization?
- Does therapist personal therapy history, work experience, trauma training, and/or professional support mediate the relationship between differentiation of self and vicarious traumatization?
- What is the relationship between therapist personal trauma history and vicarious traumatization?
- Does personal trauma history moderate the relationship between differentiation of self and vicarious traumatization?
- Does personal trauma history moderate the mediating effects that personal therapy history, work experience, trauma training, and/or professional support have on the relationship between differentiation of self and vicarious traumatization?

# Chapter Three

## Methodology

In this chapter, I describe the research design and methodology used to explore the relationship between differentiation of self (DOS), vicarious traumatization (VT), and possible contributing variables. I first discuss the research purpose, research questions, and their related hypotheses. Then, I outline the research design and procedures including the participants, assessment instruments, data collection methods, and the data analysis process.

## Research Purpose

The purpose of this study was to examine the relationship between differentiation of self (DOS) and vicarious traumatization (VT) in therapists who work with traumatized populations. Specifically, the research questions addressed in this study seek to contribute to the literature about factors that may influence the development of VT such as intrapersonal versus interpersonal aspects of self, therapist personal trauma history, personal therapy history, work experience, trauma training, and professional support. Figure 1 presents the model for my hypothesized research design.

### Research Questions and Hypotheses

Research Question 1: What is the relationship between therapist *differentiation of self* (DOS) and *vicarious traumatization* (VT)?

Hypothesis 1: DOS is negatively correlated with VT (higher levels of DOS are related to lower levels of VT).

Hypothesis 2: Intrapersonal (INTRA) dimension of DOS has a stronger negative correlation to VT than interpersonal (INTER) dimension of DOS.

Hypothesis 3: INTRA dimension of DOS has an inverse relationship to VT self-oriented subscales.

Hypothesis 4: INTER dimension of DOS has an inverse relationship to VT other-oriented subscales.

Research Question 2: Does therapist *personal therapy history* (THPY), *work experience* (WE), *trauma training* (TT) and/or *professional support* (SUPP) mediate the relationship between DOS and VT?

Hypothesis 5: Personal therapy history (THPY) partially mediates the relationship between DOS and VT.

Hypothesis 6: Work experience (WE) partially mediates the relationship between DOS and VT.

Hypothesis 7: Trauma training (TT) partially mediates the relationship between DOS and VT.

Hypothesis 8: Professional support (SUPP) partially mediates the relationship between DOS and VT.

Research Question 3: What is the relationship between therapist *personal trauma history* (PTH) and *vicarious traumatization* (VT)?

Hypothesis 9: PTH is positively correlated with VT.

Research Question 4: Does PTH moderate the relationship between DOS and VT?

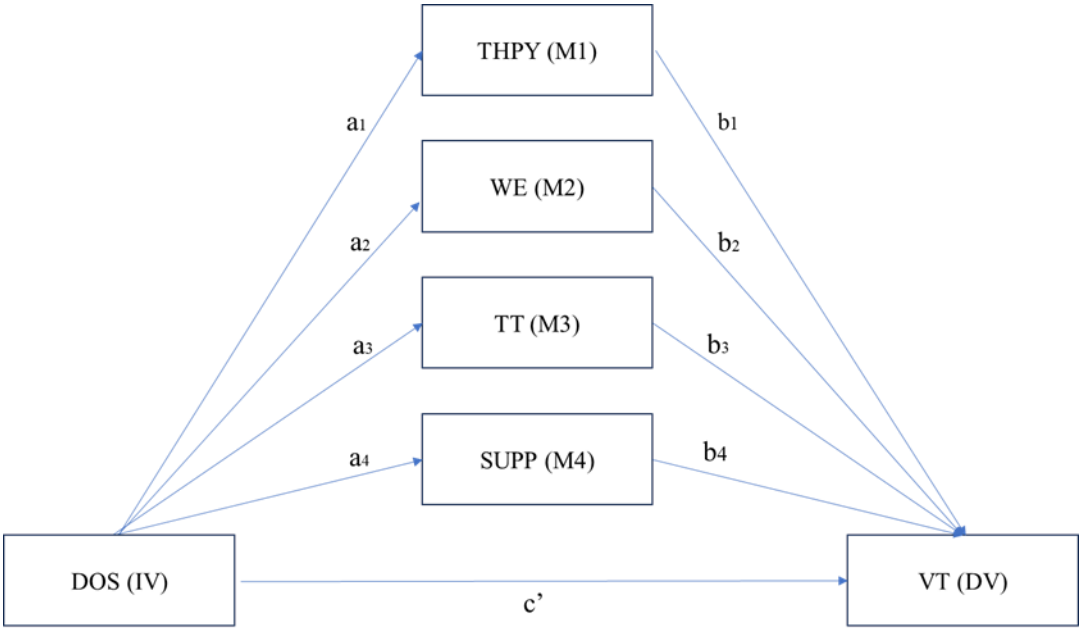
Hypothesis 10: PTH moderates the relationship between DOS and VT.

Research Question 5: Does PTH moderate the mediating effects that THPY, WE, TT, and/or SUPP have on the relationship between DOS and VT?

Hypothesis 11: PTH alters the mediating effects that THPY, WE, TT and/or SUPP have on the relationship between DOS and VT.

**Figure 3.1**

*Predicted Model for the Relationship Between Differentiation of Self and Vicarious Traumatization with Four Potential Mediating Variables.*




## Research Design

A non-experimental, quantitative survey research design was used to explore the relationship between DOS and VT. This research design was selected because of the correlational nature of the research questions. The study attempted to confirm the prior overall relationship between DOS and VT as found by Halevi and Idisis (2018) and to explore the contribution to the overall relationship between DOS and VT of their respective subscales, as well as other possible influential factors. All variables measured in this study are shown in Appendix A.

## Instrumentation

To examine the relationship between DOS and VT, as well as the factors that may influence the relationship, I used the following instruments: Background Information Questionnaire, Adverse Childhood Experiences Scale - Revised (ACES-R) and a measure of adult traumatic experiences that I developed for this study, Differentiation of Self Inventory (DSI-R), and Trauma and Attachment Belief Scale (TABS). This section will describe each of these instruments in detail.

### *Background Information Questionnaire*

I developed a background information questionnaire (Appendix B) for the purposes of this study. The questionnaire includes demographic questions, such as age, gender, and ethnicity. It also includes questions about the participant's mental health discipline and licensure status, current work setting, primary theoretical orientation, and information about work environment and caseload. Additionally, the questionnaire includes questions related to potential influential factors, such as trauma-specific training, professional support, and history of personal therapy received.

### *Personal Trauma History*

Childhood trauma history was measured using the revised Adverse Childhood Experiences Scale (ACES-R) (Finkelhor et al., 2015). The ACES-R (Appendix C) is a 14-item yes/no questionnaire that assesses adverse childhood experiences (prior to age 18) that may have lasting negative effects on one's physical, emotional, and mental health (Felitti et al., 1998; Finkelhor et al., 2015). The ACES-R improves upon the original ACES scale by adding four additional items that are widely recognized childhood adversities (Finkelhor et al., 2015). The additional items address childhood

bullying and peer victimization, isolation and peer rejection, poverty and deprivation, and exposure to community violence. The ACES-R items are coded ‘0’ or ‘1’ indicating the absence or presence of the experience. The presence of even one of these experiences is predictive of potential physical and mental health problems, with higher scores predicting more severe psychological distress (Finkelhor et al., 2015).

Neither the original ACES nor the revised ACES-R have undergone psychometric analyses that would make it applicable for diagnostic purposes (McLennan et al., 2020). However, several studies have shown support for specific constructs of ACEs using exploratory factor analysis (Afifi et al., 2020; Briggs et al., 2021; Felitti, et al, 1998; Finkelhor et al., 2015; Karatekin & Hill, 2019; Mersky et al., 2021; Negrigg, 2020). Numerous studies have demonstrated moderate to high test-retest reliability of the ACES questionnaire for both adult and adolescent samples (Dube et al., 2004; Pinto et al., 2014; Schauss et al., 2021). Two decades of research using both the original and subsequent variants of the ACES questionnaire have found repeated and consistent correlations between ACES scores and heightened risk for developing a wide range of adult psychiatric and physical health illnesses that ultimately lead to costly healthcare and early death (Zarse et al. (2019). As such, the ACES-R is accepted as an indicator of the common categories of childhood traumatic experiences.

Adult trauma history was explored using the Adult Traumatic Events (ATR) questionnaire created for this study (Appendix D). The ATR questionnaire includes 14 events that are coded ‘0’ or ‘1’ indicating the absence or presence of the event (e.g. natural disaster, physical assault, sexual assault, transportation accident, combat exposure). This instrument has not been subjected to rigorous analysis and serves the sole

purpose of determining whether one has experienced potentially traumatic events in adulthood.

### *Differentiation of Self*

The Differentiation of Self Inventory-Revised (DSI-R; Skowron & Schmitt, 2003) was used to measure DOS. The DSI-R is the most-used and psychometrically sound instrument for the measurement of Bowen's Family Systems Theory concept of DOS. The DSI was initially developed by Skowron and Friedlander (1998) and later revised by Skowron and Schmitt (2003). Though the original DSI was considered psychometrically sound (internal consistency measured with Cronbach's alpha for the full-scale DSI was 0.88 and the four subscales ranged from 0.74 - 0.88), one of the four subscales (fusion with others) was considered weaker in terms of reliability and construct-related validity and was improved in the 2003 revision of the DSI (DSI-R) (Skowron, 2000; Skowron & Friedlander, 1998; Skowron & Schmitt, 2003). The DSI-R is a self-report questionnaire with 46 items that are rated on a 6-point Likert scale from 1 (not at all true of me) to 6 (very true of me). The DSI-R measures DOS through four factors that load on two dimensions, Intrapersonal and Interpersonal. Along the Intrapersonal (INTRA) dimension are two subscales, *I-position* and *emotional reactivity*. Along the Interpersonal (INTER) dimension are two subscales, *emotional cutoff* and *fusion with others*. These four subscales and the transformation of what the scores represent during the scoring process are described next.

The I-position subscale (11 items) measures one's ability to maintain a clearly defined sense of self and personal convictions even when pressured to do otherwise (e.g. "I usually do not change my behavior simply to please another person" and "I'm less

concerned that others approve of me than I am in doing what I think is right"). Scores on the 11 items are summed (one item is reverse-scored) and divided by 11 to obtain an average I-position subscale score. Higher I-position average scores reflect greater DOS. The emotional reactivity subscale (11 items) measures one's tendency to react with automatic emotional intensity when exposed to the emotions of others (e.g., "At times my feelings get the best of me and I have trouble thinking clearly" and "I'm overly sensitive to criticism"). The emotional cutoff subscale (12 items) measures one's tendency to feel threatened by intimacy and to protect oneself by distancing from others (e.g. "I have difficulty expressing my feelings to people I care for" and "I'm concerned about losing my independence in intimate relationships") (Halevi & Idisis, 2018; Skowron & Friedlander, 1998; Skowron & Schmitt, 2003). All items on both the emotional reactivity and emotional cutoff subscales are reverse-scored, summed across each subscale, and divided by the number of items to obtain the emotional reactivity and emotional cutoff subscale average scores. Higher average subscale scores reflect higher levels of DOS. The fusion with others subscale is the subscale that received a complete revision by Skowron and Schmitt (2003). No revisions were made to the other three subscales. The fusion with others subscale (12 items) measures one's tendency to become overinvolved or enmeshed with significant others under stressful circumstances (e.g. "I often feel unsure when others are not around to help me make a decision" and "Sometimes I feel sick after arguing with my significant other"). All but one of the fusion with others items are reverse-scored so that greater subscale scores indicate higher DOS. The DSI-R full-scale score is obtained by summing all 46 items (after reversing scores on the items noted) and dividing the total by 46. The full-scale score and each of the four subscale

scores range from 1-6 with higher scores indicating higher levels of DOS. The DSI-R has strong internal consistency with Cronbach's alpha for the full-scale instrument of .92 and ranges from .81 to .89 for the four subscales (Skowron & Schmitt, 2003).

***Vicarious Traumatization***

VT was measured using the Trauma and Attachment Belief Scale (TABS) (Pearlman, 2003; Varra et al., 2008). The TABS was designed to measure cognitive schemas and beliefs about self and others for five psychological needs described by Constructivist Self-Development Theory (CSDT) - safety, esteem, intimacy, trust, and control - that are vulnerable to the negative effects of traumatic experiences (McCann & Pearlman, 1992; Varra et al., 2008). Because the five psychological needs are assessed for both beliefs about self and beliefs about others, there are a resulting ten subscale scores and a total score (Pearlman, 2003; Varra et al., 2008).

The TABS consists of 84 items (10 scales with varied number of items) that participants respond to on a Likert scale from 1 to 6 (1 = *Disagree strongly*; 6 = *Agree strongly*). Table 1 shows the 10 subscales, the number of items within each subscale, and sample items. Raw scores are totaled within each subscale and then divided by the number of items in that subscale. The total TABS score is also obtained by adding all raw scores and then dividing by the total number of items (84) (Pearlman, 2003). The normative group for the TABS consisted of 1,743 participants ranging in age from 17 to 78. Higher subscale scores indicate relative disruption in a given need area. Lower subscale scores indicate relative composure and freedom from disruption. The higher an overall TABS score indicates a higher level of VT (Pearlman, 2003).

**Table 3.1**

*Trauma and Attachment Belief Scale (TABS) Subscales*

| Subscale | # of Items | Sample Items |
|---|---|---|
| Self-Safety (SS) | 13 | I worry about what other people will do to me. |
| Other-Safety (OS) | 8 | The important people in my life are in danger. |
| Self-Esteem (SE) | 9 | I'm not worth much. |
| Other-Esteem (OE) | 8 | I don't respect the people I know best. |
| Self-Intimacy (SI) | 7 | I keep busy to avoid my feelings. |
| Other-Intimacy (OI) | 8 | When I am with people, I feel alone. |
| Self-Trust (ST) | 7 | I have a hard time making decisions. |
| Other-Trust (OT) | 8 | People who trust others are stupid. |
| Self-Control (SC) | 9 | Strong people don't need to ask for help. |
| Other-Control (OC) | 7 | I can't do good work unless I am the leader. |

Pearlman (2003) stated that often, individuals "whose self-oriented subscale scores are all elevated relative to their other-oriented scores have experienced very early trauma and have impaired self-capacities" (p. 19). Conversely, individuals whose other-oriented subscale scores are elevated relative to their self-oriented scores are likely to have difficulties in relationships, project blame on others, and engage in aggressive behavior toward others. The reliability and validity of the TABS are discussed next.

Instrument reliability describes the ability to reproduce test results across various settings and over time. Instrument validity informs users of the appropriateness of the test within a given setting and the ability of the test to measure the stated construct. The

TABS has shown strong reliability with an internal consistency of .96 and a test-retest correlation of .75 overall. Internal consistency for the individual subscales ranged from .67 (Self-Intimacy) to .87 (Other-Intimacy). Test-retest correlations for the individual subscales ranged from .60 (Other-Intimacy) to .79 (Other-Trust). The TABS items directly inquire about beliefs in the five psychological needs areas as presented in Constructivist Self-Development Theory (CSDT) and respondents, when shown their scores, have agreed that the results match their perceived areas of sensitivity (Pearlman, 2003). Validity was maximized through the use of theory (CSDT) to generate items to include in the instrument and the use of experts to review the assignment of items to scales. Interscale correlations and factor analysis confirmed the presence of 10 unique subscales (Pearlman, 2003). Jenkins and Baird (2002) compared a previous iteration of the TABS (TSI-BSL with 80 items versus the TABS' 84 items) to several measures for burnout, compassion fatigue, and secondary traumatic stress and found discriminant validity for the TABS as a measure that emphasizes the cognitive beliefs of secondary exposure to trauma as intended. Pearlman & Mac Ian (1995) used the TABS to measure the impact of indirect, or vicarious, trauma on therapist beliefs about self, others, and the world. They found higher TABS scores in therapists with a personal trauma history and therapists who have extensive exposure to clients' traumatic experiences in their caseload. The above demonstrates the reliability and validity of the TABS for use in measuring VT.

## Procedures

An application was submitted to Oakland University's Internal Research Board, which approved this study (See Appendix A). Subsequently, permission was sought to utilize the TABS and DSI-R inventories (See Appendix B). The survey set was created using Qualtrics, a confidential survey tool used for the construction, distribution, and data collection of Internet surveys.

### Participants

Participants were broadly recruited to procure a large and diverse sample of mental health therapists. Recruitment requests were submitted through professional organizations and listservs, including Oakland University's counseling students and alumni listservs, International Society for the Study of Trauma and Dissociation (ISSTD), American Counseling Association's International Association for Resilience and Trauma Counseling (IARTC), Catholic Charities Southeast Michigan, Dissociative Disorders listserv, and CESNET listserv. Additionally, the researcher distributed recruitment requests directly to professional colleagues and professional social networking sites. The recruitment request (See Appendix C) described the study, inclusion and exclusion criteria, and provided a link for anonymous participation in the survey. Additionally, snowball recruitment was used whereby participants were asked to share the study information and link with eligible colleagues. Participants in the study included mental health therapists from a variety of disciplines (e.g. counseling, social work, psychology, psychiatry). Eligible participants had to be fully-licensed, conditionally-licensed, or a graduate student currently in the clinical internship portion of their program. Additional inclusion criteria for participants were 25 years of age or older, English-speaking, and

carrying an active caseload of at least 5 clients. Excluded from the study were individuals whose primary work setting is inpatient hospitalization, intensive outpatient, educational, or career counseling. Participants were initially presented with an informed consent form. Once accepted, they began to complete the background information questionnaire (Appendix E) followed by the ACES-R (Appendix F), Adult Traumatic Events questionnaire (Appendix G), DSI-R, and TABS. At the end of the survey, the participant was given the choice to submit their responses. There was no follow-up involvement required or requested of the participants.

**Data Analysis**

Once data collection was complete, the data was scrubbed to remove incomplete or invalid data from the database and then exported to IBM SPSS version 27, a statistical analysis program widely used for research purposes. To conduct the analysis, a combination of bivariate correlational analysis, linear regression, multiple regression, and hierarchical regression was utilized. Bivariate correlational analysis was used to test whether relationships existed between variables and the strength and significance of those relationships. Linear regression was used to analyze the impact of single predictor variables on the outcome variable. Multiple regression was used when there was more than one predictor variable under consideration. Hierarchical regression was used when layering the analysis of the impact of multiple predictor variables on an outcome variable. Additionally, an analysis of the significance of the difference between two correlations was used when examining whether there was a significant difference in the impact of one relationship to another. The moderated mediation analysis consisted of a series of

regression analyses. The data analysis procedures will be explained in detail in the next chapter.

# Chapter Four

## Results

This chapter details the results of the statistical analysis, including data preparation, an overview of the sample studied, and the specific findings related to the research questions and hypotheses tested. The purpose of the study was to examine the relationship between differentiation of self (DOS) and vicarious traumatization (VT) in therapists who work with traumatized populations and to explore several potential mediating and moderating variables that impact the relationship between DOS and VT. The four potential mediating variables examined were personal therapy history (THPY), work experience (WE), trauma-specific training (TT), and satisfaction with professional support (SUPP). The potential moderating variable was therapist personal history of trauma (PTH). An alpha level of .05 was used for all statistical tests.

## Data Preparation

To prepare for data analysis, several steps were taken to organize and clean the data. Survey responses from 144 participants were exported from Qualtrics.com into an Excel spreadsheet for initial analysis of the raw data. Items such as IP address, user language, and start/end date were removed from the data file as these were not necessary for data analysis. Several items in the surveys allowed for text responses, and this information was placed in a separate file to be used for elaboration of sample demographics. Next, cases with no data ($n$ = 10) or substantially incomplete data ($n$ = 14) were removed resulting in an adjusted sample size of $N$ = 120 participants. Single items with missing data or data that were incorrectly inputted were corrected. For example, personal trauma history was assessed through dichotomous items (yes = 1, no = 0) where

the response indicated whether the traumatic event had or had not been experienced during the participant's life. When these items were left blank, the default response of "no" (0) was inserted.

With the initial data cleaning complete, the scrubbed file was imported into IBM SPSS Statistics v27 for analysis. Further adjustments were made for singular missing items. Two variables, work experience and age, each had four participants with a missing response. These fields were populated with the mean value of those variables respectively. Both the instrument used to measure DOS and the instrument used to measure VT included multiple reverse-scored items. Using the Compute Variable function in SPSS, these scores were adjusted as appropriate. Data transformations were performed to calculate and create the necessary subscales of DOS, VT, and PTH.

Frequency descriptives were run to test assumptions for normality and homoscedasticity. Personal therapy history (THPY) was outside the acceptable range (skewness = -1.906, kurtosis = 3.195), however, this is an expected result for a population of therapists. All other predictor and outcome variables analyzed were within acceptable levels for skewness and kurtosis. However, several demographic variables were skewed. These will be discussed in the section describing the sample characteristics. A box plot analysis conducted on DOS and VT revealed two outliers. A comparison analysis was conducted to determine if the outliers should be removed. However, their removal did not significantly alter the results of the analysis, and thus they were retained.

## Sample Characteristics

The sample population for this research study included 120 therapists from a variety of mental health disciplines including counseling (*N* = 60, 50.0%), social work (*N* = 31, 25.8%), psychology (*N* = 18, 15.0%), and marriage and family therapists (*N* = 7, 5.8%). The majority of participants were Caucasian (*N* = 100, 83.3%) and identified as cis-gender female (*N* = 96, 80.0%). Participants ranged in age from 25 to 78 years (*M* = 47.85, *SD* = 13.77) and ranged in work experience from 0 to 57 years (*M* = 14.29, *SD* = 11.79). Additionally, 89.9% of participants were fully-licensed (*N* = 107) in their respective disciplines.

Regarding the participants' work settings, 75.0% of participants reported working in private practice (*N* = 90) and 18.3% reported working in community mental health or non-profit agencies (*N* = 22). While the majority of participants practiced solely within the United States (*N* = 99, 82.5%), the remaining 17.5% (*N* = 21) practiced outside of the United States (one participant practiced both within the US and in Canada). Countries represented in this sample included Australia, Canada, France, Netherlands, Mexico, UK, Ireland, Israel, South Africa, and Singapore. When asked to estimate the percentage of clients within their caseload who have a history of trauma, responses ranged from 10%-100% with a mean of 82.31%. This result was outside the range of acceptable tests of normality (skewness = -1.590, kurtosis = 2.202). However, because this research study attempted to capture therapists who work with traumatized populations, these results were expected.

## Data Analysis Results

Since my first research question was a duplication of the Halevi and Idisis (2018) study upon which this study was built, a comparison of this study's findings to the 2018 study was completed. Tables 4.1 and 4.2 present the means and standard deviations of DOS and VT, in comparison to the Halevi and Idisis (2018) findings. Figures 4.1 and 4.2 graphically depict the comparison between the two studies with respect to DOS and VT. These tables and figures demonstrate the similarity between the two samples and their resulting scores on the instruments used to measure DOS and VT. Thus, the Halevi and Idisis (2018) study is replicable and reliable.

**Table 4.1**

*Differentiation of Self Mean and Standard Deviation Values*
*Comparison of Current Study (N=120) with Halevi and Idisis (2018) Study (N=134)*

| | Current Study (*N* = 120) | | Halevi & Idisis (*N* = 134) | |
|---|---|---|---|---|
| Variable | Mean | SD | Mean | SD |
| Differentiation of Self (DOS) | 4.25 | .65 | 4.00 | .64 |
| Intrapersonal Dimension (INTRA) | 4.10 | .73 | -- | -- |
| Emotional Reactivity (ER) | 3.93 | .87 | 3.53 | .92 |
| I-Position (IP) | 4.27 | .80 | 4.10 | .77 |
| Interpersonal Dimension (INTER) | 4.38 | .68 | -- | -- |
| Emotional Cutoff (EC) | 4.57 | .86 | 4.69 | .81 |
| Fusion With Others (FO) | 4.19 | .79 | 3.67 | .80 |

**Table 4.2**

*Vicarious Traumatization Mean and Standard Deviation Values*
*Comparison of Current Study (N=120) with Halevi and Idisis (2018) (N=134) Study*

| | Current Study | | Halevi & Idisis Study | |
|---|---|---|---|---|
| Variable | Mean | SD | Mean | SD |
| Vicarious Traumatization (VT) | 2.19 | .55 | 2.02 | .46 |
| (VTSelf) | 2.15 | .55 | -- | -- |
| (VTOther) | 2.25 | .60 | -- | -- |
| Self Safety (SS) | 2.03 | .63 | 2.06 | .62 |
| Other Safety (OS) | 1.90 | .64 | 2.09 | .53 |
| Self Trust (ST) | 2.07 | .60 | 2.07 | .63 |
| Other Trust (OT) | 2.30 | .75 | 1.76 | .60 |
| Self Esteem (SE) | 1.89 | .68 | 1.91 | .69 |
| Other Esteem (OE) | 2.40 | .73 | 2.01 | .58 |
| Self Intimacy (SI) | 2.55 | .62 | 2.43 | .70 |
| Other Intimacy (OI) | 2.60 | .97 | 1.84 | .61 |
| Self Control (SC) | 2.33 | .70 | 2.06 | .62 |
| Other Control (OC) | 2.08 | .54 | 2.07 | .59 |

**Figure 4.1**

*Differentiation of Self Mean and Standard Deviation Values*
*Comparison of Current Study (N=120) with Halevi and Idisis (2018) Study (N=134)*

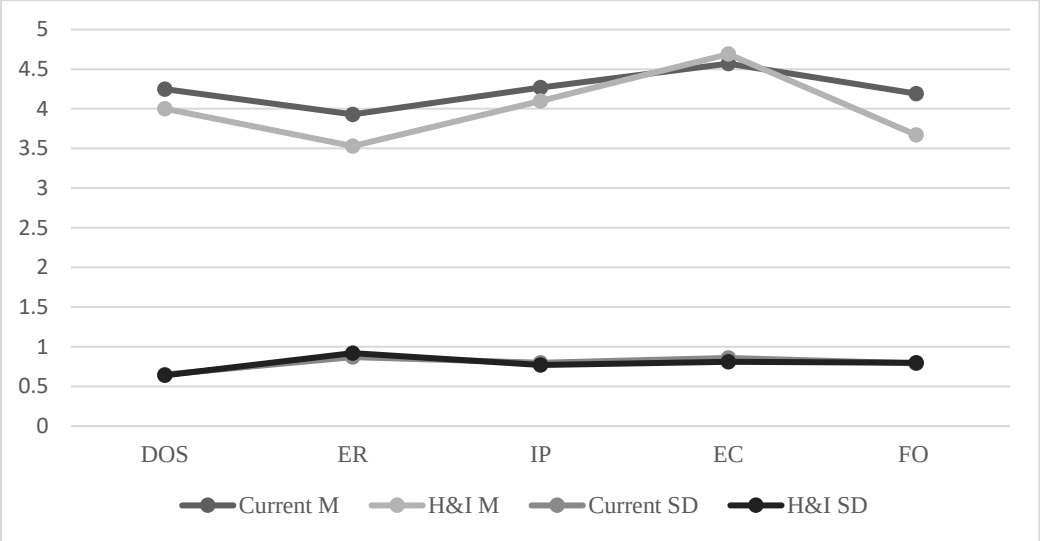
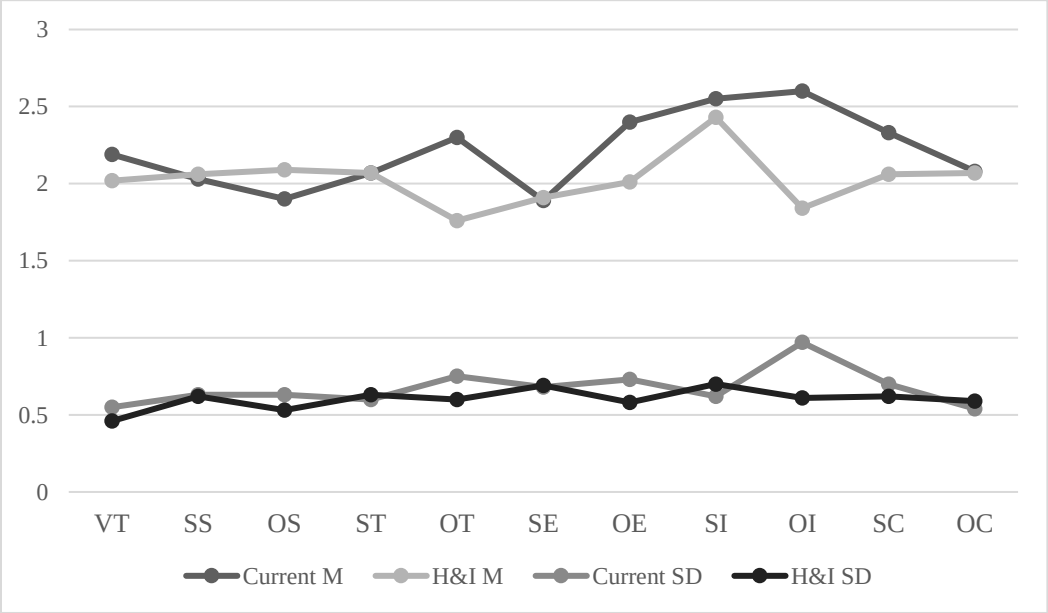



**Figure 4.2**

*Vicarious Traumatization Mean and Standard Deviation Values*
*Comparison of Current Study (N=120) with Halevi and Idisis (2018) (N=134) Study*



**Research Question 1: Relationship Between Differentiation of Self (DOS) and Vicarious Traumatization (VT)**

The first research question explored the relationship between DOS and VT and included four hypotheses. A Pearson product-moment correlation coefficient was computed to evaluate the relationship between a therapist's level of DOS and their level of VT. Table 4.3 summarizes the correlation coefficients for the overall relationship between DOS and VT as well as the relationships between the two dimensions of DOS (intrapersonal and interpersonal) and the two dimensions of VT (self-oriented and other-oriented).

**Table 4.3**
*Zero-order Correlations between Differentiation of Self and Vicarious Traumatization*

| | DOS-Full Scale | DOS-INTRA | DOS-INTER |
|---|---|---|---|
| VT-Full Scale | -.73** | -.66** | -.68** |
| VT-Self | -.78** | -.72** | -.71** |
| VT-Other | -.61** | -.54** | -.58** |

*$p < .05$. **$p < .01$.

This analysis exhibited a strong and significant inverse relationship between therapist level of DOS and VT (Hypothesis 1). The higher a therapist's level of self-differentiation, the lower their level of VT. There were similarly strong and significant inverse relationships between the INTRA dimension of DOS and VT-Self dimension (Hypothesis 3) and between the INTER dimension of DOS and VT-Other dimension (Hypothesis 4).

Hypothesis 2 stated that the INTRA dimension of DOS had a stronger negative correlation to VT than the INTER dimension of DOS. This hypothesis was analyzed using Daniel Soper's online calculator to determine whether two correlation coefficients were significantly different from each other (Soper, n.d.). The values resulting from the calculation include a z-score and its related probability (p) value. A *p* value of less than .05 indicates that the two correlation coefficients were significantly different from each other. Hypothesis 2 stated that the INTRA dimension of DOS would have a stronger negative correlation to VT than the INTER dimension of DOS. However, this hypothesis was not supported by the findings ($z$ = -0.194, $p$ = .85).

Because all correlations among the various dimensions and subscales of DOS and VT (ranging from -.347 to -.776) were significant, I examined whether there were significant differences in the correlations between the subscales of DOS and VT. Using Soper's significance of the difference between two correlations calculator (Soper, n.d.), findings showed DOS was significantly more strongly correlated ($p$ = .011) to VT-Self (-.78) than VT-Other (-.61) . Additionally, the INTRA dimension was significantly more strongly correlated to VT-Self than VT-Other ($p$ = .019). DOS indicates the strength of one's sense of self and ability to engage with others while maintaining integrity regarding self, balancing emotion and intellect. Therefore, it makes sense that DOS would be more influential in predicting potential disruptions to self-oriented aspects of VT rather than other-oriented aspects.

**Research Question 2: Examining Potential Mediators**

The second research question explored whether personal therapy history (THPY), work experience (WE), trauma-specific training received (TT), and/or satisfaction with

professional support (SUPP) mediated the relationship between DOS and VT. According to the Baron and Kenny (1986) model for determining mediation, a variable functions as a mediator between a predictor variable and an outcome variable when it accounts for part or all of the relationship between the predictor and outcome variables. A variable fully mediates when its inclusion in the model reduces the prior predictor-outcome relationship to zero. Partial mediation is said to occur when the predictor-outcome relationship is only partially and significantly explained by the inclusion of the mediating variable. In this case, there are likely multiple mediating variables. The Baron and Kenny test for the mediation model involves three linear regression equations: 1) regress the mediator on the independent variable; 2) regress the dependent variable on the independent variable; and, 3) regress the dependent variable on both the mediator and the independent variable. These steps are conducted separately for each of the four potential mediating variables. For each of these analyses, the standardized regression coefficient (β) will be reported. Prior to testing for mediation of the relationship between DOS and VT by the four predictors, bivariate correlational analyses were conducted to ensure a relationship exists between each of the four predictors and the outcome variable. Table 4.4 displays the results of this analysis which shows a statistically significant relationship between each of the predictor variables and VT. Therefore, it is appropriate to conduct a regression analysis to test for mediation using the Baron and Kenny (1986) model.

**Table 4.4**

*Bivariate Correlations Among Predictor Variables and Outcome Variables*

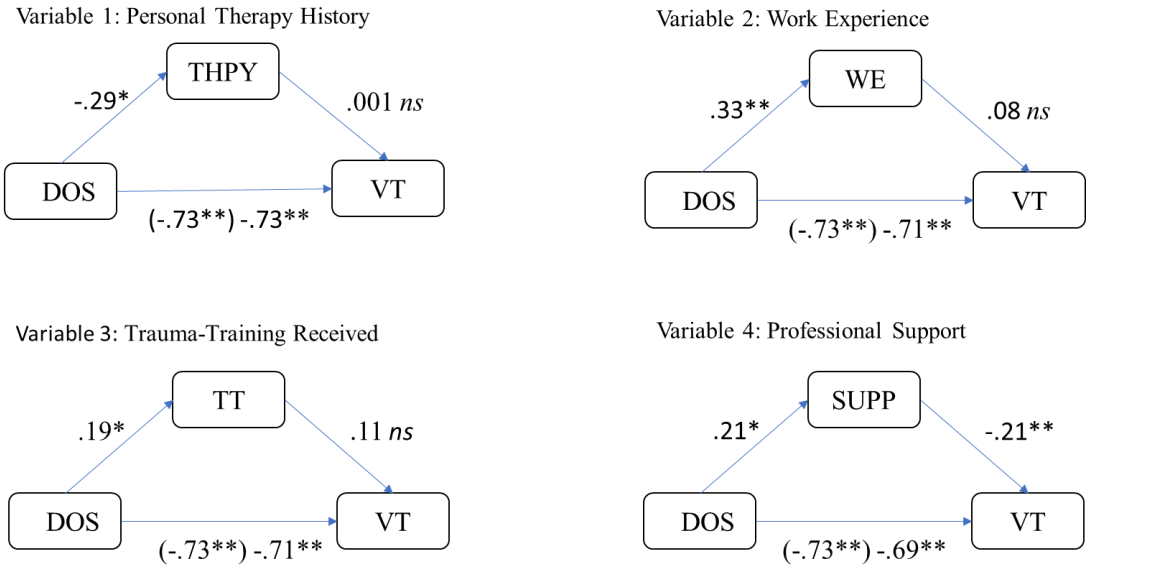
| Predictor | DOS | VT |
|---|---|---|
| THPY | -.294, $p < .02$* | .216, $p < .02$* |
| WE | .334, p < .001** | -.313, $p < .001$** |
| TT | .191, $p = .037$* | -.247, $p < .01$** |
| SUPP | .205, $p = .026$* | -.352, $p < .001$** |
| DOS | --- | -0.730, $p < .001$** |

*$p < .05$. **$p < .01$.

Figure 4.3 shows the results of the mediation analyses that were conducted separately on each of the four potential mediating variables. This was accomplished by first conducting a linear regression with THPY and DOS as predictor variables and VT as the outcome variable, then noting whether the inclusion of the potential mediating variable (THPY) significantly impacted the standardized regression coefficient for DOS. In this case, there was no change in DOS when THPY was added to the model. This regression analysis was repeated for each of the remaining three potential mediator variables (WE, TT, and SUPP). Of the four tested variables, only SUPP resulted in a small but significant partial mediation of the relationship between DOS and VT; however, the reduction in the standardized regression coefficient of 8% falls just short of the most liberal standards, which recommend a minimum of 10% reduction in the standardized regression coefficient (Cohen et al., 2003). Therefore, SUPP is not a statistically meaningful mediator.

**Figure 4.3**

*Results of Tests for Mediation (Baron & Kenny, 1986) of Relationship Between Differentiation of Self and Vicarious Traumatization by Four Potential Variables*




The value in parentheses is the beta for the unmediated relationship between DOS and VT. *$p < .05$. **$p < .01$.

## Research Question 3: The Relationship Between Personal Trauma History (PTH) and Vicarious Traumatization (VT)

Data collected for PTH was gathered with two separate instruments (ACES-R and Adult Trauma Questionnaire) to measure trauma that was experienced during childhood prior to age 18 (ACESR) and trauma experienced during adulthood (ATR). Adding these two variables together produced lifetime trauma history (PTH). The hypothesis explored predicted that PTH was positively correlated with VT, and the findings supported this hypothesis ($r = .230$, $p = .012$). Similarly, ACESR was positively correlated with VT ($r = .215$, $p = .019$); however, ATR was not found to be significantly correlated to VT ($r =$

.168, $p$ = .067). It is notable that the relationship between childhood and adult trauma (ACESR and ATR) was positively correlated and significant ($r$ = .422, $p$ < .001). This is consistent with the Adverse Childhood Experiences study (Felitti et al., 1998), which found that childhood trauma predicts adult trauma.

**Research Questions 4: The Impact of Personal Trauma History (PTH) on the Relationship Between Differentiation of Self (DOS) and Vicarious Traumatization (VT)**

Multiple regression analysis was used to test the hypothesis that PTH moderates the relationship between DOS and VT. The first step was to create a new variable that was the product of DOS x PTH (i.e., the interaction term). Then, a linear regression was conducted that included the two main effect variables and the new interaction variable as predictors (DOS, PTH, DOS x PTH) and VT as the outcome. The results indicated that there is no significant interaction effect between DOS and PTH ($\beta$ = -.078, $p$ = .225), and therefore, PTH did not moderate the relationship between DOS and VT.

**Research Question 5: Moderated Mediation**

The final research question asks whether PTH moderates the mediating effect of the previously examined predictor variables. Since there were no statistically significant meaningful mediators found, this analysis is not appropriate.

## Post Hoc Exploratory Analysis

A post hoc (after this) analysis is conducted after the initial planned analysis to gain further insight into the obtained data (Pamplona, 2022). Post hoc analyses do not change the outcome of the results of the original study as designed. As such, the following discussion does not represent a retrospective change in this study's hypotheses.

Rather, this exploration is pursued to assist in the conceptualization of potential future research objectives.

There were several areas worthy of further examination beyond the results of the original planned research questions that will be discussed in this section. As mentioned in the previous chapter, Pearlman (2003) stated, regarding the TABS measurement of VT, that often individuals "whose self-oriented subscale scores are all elevated relative to their other-oriented scores have experienced very early trauma and have impaired self capacities" (p. 19). Conversely, individuals whose other-oriented subscale scores are elevated relative to their self-oriented scores are likely to have difficulties in relationships, project blame on others, and engage in aggressive behavior toward others. To explore these statements, I examined two subsets of the present sample: 1) those participants whose VT self-oriented subscales were higher than their other-oriented subscales (Self group, $n = 51$), and 2) those participants whose other-oriented subscales were higher than their self-oriented subscales (Other group, $n = 69$). Based on Pearlman's (2003) statement that the Self group likely has experienced very early trauma, I anticipated that this group's ACESR score would be higher than the Other group's ACESR score. However, this was not the case. The mean ACESR score for the Self group was 3.90, compared with the Other group's ACESR mean score of 4.28. An independent-samples *t-test* was calculated comparing the mean ACESR scores for the Self and Other groups. No significant difference was found $t(118) = -.630$, $p = .530$. The mean ACESR for the Self was not higher than the mean ACESR for the Other group, and there was no significant difference between the means.

Pearlman's statement that the Self group will likely have impaired self-capacities is difficult to determine as nowhere within the measurement of VT does Pearlman (2003) define a cutoff score that determines impairment. Rather, the subscales (Self versus Other) for the TABS scores (measure of VT) are evaluated in relative terms. A VT score that is higher for Self-subscales than Other-subscales indicates more disruption to one's relationship with self than with others. Indeed, the findings detailed in the Research Question 1 section indicated that both overall DOS and the INTRA dimension of DOS were significantly more strongly inversely correlated to the VTSelf subscales than the VTOther subscales. This finding may suggest that Self experienced more disruption or, alternatively, that DOS as a measurement of self is more strongly predictive of self-oriented disruptions than other-oriented disruptions. Therefore, comparative differences between the Self group and Other group on DOS dimensions (two subscales per dimension) were probed using a series of independent-samples *t* tests. Table 4.5 shows the results of independent-samples *t* tests for all dimensions and subscales of DOS. Results revealed that the DOS mean for the Self group ($M$ = 4.06, $sd$ = .65) was significantly lower than the mean of the Other group ($M$ = 4.39, $sd$ = .61), $t(118) = -2.85$, $p = .005$.

**Table 4.5**

*Results of Independent-Samples t tests Between Self Group (VTSelf > VTOther) and Other Group (VTOther > VTSelf) Means for DOS and its Subscales*

| | Self M | Self SD | Other M | Other SD | df | t | p | Cohen's d |
|---|---|---|---|---|---|---|---|---|
| DOS | 4.06 | .65 | 4.39 | .61 | 118 | -2.85 | .005 | -.53 |
| INTRA | 3.90 | .72 | 4.25 | .71 | 118 | -2.64 | .009 | -.49 |
| INTER | 4.20 | .71 | 4.52 | .63 | 118 | -2.59 | .011 | -.48 |
| ER | 3.81 | .88 | 4.03 | .87 | 118 | -1.36 | .176 | -.25 |
| IP | 3.99 | .79 | 4.48 | .75 | 118 | -3.38 | <.001 | -.62 |
| EC | 4.51 | .89 | 4.62 | .83 | 118 | -.71 | .477 | -.13 |
| FO | 3.89 | .81 | 4.42 | .70 | 118 | -3.77 | <.001 | -.70 |

Note: Bonferroni corrected p value for INTER and INTRA was .025 (.05/2). Bonferroni corrected p value for ER, IP, EC, and FO was .0125 (.05/4). Cohen's d effect size: 0.2 = small; 0.5 = medium; 0.8 = large.

As shown in Table 4.5, all dimension and subscale means of DOS were lower for the Self group than the Other group except ER (emotional reactivity, a subscale of the INTRA dimension of DOS) and EC (emotional cutoff, a subscale of the INTER dimension of DOS). This remains true even after applying the Bonferroni correction to control for Type I error (Field, 2016). Thus, this analysis implies that a lower DOS is not only predictive of increased VT overall, but may predict more disruption to the self-oriented aspects of VT than the other-oriented aspects.

Pearlman's (2003) statement that the Other group would likely have difficulties in relationships, project blame on others, and engage in aggressive behavior toward others cannot be directly measured with the data on hand, however, the increased level of DOS

overall and within each subscale of DOS for the Other group compared to the Self group implies a greater ability to regulate one's emotional behavior with others rather than heightened challenges.

The above analysis highlights the impact that one's level of DOS has on the level of VT, especially with regard to disruptions of self-oriented cognitive schemas. The original research design hypothesized that there were four mediating variables that, when included in the model, would reduce the impact of DOS on VT. This was not supported by the data. However, it is conceivable that rather than these variables acting as mediators between DOS and VT, their impact on DOS is direct. For example, personal therapy (THPY) may improve the ability to manage boundaries more effectively and thereby strengthen DOS, but may also instigate awareness of unresolved boundary dilemmas which could weaken one's DOS. Similarly, increased work experience (WE) and trauma-specific training (TT) may, over time, provide enough contextual knowledge to improve DOS and thereby lessen the activation of VT from subsequent clinical relationships. Professional support (SUPP) may enhance the therapist's confidence in their ability to maintain a sense of self in their work with clients, knowing they will be supported to process any felt disruptions to self that occur in sessions. It is possible then, that the impact of these four variables is on DOS *directly* and thereby, *indirectly* impacting VT. Therefore, an alternative analytic model was tested to better understand the causal relationships between the predictor variables and DOS to assist in formulating recommendations for future research designs.

A post hoc exploratory analysis was conducted to examine the possible indirect effects among the variables (Rucker et al., 2011) to identify alternative pathways not

captured in the original research design. Understanding these possible alternative pathways may have practical implications related to proposed interventions targeting the variables that may impact VT through DOS (Andrade, 2023). The technique used to examine an alternative causal relationship between a set of independent variables and the dependent variable is called *path analysis* (Hooshang Nayebi, 2021). The purpose of the path analysis is to determine if any of the independent variables act *through* another independent variable to impact the outcome variable (indirect effect), rather than acting directly on the outcome variable (direct effect). We know from Table 4.4 that there was a statistically significant correlational relationship between each of the four predictor variables and VT. The goal of the path analysis is to understand how these variables are impacting VT. First, the bivariate correlations between the variables (THPY, WE, TT, SUPP) were inspected for potential multicollinearity. The correlations ranged from .054 to .267 indicating that collinearity was not an issue. Second, a multiple linear regression analysis was performed using DOS as the outcome variable and the four remaining independent variables (THPY, WE, TT, SUPP) as predictors. Of the four predictor variables only TT yielded a non-significant relationship ($r$ = .17, $p$ = .054). The remaining three predictor variables (THPY, WE, SUPP) were each significant contributors to DOS (See Table 4.6). Third, a multiple linear regression analysis was performed with VT as the outcome variable and all five independent variables as predictors. Non-significant variables are then removed one at a time from the regression until only significant predictor variables remain. Table 4.6 shows the full results of the path analysis.

**Table 4.6**

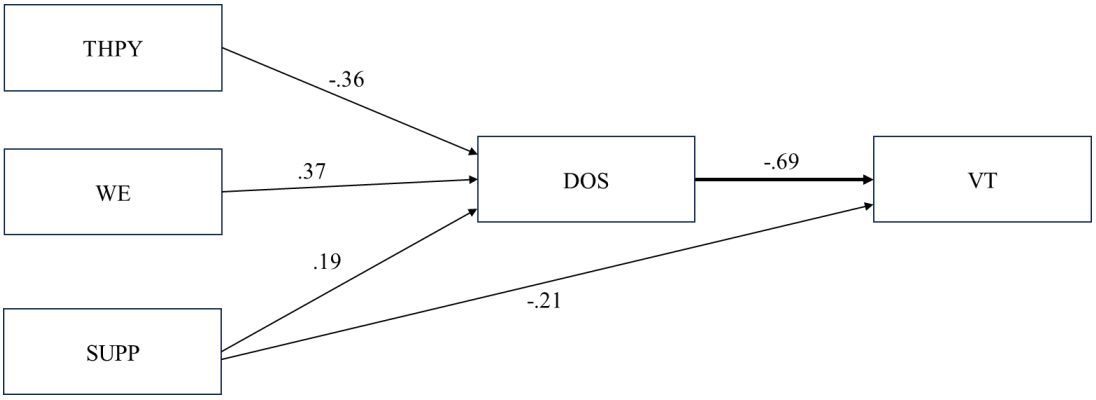
*Results of Path Analysis Connecting Background Variables Through DOS to VT*

| Predictor | to DOS *r-value* | to VT *r-value* |
|---|---|---|
| THPY | -.39<br>($t$ = -4.73, $p$ < .001) | .06<br>($t$ = 0.79, $p$ = .43) |
| WE | .33<br>($t$ = 3.93, p < .001) | -.06<br>($t$ = -.87, $p$ = .39) |
| TT | .17<br>($t$ = 1.94, $p$ = .054) | -.08<br>($t$ = -1.26, $p$ = .21) |
| SUPP | .19<br>($t$ = 2.37, $p$ < .02) | -.21<br>($t$ = -3.33, $p$ < .001) |
| DOS | --- | -.63<br>($t$= -8.60, $p$ < .001) |

This analysis indicates three of the four predictor variables had an independent and unique impact on DOS. Of these, WE and SUPP are positively related to DOS, and THPY is negatively related to DOS. The third column shows that when all of these variables are included as predictors for VT, the variables THPY, WE, and TT are subsumed by DOS, meaning they influence VT through their impact on DOS. SUPP, however, has a continued independent effect on VT even after taking into account its relationship to DOS. Figure 4.4 provides a graphical representation of the full analytic path model.

**Figure 4.4**

*Final Path Model Connecting Predictor Variables Through DOS to VT*




(THPY-Personal Therapy Received; WE-Work Experience; SUPP-Support; DOS-Differentiation of Self; VT-Vicarious Traumatization)

In addition to the direct effects that THPY, WE, and SUPP have on DOS, they also have indirect effects on VT. The indirect effect of THPY on VT, operating through DOS, is calculated by multiplying the direct effect of THPY on DOS by the direct effect of DOS on VT (-.36 x -.69 = .25). Therefore, for every one standard deviation increase in THPY, there is a corresponding .25 standard deviation increase in VT. The indirect effect of WE on VT is -.26 (.37 x -.69) which indicates that for every one standard deviation increase in WE, there is a corresponding .26 standard deviation decrease in VT. The indirect effect of SUPP on VT is -.13 (.19 x -.69). However, because there is also a direct negative effect (-.21) of SUPP on VT, the indirect and direct effects are combined to indicate an overall combined effect of SUPP on VT of -.34 (-.13 + -.21). This means that for every one standard deviation increase in SUPP, there is a corresponding decrease in VT of -.34 standard deviations.

## Summary of Data Analysis Findings

Differentiation of self had a strong and significant inverse relationship with vicarious traumatization. As one's level of differentiation increased (strengthened), vicarious traumatization decreased. Similarly, strong and significant inverse relationships were found between the intrapersonal dimension of DOS and VTSelf, and the interpersonal dimension of DOS and VTOther. However, the intrapersonal dimension of DOS was not significantly more strongly correlated to VT than the interpersonal dimension of DOS. Therefore, both dimensions of DOS must be taken into account when measuring overall VT. DOS and the intrapersonal dimension of DOS are both more significantly correlated to VTSelf than VTOther. The construct of DOS as measured in this research study indicates the strength of one's sense of self and ability to engage with others while maintaining integrity regarding self, balancing emotion and intellect. Therefore, it makes sense that DOS would be more influential in predicting potential disruptions to self-oriented aspects of VT rather than other-oriented aspects.

A post hoc exploratory analysis revealed that DOS is especially impactful on self-oriented aspects of VT. A lower DOS is not only predictive of increased VT overall but may predict more disruption to the self-oriented aspects of VT than the other-oriented aspects. These findings should be considered preliminary and warrant further study.

Personal trauma history was positively correlated to VT, meaning that increased levels of trauma in therapists' past predicted heightened levels of VT. However, the level of PTH did not moderate the relationship between differentiation of self and vicarious traumatization. Further, higher levels of childhood trauma (versus adult trauma) in this sample were significantly correlated with stronger levels of differentiation of self.

Though no variables were found to be meaningful mediators of the relationship between DOS and VT, professional support evidenced a weak yet significantly direct effect on the relationship. A post hoc exploratory analysis suggested that personal therapy received, work experience, and professional support each influenced vicarious traumatization indirectly through differentiation of self. It appears the impact of these variables is subsumed within the DOS construct. Only professional support had both an indirect effect on vicarious traumatization through differentiation of self and a direct effect on vicarious traumatization.

# Chapter Five

## Discussion

The purpose of this dissertation was to explore the factors that contribute to the development of vicarious traumatization (VT) in therapists who work with traumatized clients. This exploration was investigated through the lens of Bowen's (1978) concept of differentiation of self (DOS). DOS refers to the capacity to maintain a strong sense of self and psychological boundaries, especially when in emotionally intimate relationships with others. The higher one's DOS, the better able they are to maintain their sense of self while in emotional contact with others (Bowen, 1978; Connery & Murdock, 2019; Halevi & Idisis, 2018; Kapel Lev-Ari et al., 2020; Kerr & Bowen, 1988; Lampis, 2016; Lampis & Cataudella, 2019; Skowron, 2000; Skowron et al., 2003; Skowron & Friedlander, 1998; Titelman, 2014). VT, as conceptualized by McCann and Pearlman (1990a; 1990b) through the lens of Constructivist Self Development Theory, describes the potential negative consequences to therapists from cumulative secondary exposure to the details of the traumatic experiences of their clients. VT represents the pervasive and negative changes in a therapist's beliefs about, and relationships with, self, others, and the world (McCann & Pearlman, 1992; McCann & Pearlman, 1990a; McCann & Pearlman, 1990b; McCann et al., 1988; Pearlman & Mac Ian, 199; Pearlman & Saakitne, 1995). Halevi and Idisis (2018) were the first researchers to investigate the relationship between DOS and VT. This study builds upon the research of Halevi and Idisis who found a strong inverse relationship between therapist level of DOS and VT. To extend the understanding of the relationship between DOS and VT, I examined the influence of therapists' personal

therapy history, work experience, trauma-specific training, professional support, and personal trauma history on the relationship between DOS and VT.

## Summary of Research Results

Prior to addressing the research questions and hypotheses, I compared my study's sample to the Halevi and Idisis (2018) sample. The two samples were similar in size and demographic characteristics. A review of the means and standard deviations of DOS, VT, and subscales of both samples revealed further similarities, thus providing the foundation to state that the Halevi and Idisis study is replicable and reliable.

### The Relationship Between Differentiation of Self and Vicarious Traumatization

The first research question examined the relationship between DOS and VT and included four hypotheses. Hypothesis 1 confirmed Halevi and Idisis (2018) finding that DOS is negatively correlated with VT. My analysis exhibited a strong and significant inverse relationship between DOS and VT indicating that the higher a therapist's level of self-differentiation, the lower their level of reported VT. Similarly, there was a strong and significant inverse relationship between the intrapersonal dimension (INTRA) of DOS and the self-oriented subscales of VT, and between the interpersonal dimension (INTER) of DOS and the other-oriented subscales of VT (Hypotheses 3 and 4, respectively). These findings are not surprising since virtually all subscales of DOS and VT were significantly and inversely correlated. Because the INTRA dimension of DOS reflects the internal process of balancing emotional reactions with a grounded sense of one's identity, while the INTER dimension of DOS reflects the way the self interacts with others through the balance of intimacy and autonomy, I predicted that the INTRA dimension would have a

stronger inverse correlation to VT than the INTER dimension (Hypothesis 2). However, this was not supported by the data.

Extending the investigation regarding the relationship between DOS and VT beyond the results of the stated hypotheses yielded further information. DOS was significantly more strongly correlated with the self-oriented (VT-Self) subscales of VT than the other-oriented (VT-Other) subscales. Additionally, the INTRA dimension of DOS was significantly more strongly correlated to VT-Self than VT-Other. This was not the case with respect to the INTER dimension of DOS.

**Examining Factors That Influence the Relationship Between DOS and VT**

Vicarious traumatization does not result from any single client session or relationship but rather from the cumulative effect over both time and multiple clients. In this regard, Pearlman and Mac Ian (1995) state that the interaction of specific therapist characteristics with elements of trauma work over time predicts a therapist's vulnerability to VT. However, research investigating the impact of various therapist characteristics on therapists' manifestations of secondary stress has yielded inconsistent outcomes (Adams & Riggs, 2008; Branson, 2019; Butler et al., 2017; Courtois and Gold, 2009; DelTosta et al., 2019; Gaboury & Kimber, 2022; Halevi & Idisis, 2018; Neumann & Gamble, 1995; Pearlman & Mac Ian,1995; Shannon et al., 2014; Schauben & Frazier, 1995; VanDeusen & Way, 2006; Way et al., 2007; Williams et al., 2012). Therefore, the second research question examined four variables (personal therapy history, work experience, trauma training, and professional support) as potential mediators of the relationship between DOS and VT. I briefly describe each of these four variables and how they were measured for the purposes of this study.

Personal therapy history (THPY) was measured through a background questionnaire, which asked subjects (therapists) to categorically rate the total duration of personal therapy they had received throughout their lives. Response options ranged from "1" (none) to "5" (more than 3 years). The majority of respondents (85%) had received over one full year of therapy, with 65% having participated in more than 3 years of personal therapy. THPY had a small but significant positive correlation with VT (i.e., the more time therapists spent in personal therapy, the higher their reported level of VT). Respondents were also asked whether or not they were currently participating in personal therapy. Roughly half (48%) of respondents reported currently attending therapy. Consistent with the Halevi and Idisis (2018) finding that those currently in therapy scored lower on DOS than those not currently in therapy, my analysis found DOS to be lower (3.95 vs. 4.53) and VT to be higher (2.42 vs. 1.98) for therapists who were currently in therapy.

Work experience (WE) was measured with a single question: How many years of post-licensure work experience do you have? Prior research has shown that new and less experienced therapists are at greater risk of developing VT (Adams & Riggs, 2008; Pearlman & Mac Ian, 1995). Work experience is highly positively correlated with age (i.e., older therapists generally have more work experience). The current study results confirm these prior findings in that WE and age were strongly positively and significantly correlated. Further, the current study found both work experience and age have an inverse relationship with VT levels.

Prior researchers have theorized an inverse relationship between the level of therapist trauma-specific training (TT) and the risk of VT, specifically that low levels of

TT make therapists particularly vulnerable to the development of VT when encountering traumatized clients (Adams & Riggs, 2008; Butler et al., 2017; Courtois & Gold, 2009; Pearlman & Saakvitne, 1995). Despite a call to action by Courtois and Gold (2009) for all mental health professions to include trauma-specific training in their graduate curricula, specialized training is generally left to individual therapists to pursue through continuing education. Only 29% of respondents in this study stated they had taken a trauma-specific course during their graduate program. To measure the extent of TT, respondents were asked how much trauma-specific training they had obtained since attaining licensure with response options from "1" (none) to "5" (substantial; certified in at least one trauma-specialty). Sixty-nine percent (69%) of respondents reported an advanced (4) or substantial (5) amount of TT.

Professional support (SUPP) includes individual supervision, group supervision, and peer consultation. Because of the professional and ethical mandate for confidentiality, the processing of distressing client material must be done within a professional supervisory or consultative relationship (DelTosta et al., 2019; Neumann & Gamble, 1995; Pearlman & Saakvitne, 1995). Halevi and Idisis (2018) studied one aspect of professional support, individual supervision, with respect to whether it was provided through one's workplace or obtained privately. They found that those who received supervision privately experienced less VT. This study investigated SUPP from a different perspective - the respondent's satisfaction with the quality and quantity of professional support. The results of this study found that 61% of respondents received individual supervision (minimum 1x month), 44% received group supervision, and 81% participated in peer consultation more than once a month. SUPP was measured on a sliding scale from

1-100 denoting the percentage satisfaction with overall professional support. Fifty-five percent (55%) of respondents rated satisfaction above 80%.

These four variables - THPY, WE, TT, and SUPP - were examined to determine if they functioned as mediators of the relationship between DOS and VT (Hypotheses 5-8). Prior to conducting mediation analysis, bivariate correlational analyses were conducted to determine whether relationships exist between each of the four predictor variables and the outcome variable (VT). Each of the four predictor variables had a small and significant correlation with VT, thus a mediation analysis was appropriate. Mediation occurs when a variable partially or fully reduces, or explains, the correlation between DOS and VT. Mediation is analyzed through linear regression (Barron & Kenny, 1986). Of the four tested variables, only SUPP resulted in a small but significant partial mediation of the relationship between DOS and VT; however, the reduction in the standardized regression coefficient of 8% falls just short of the most liberal standards, which recommend a minimum of 10% reduction in the standardized regression coefficient (Cohen et al., 2003). Therefore, none of the four factors may be considered mediators of the relationship between DOS and VT.

Though the mediation model did not yield the hypothesized results, the finding that all four predictor variables had a significant correlation with VT left me curious about how to best conceptualize the influence of the predictor variables on VT. Therefore, I conducted a post hoc analysis to determine if the variables impact DOS d*irectly*, thereby *indirectly* influencing VT. I used path analysis to explore alternative pathways. The purpose of the path analysis was to determine if any of the predictor variables act *through* DOS to impact VT, rather than on VT directly (Andrade, 2023;

Hooshang Nayebi, 2021; Rucker et al., 2011). First, I examined the bivariate correlations between the variables (THPY, WE, TT, and SUPP) and confirmed there were no issues with multicollinearity. Then, using multiple linear regression, an analysis was conducted using DOS as the outcome variable and the four remaining independent variables as predictors. The analysis found that three of the four variables (THPY, WE, and SUPP) had an independent and unique impact on DOS. Only one variable (TT) yielded a non-significant relationship, though this was a borderline result that may prove significant in future research samples. The variables THPY, WE, and SUPP were subsumed by DOS, meaning that they influenced VT indirectly through their impact on DOS. SUPP, however, had a continued independent effect on VT even after taking into account its relationship to DOS. The full path analysis model can be found in Chapter 4 (Figure 4.3). Possible explanations for these findings are discussed below.

WE yielded a positive and significant impact on DOS, meaning that the more work experience a therapist had, the higher their level of self-differentiation. Since we know that newer therapists are more vulnerable to secondary stress symptoms that may result in VT (Adams & Riggs, 2008; Pearlman & Mac Ian, 1995), it makes sense that as a therapist gains more experience, they also gain confidence in their efficacy in treating traumatized clients, thus strengthening their sense of self. Further, therapists also witness the growth, healing, and resilience of their clients as they process and move through their trauma. Trauma training may also contribute to the therapist's strengthened self as they gain contextual knowledge in conjunction with their experiential knowledge leading to strengthened DOS and reduced activation of VT in subsequent clinical relationships. Professional support (SUPP) was the only variable that had both direct and indirect

(through its direct impact on DOS) impact on VT. This is an important finding as it demonstrates that therapists' satisfaction with the quality and quantity of professional support plays a key role both in developing a strong sense of self and in reducing the activation of VT.

The most curious finding was that THPY had a negative impact on DOS, meaning that the more time a therapist spent in their own personal therapy, the lower their reported level of DOS. Further, those participants who stated they were currently in therapy scored lower on DOS (3.95 vs. 4.53) and higher on VT (2.42 vs. 1.98) than those not currently in therapy.

**Examining the Impact of Therapist Personal History of Trauma**

A therapist's personal history of trauma (PTH) has been proposed as a factor influencing their level of VT, with more trauma in one's past indicative of higher risk for developing VT (McCann & Pearlman, 1990b). Research studies have shown inconsistent results in this regard likely due to conflation of VT with burnout, compassion fatigue, and secondary traumatic stress as well as different methods of measuring trauma history (Branson, 2019; Gaboury & Kimber, 2022). Research does indicate that therapists report higher levels of PTH than non-therapists, however, there is inconsistency within the research regarding whether this translates to negative consequences including increased vulnerability to VT (Adams & Riggs, 2008; Barnett, 2007; DiCaccavo, 2002; Elliott & Guy, 1993; Esaki & Larkin, 2013; Hiles Howard et al., 2015; Nikčević et al., 2007; VanDeusen & Way, 2006; Way et al., 2007; Williams et al., 2012). Pearlman & Mac Ian (1995) found higher VT in therapists with a personal trauma history and therapists who have extensive exposure to clients' traumatic experiences in their caseload. This study

attempted to seek clarification regarding the relationship between PTH and VT (Hypothesis 9) and whether PTH moderates the relationship between DOS and VT (Hypotheses 10 and 11).

To measure lifetime PTH, I used two separate instruments. The Adverse Childhood Experiences Scale - Revised (Finkelhor et al., 2013; Finkelhor et al., 2015) measured trauma that was experienced during childhood prior to age 18 (ACESR). Trauma experienced during adulthood (ATR) was measured with an instrument created for the purpose of this study. Adding these two scores together produced PTH. My analysis found that PTH had a small but significant positive correlation with VT meaning higher levels of reported trauma history are correlated with increased levels of VT (Hypotheses 9). Childhood trauma also yielded a small but significant positive correlation with VT, however, adult trauma did not. The relationship between childhood trauma and adult trauma was moderately positively correlated and significant, which is consistent with the Adverse Childhood Experiences study (Felitti et al., 1998) findings that childhood trauma predicts adult trauma.

Hypothesis 10 stated that PTH moderates the relationship between DOS and VT. Essentially, this asks whether the relationship between DOS and VT is altered at varying levels of PTH. Multiple regression analysis was used to test this hypothesis and found that there is no significant interaction effect between DOS and PTH and, therefore, PTH does not moderate the relationship between DOS and VT. Together, the above findings regarding PTH indicate that higher levels of therapist PTH leads to a small, but significant increase in vulnerability to VT. Interestingly, PTH had no significant

relationship to DOS, indicating that one's level of differentiation of self is not dependent on the extent of trauma experienced in one's life.

The final research question asked whether PTH moderates the mediating effect of the previously examined predictor variables (Hypothesis 11). Since there were no statistically significant meaningful mediators, this analysis is not appropriate.

## Theoretical Implications

There are several theoretical implications arising from the research results. This study is only the second to examine therapist VT through the lens of Bowen theory, and the results replicate the Halevi and Idisis (2018) finding that DOS is strongly inversely correlated with VT. This makes theoretical sense. If a therapist is weakly differentiated, their psychic boundaries will be more permeable, making them more vulnerable to the toxic intensity of their clients' traumatic experiences, resulting in heightened vicarious traumatization. On the other hand, a strongly differentiated therapist will have the ability to be empathically present with their client while remaining grounded in, and more protective of, the self.

My prediction that the intrapersonal dimension would have a stronger inverse correlation to vicarious traumatization than the interpersonal dimension was based on my understanding that the two dimensions of differentiation of self (i.e., internal/self and external/other) would impact vicarious trauma differently. The intrapersonal dimension reflects the internal process of balancing emotional reactivity with a sense of self, enabling a therapist to both empathically attune to the client's emotional state while remaining aware that the therapist and client are separate individuals with separate experiences. The interpersonal dimension reflects the dance a therapist engages in

between intimacy and autonomy relative to the way they interact with clients (i.e., external interactions). It seemed reasonable to predict that the intrapersonal dimension of differentiation of self would have a greater relationship with vicarious traumatization than the interpersonal dimension because the psychological boundaries of differentiation of self (i.e., intrapersonal dimension) are presumably responsible for shielding the self from the toxic elements of vicarious traumatization, while the interpersonal dimension of differentiation of self is merely the behavioral manifestation of the external boundaries between therapist and client. However, my prediction that the intrapersonal and interpersonal dimensions of differentiation of self would have distinct impacts on vicarious traumatization was not supported. This is a theoretically interesting finding as it seemed reasonable to hypothesize that the internal ability to protect the self would have a larger impact on vicarious traumatization than the external boundaries between therapist and client. As a possible explanation for this finding, perhaps one's intrapersonal differentiation of self determines, at least somewhat, one's interpersonal differentiation of self. For instance, if a therapist has weak intrapersonal differentiation of self, this weakness would likely be reflected in the therapist's interpersonal differentiation of self. Therefore, at least with regard to vicarious traumatization, perhaps the intrapersonal and interpersonal dimensions of self align and thereby did not show significant differences.

My predictions that a therapist's history of personal therapy, years of work experience, extent of trauma-specific training, and satisfaction with quantity and quality of professional support would impact the relationship between differentiation of self and vicarious traumatization were not supported by this study. My predictions sought to determine whether these variables would impact the strength of the association between

differentiation of self and vicarious traumatization. In other words, would any of these variables lessen or increase the strength of the relationship between differentiation of self and vicarious traumatization experienced by the therapist? For this study, the answer was "no" with the exception of a small impact by professional support on the level of vicarious traumatization. However, reconceptualizing the chronology of variables through the post hoc path analysis provided further insight. The path analysis demonstrated that a therapist's history of personal therapy, years of work experience, and satisfaction with quantity and quality of professional support are associated with the level of differentiation of self, thereby perhaps *indirectly* impacting the level of vicarious traumatization experienced. Although these relationships are correlational and not necessarily causal, these findings suggest the possibility that one's level of differentiation of self is not necessarily locked-in once they reach adulthood (as originally conceived by Bowen) but rather may be influenced by other variables. Therefore, my findings suggest that Bowen's theoretical assumptions about the stability of differentiation of self may need to be revised.

I found it curious that therapist history of personal therapy was negatively correlated with differentiation of self. That is, the more personal therapy a therapist has received throughout their lifetime, the lower their level of differentiation of self. Halevi and Idisis (2018) previously found differentiation of self to be lower, and vicarious traumatization higher, for those individuals who were 'currently in therapy' (versus those not currently in therapy), and my results mirrored this finding. It is possible that being in therapy is an indicator that a therapist is presently struggling with symptoms of vicarious traumatization and therefore, seeking counseling. Alternatively, being in therapy may stir

up personal traumas that challenge the therapist's capacity for self-protection, thereby leaving them vulnerable to absorbing increased amounts of toxic emotions emanating from their client's traumatic experiences.

To summarize the theoretical implications, differentiation of self is highly inversely related to vicarious traumatization. There was no significant difference between the intrapersonal and interpersonal dimensions of differentiation of self as to their relationship to vicarious traumatization. None of the therapist factors studied demonstrated a significant influence on the relationship between differentiation of self and vicarious traumatization. However, several variables did have a significant correlation with differentiation of self and thus hints at the possibility that differentiation of self may be more flexible than Bowen initially theorized. Higher levels of personal therapy received was associated with both higher levels of vicarious traumatization and lower levels of differentiation of self, which may indicate that personal therapy heightens a therapist's ability to attend to the nuances of their emotional reactions to their clients.

## Practical Implications

The findings from this dissertation have implications for the education of therapists-in-training and the development of therapist professional identity. Although none of the four tested variables (i.e., personal therapy received, work experience, trauma training, and professional support) were found to impact the strength of the relationship between differentiation of self and vicarious traumatization, each of the variables had significant correlations with both differentiation of self and vicarious traumatization. While it is unclear whether these variables are causally related to differentiation of self or vicarious traumatization, my findings suggest that therapist educators should make

students aware of these therapist factors and their relationship to the level of differentiation and the risk of vicarious traumatization. Specifically, therapist educators should highlight the findings that increased amounts of work experience, professional support, and trauma-specific training may both increase level of differentiation of self and decrease level of vicarious traumatization. In so doing, educators would normalize the challenges of being a new therapist and reinforce the benefits of trauma-specific continuing education. Furthermore, my findings suggest that students should be encouraged to develop a strong network of professional support that extends beyond mandated supervision requirements (e.g., peers and consultation groups). Again, my findings were correlational. However, there are good reasons to suspect that a causal relationship might exist between these variables.

My research demonstrated the challenges that result from conflating vicarious traumatization with other stress-related constructs (i.e. burnout, secondary traumatic stress, and compassion fatigue) in both clinical and research realms. For therapists to learn to recognize symptoms of vicarious traumatization versus other forms of work-related stress, educators should understand the distinctions between these varied manifestations and teach students to do the same. This prepares therapists with the knowledge to internally assess their stress symptoms, recognize if the symptoms are indicative of vicarious traumatization or a different form of stress (i.e. burnout, secondary traumatic stress, or compassion fatigue), and then implement the appropriate remediation strategies. It is also imperative that researchers are intentional in their use of the correct terminology and related measurement instruments. This will provide consistency and

comparability of research studies regarding therapist factors which may contribute to, or insulate from, the development of vicarious traumatization.

Another practical implication of my findings is that the ability of therapists to recognize when they are effectively maintaining an optimal psychological separation between themselves and their clients requires the therapist to be highly attuned to their own emotional states. In this regard, the expression of empathic attunement from a highly self-aware therapist is a key component to effective therapeutic outcomes (McCann & Pearlman, 1992). Educators should advise therapists-in-training to address their own psychological issues in personal therapy to gain greater self-awareness and enable a more effective and empathic therapeutic alliance. Therapists should also remain mindful during sessions of not only their client's shifting emotional states, but their own as well. A therapist who is able to recognize the nuanced shifts in their own internal states will be able to maintain an empathic separateness from their client, and thereby better insulate themselves from vicarious traumatization. Therapist educators and supervisors should encourage trainees to engage in continual self-reflection when meeting with clients to self-monitor their shifting emotional states. Doing this will teach therapists to value and prioritize self-reflection as part of the clinical process, and it may alert the educator and the therapist-in-training that personal therapy for the trainee would be advisable.

To summarize the practical implications, therapists and educators should be made aware of the importance for therapists to develop a strong differentiated self and the ability to be highly attuned to the nuances of their shifting emotional states while engaging with their clients. This is especially true when clients are sharing details of traumatic experiences with the therapist. Therapists and educators should also be made

aware of the therapist factors (i.e. personal therapy, work experience, and professional support) that were shown to have a relationship to both differentiation of self and vicarious traumatization. Though not conclusive as to causality, the relationships are worth noting, especially the importance of establishing and maintaining a strong professional network of support. Lastly, therapists, educators, and researchers alike, should understand, and apply to their work, the distinctions between vicarious traumatization and other forms of secondary traumatic stress. This includes the potential causes, symptoms, and approaches to remediation.

## Limitations

This study had limitations that will be addressed in this section. The study participants were predominantly caucasian, cis-gender females. While a narrow subject pool is generally problematic in research, the subject pool in this study is largely representative of the population of mental health therapists. Additionally, the current sample mirrored the Halevi and Idisis (2018) study sample characteristics and thus enabled the comparison of the two studies. Therefore, my limited pool of subjects is arguably not a true limitation. However, the current study was self-report in nature, and therefore subject to participant bias and participants' varied interpretations of the survey items.

Another limitation is related to the measurement instruments used in this study. While the instruments that measured differentiation of self and vicarious traumatization are well-established, some of the remaining independent variables within this study have potential measurement issues. Specifically, the levels of therapist trauma-specific training, personal therapy received, and satisfaction with quality and quantity of

professional support were assessed by single item responses. The rationale for using single items to measure these variables was to reduce the total survey items and time required to complete the survey. However, each of these variables may benefit from a more detailed and nuanced exploration. Similarly, therapist personal trauma history was measured by combining an established childhood trauma measure (Adverse Childhood Experiences Scale), and an adapted adult trauma questionnaire with a matching number of items as the childhood measure. This equal weight given to childhood and adult traumatic events was arbitrary and may have impacted the results.

Furthermore, this study did not include an assessment of secondary traumatic stress symptoms that mirror PTSD (i.e. intrusive thoughts, avoidance, and arousal). This may have provided further insight into the distinction between vicarious traumatization and secondary traumatization or compassion fatigue. Lastly, this study was conducted at a single point-in-time. As a result, it does not yield any information about the possible fluctuation of differentiation of self or vicarious traumatization in therapists.

## Implications for Future Research

This study clearly demonstrated the strong inverse relationship between differentiation of self and vicarious traumatization and provides implications for future research. First, our understanding of whether and how differentiation of self and/or vicarious traumatization may fluctuate over time would be illuminated through longitudinal studies. These may include both experimental and non-experimental studies. For example, a longitudinal study of therapists-in-training might measure differentiation of self at matriculation and then again at the completion of graduate training. This may yield information regarding whether the professional identity development that occurs

over the course of a graduate program translates into a strengthened differentiated self. An experimental element might also be included such as directed self-reflection journals, supervision groups incorporating targeted psychoeducation and self-reflection regarding countertransference processes, or the incorporation of trauma-specific courses into the graduate curriculum. These types of studies may provide valuable insights into the ways that educators and therapist training programs may impact their students' level of self differentiation.

Another example of a longitudinal study would be to measure vicarious traumatization pre-practicum, early licensure, and then several years into professional practice. This study may deepen our understanding regarding the impact of work experience on levels of vicarious traumatization. Pearlman and Saakvitne (1995) stated that vicarious traumatization is inevitable, and that it is the result of the cumulative exposure to clients' traumatic experiences over time. This potential study may yield insight into whether there is an initial increase in vicarious traumatization during the early years of therapeutic practice, and whether vicarious traumatization continues to increase, plateaus, or declines as practice experience increases.

As stated in the Limitations section, the independent variables (i.e. personal therapy received, trauma-specific training, and professional support) were measured with single-item survey questions. Important information may be gleaned from assessing the relationship between differentiation of self and vicarious traumatization using more targeted and detailed measurement instruments for each of these variables. Also, the addition of instruments to measure other types of stress symptoms that are more indicative of constructs related to vicarious traumatization (e.g., compassion fatigue)

would help to clarify the distinctions between vicarious traumatization and other manifestations of secondary exposure to clients' traumatic experiences.

Both the Halevi and Idisis (2018) study and the current study demonstrated the strong and significant inverse relationship between differentiation of self and vicarious traumatization. At least where therapists are concerned, that question seems to be adequately answered. Replicating this study with non-therapist frontline professions (i.e. law enforcement, emergency responders) may yield important information regarding the uniqueness of the therapeutic relationship to the development of vicarious traumatization. For example, do non-therapist frontline workers experience vicarious traumatization? If so, is their level of differentiation of self an important influence regarding the level of vicarious traumatization? The answers to these question would help clarify whether the relationship between differentiation of self and vicarious traumatization is unique to therapists or whether this relationship would also be characteristic of other professionals who are exposed to traumatic stimuli.

## Conclusion

This study, building upon Halevi and Idisis (2018), has extended the application of the Bowen Family Systems Theory (1978) concept of *differentiation of self* to the therapeutic dyad and vicarious traumatization. Differentiation of self, as a measure of the strength of a therapist's ability to remain empathically attuned with their client while maintaining clarity as to their separateness, is highly inversely correlated with the level of vicarious traumatization experienced. That is, the stronger a therapist's ability to differentiate self from other, especially when empathically engaged in the absorbing the details of their client's traumatic experiences, the less vulnerable they are to vicarious

traumatization. This study found a strong relationship between therapist factors (i.e., personal history of therapy received, work experience, trauma-training, and professional support) and both the strength of differentiation of self and the level of vicarious traumatization reported. Differentiation of self is clearly a useful window into understanding the internal experience of therapists and is a meaningful tool for future research regarding the therapist's capacity for maintaining psychological boundaries, particularly as these boundaries relate to vicarious traumatization.

## References


Adams, S. A., & Riggs, S. A. (2008). An exploratory study of vicarious trauma among therapist trainees. *Training and Education in Professional Psychology*, *2*(1), 26–34. https://doi.org/10.1037/1931-3918.2.1.26

Afifi, T. O., Salmon, S., Garcés, I., Struck, S., Fortier, J., Taillieu, T., Stewart-Tufescu, A., Asmundson, G. J. G., Sareen, J., & MacMillan, H. L. (2020). Confirmatory factor analysis of adverse childhood experiences (ACEs) among a community-based sample of parents and adolescents. *BMC Pediatrics*, *20*(1). https://doi.org/10.1186/s12887-020-02063-3

Afifi, T. O., Taillieu, T., Salmon, S., Davila, I. G., Stewart-Tufescu, A., Fortier, J., Struck, S., Asmundson, G. J. G., Sareen, J., & MacMillan, H. L. (2020). Adverse childhood experiences (ACEs), peer victimization, and substance use among adolescents. *Child Abuse & Neglect*, *106*, 104504. https://doi.org/10.1016/j.chiabu.2020.104504

American Counseling Association. (2014). *ACA Code of Ethics*. https://www.counseling.org/docs/default-source/ethics/2014-aca-code-of-ethics.pdf?sfvrsn=fde89426_5

American Psychiatric Association. (1980). *Diagnostic and Statistical Manual of Mental Disorders (DSM-III)*. American Psychiatric Association.

American Psychiatric Association. (1987). *Diagnostic and Statistical Manual of Mental Disorders* (III-R). American Psychiatric Association.

American Psychiatric Association. (1994). *Diagnostic and Statistical Manual of Mental Disorders : DSM-IV* (4th ed.). American Psychiatric Association.

American Psychiatric Association. (2013). *Diagnostic and Statistical Manual of Mental disorders* (5th ed.). American Psychiatric Association.

American Psychological Association. (1998a). American Psychological Association Working Group on Investigation of Memories of Childhood Abuse: Preface to the final report. *Psychology, Public Policy, and Law*, *4*(4), 931–932. https://doi.org/10.1037/h0092731

American Psychological Association. (1998b). Final conclusions of the American Psychological Association Working Group on investigation of memories of child abuse. *Psychology, Public Policy, and Law*, *4*(4), 933–940. https://doi.org/10.1037/1076-8971.4.4.933

American Psychological Association. (2017). *Ethical principles of psychologists and code of conduct*. https://www.apa.org/ethics/code

Anda, R. F., Felitti, V. J., Bremner, J. D., Walker, J. D., Whitfield, Ch., Perry, B. D., Dube, Sh. R., & Giles, W. H. (2005). The enduring effects of abuse and related adverse experiences in childhood. *European Archives of Psychiatry and Clinical Neuroscience*, *256*(3), 174–186. https://doi.org/10.1007/s00406-005-0624-4

Anda, R., Felitti, V., Bremner, J. D., Walker, J., Whitfield, C., Perry, B., Dube, S., & Giles, W. (2006). The enduring effects of abuse and related adverse experiences in childhood. A convergence of evidence from neurobiology and epidemiology. *Child: Care, Health and Development*, *32*(2), 253–256. https://doi.org/10.1111/j.1365-2214.2006.00614_2.x

Andrade, C. (2023). Types of analysis: Planned (prespecified) vs post hoc, primary vs secondary, hypothesis-driven vs exploratory, subgroup and sensitivity, and others.

*Indian Journal of Psychological Medicine*, *45*(6), 640–641. https://doi.org/10.1177/02537176231216842

Andreasen, N. C. (2010). Posttraumatic stress disorder: A history and a critique. *Annals of the New York Academy of Sciences*, *1208*(1), 67–71. https://doi.org/10.1111/j.1749-6632.2010.05699.x

Aponte, H. J. (2021). The soul of therapy: The therapist's use of self in the therapeutic relationship. *Contemporary Family Therapy*, *44*(44). https://doi.org/10.1007/s10591-021-09614-5

Barnett, M. (2007). What brings you here? An exploration of the unconscious motivations of those who choose to train and work as psychotherapists and counsellors. *Psychodynamic Practice*, *13*(3), 257–274. https://doi.org/10.1080/14753630701455796

Baron, R. M., & Kenny, D. A. (1986). The moderator-mediator variable distinction in social psychological research: Conceptual, strategic, and statistical considerations. *Journal of Personality and Social Psychology*, *51*(6), 1173–1182. https://doi.org/10.1037//0022-3514.51.6.1173

Becker-Blease, K., & Freyd, J. J. (2016). Additional questions about the applicability of "false memory" research. *Applied Cognitive Psychology*, *31*(1), 34–36. https://doi.org/10.1002/acp.3266

Benjet, C., Bromet, E., Karam, E. G., Kessler, R. C., McLaughlin, K. A., Ruscio, A. M., Shahly, V., Stein, D. J., Petukhova, M., Hill, E., Alonso, J., Atwoli, L., Bunting, B., Bruffaerts, R., Caldas-de-Almeida, J. M., de Girolamo, G., Florescu, S., Gureje, O., Huang, Y., & Lepine, J. P. (2015). The epidemiology of traumatic

event exposure worldwide: results from the World Mental Health Survey Consortium. *Psychological Medicine*, *46*(02), 327–343. https://doi.org/10.1017/s0033291715001981

Blakemore, E. (2019, February 27). *Why the Fight Over the Equal Rights Amendment Has Lasted Nearly a Century*. History. https://www.history.com/news/equal-rights-amendment-fail-phyllis-schlafly

Blizard, R. A., & Shaw, M. (2019). Lost-in-the-mall: False memory or false defense? *Journal of Child Custody*, *16*(1), 20–41. https://doi.org/10.1080/15379418.2019.1590285

Bottoms, B. L., & Davis, S. L. (1997). The creation of satanic ritual abuse. *Journal of Social and Clinical Psychology*, *16*(2), 112–132. https://doi.org/10.1521/jscp.1997.16.2.112

Bowen, M. (1966). The use of family theory in clinical practice. *Comprehensive Psychiatry*, *7*(5), 345–374. https://doi.org/10.1016/s0010-440x(66)80065-2

Bowen, M. (1978a). *Family therapy in clinical practice*. Rowman & Littlefield ; Northvale, N.J.

Bowen, M. (1978b). Theory in the practice of psychotherapy. In *Family Therapy in Clinical Practice* (pp. 337–387). Jason Aronson.

Brand, B. L., & McEwen, L. (2016). Ethical standards, truths, and lies. *Journal of Trauma & Dissociation*, *17*(3), 259–266. https://doi.org/10.1080/15299732.2016.1114357

Branson, D. C. (2019). Vicarious trauma, themes in research, and terminology: A review of literature. *Traumatology*, *25*(1), 2–10. https://doi.org/10.1037/trm0000161

Brewin, C. R. (2020). Tilting at windmills: Why attacks on repression are misguided. *Perspectives on Psychological Science*, *16*(2), 174569162092767. https://doi.org/10.1177/1745691620927674

Brewin, C. R., & Andrews, B. (2016). Creating memories for false autobiographical events in childhood: A systematic review. *Applied Cognitive Psychology*, *31*(1), 2–23. https://doi.org/10.1002/acp.3220

Bride, B. E. (2004). The impact of providing psychosocial services to traumatized populations. *Stress, Trauma, and Crisis*, *7*(1), 29–46. https://doi.org/10.1080/15434610490281101

Briere, J., & Conte, J. (1993). Self-reported amnesia for abuse in adults molested as children. *Journal of Traumatic Stress*, *6*(1), 21–31. https://doi.org/10.1002/jts.2490060104

Briere, J., & Runtz, M. (1988). Multivariate correlates of childhood psychological and physical maltreatment among university women. *Child Abuse & Neglect*, *12*(3), 331–341. https://doi.org/10.1016/0145-2134(88)90046-4

Briggs, E. C., Amaya-Jackson, L., Putnam, K. T., & Putnam, F. W. (2021). All adverse childhood experiences are not equal: The contribution of synergy to adverse childhood experience scores. *American Psychologist*, *76*(2), 243–252. https://doi.org/10.1037/amp0000768

Bromley, D. G. (1991). Satanism: The new cult scare. In *The Satanism Scare* (pp. 297–310). A. de Gruyter.

Brown, L. S. (1996). Politics of memory, politics of incest: Doing therapy and politics that matter. In S. Contratto & M. J. Gutfreund (Eds.), *A Feminist Clinician's*

*Guide to the Memory Debate* (pp. 5–18). Routledge.

Brown, L. S. (2007). Empathy, genuineness--And the dynamics of power: A feminist responds to Rogers. *Psychotherapy: Theory, Research, Practice, Training*, *44*(3), 257–259. https://doi.org/10.1037/0033-3204.44.3.257

Brownmiller, S. (1975). *Against Our Will: Men, Women and Rape*. Simon and Schuster.

Bryant, S. L., & Range, L. M. (1995). Suicidality in college women who were sexually and physically abused and physically punished by parents. *Violence and Victims*, *10*(3), 195–201. https://doi.org/10.1891/0886-6708.10.3.195

Buber, M. (1923). *I and thou*. Clark.

Butler, L. D., Carello, J., & Maguin, E. (2017). Trauma, stress, and self-care in clinical training: Predictors of burnout, decline in health status, secondary traumatic stress symptoms, and compassion satisfaction. *Psychological Trauma: Theory, Research, Practice, and Policy*, *9*(4), 416–424. https://doi.org/10.1037/tra0000187

Calatrava, M., Martins, M. V., Schweer-Collins, M., Duch-Ceballos, C., & Rodríguez-González, M. (2022). Differentiation of self: A scoping review of Bowen Family Systems Theory's core construct. *Clinical Psychology Review*, *91*(91), 102101. https://doi.org/10.1016/j.cpr.2021.102101

Card, C. (2002). *The atrocity paradigm: a theory of evil*. New York Oxford University Press -10-03.

Card, C. (2010). *Confronting evils : terrorism, torture, genocide*. Cambridge University Press.

CDC. (2021, August 23). *Preventing Adverse Childhood Experiences*. Centers for

Disease Control and Prevention. https://www.cdc.gov/vitalsigns/aces

Cheit, R. E. (1998). Consider this, skeptics of recovered memory. *Ethics & Behavior, 8*(2), 141–160. https://doi.org/10.1207/s15327019eb0802_4

Cheit, R. E. (1999). Junk skepticism and recovered memory: A reply to Piper. *Ethics & Behavior*, *9*(4), 295–318. https://doi.org/10.1207/s15327019eb0904_2

Cheit, R. E. (2014). *The witch-hunt narrative*. Oxford University Press.

Chu, J. A. (2011). *Rebuilding shattered lives: Treating complex PTSD and dissociative disorders*. John Wiley & Sons.

Cloitre, M., Petkova, E., Wang, J., & Lu Lassell, F. (2012). An examination of the influence of a sequential treatment on the course and impact of dissociation among women with PTSD related to childhood abuse. *Depression and Anxiety, 29*(8), 709–717. https://doi.org/10.1002/da.21920

Coan, J. A. (1997). Lost in a shopping mall: An experience with controversial research. *Ethics & Behavior*, *7*(3), 271–284. https://doi.org/10.1207/s15327019eb0703_9

Cohen, J., Cohen, P., West, S. G., & Aiken, L. S. (2003). *Applied multiple regression/correlation analysis for the behavioral sciences* (3rd ed.). Routledge.

Cohen, K., & Collens, P. (2013). The impact of trauma work on trauma workers: A metasynthesis on vicarious trauma and vicarious posttraumatic growth. *Psychological Trauma: Theory, Research, Practice, and Policy*, *5*(6), 570–580. https://doi.org/10.1037/a0030388

Connery, A. L., & Murdock, N. L. (2019). An interactive view of countertransference: Differentiation of self and client presentation. *Psychotherapy, 56*(2), 181–192. https://doi.org/10.1037/pst0000218

Cook, R. M., Fye, H. J., & Wind, S. A. (2020). An examination of the Counselor Burnout Inventory using item response theory in early career post-master's counselors. *Measurement and Evaluation in Counseling and Development, 54*(4), 1–18. https://doi.org/10.1080/07481756.2020.1827439

Courtois, C. A., & Ford, J. D. (2016). *Treatment of complex trauma: A sequenced, relationship-based approach*. The Guilford Press.

Courtois, C. A., & Gold, S. N. (2009). The need for inclusion of psychological trauma in the professional curriculum: A call to action. *Psychological Trauma: Theory, Research, Practice, and Policy*, *1*(1), 3–23. https://doi.org/10.1037/a0015224

Courtois, C., Ford, J., Cloitre, M., & Schnyder, U. (2020). Best practices in psychotherapy for adults. In J. Ford & C. Courtois (Eds.), *Treating Complex Traumatic Stress Disorders in Adults: Scientific Foundations and Therapeutic Models* (pp. 62–98). The Guilford Press.

Crook, L. (2022). *False Memories: The deception that silenced millions*.

Crook, L. S., & McEwen, L. E. (2019). Deconstructing the lost in the mall study. *Journal of Child Custody*, *16*(1), 7–19. https://doi.org/10.1080/15379418.2019.1601603

Cuff, B., Brown, S. J., Taylor, L., & Howat, D. (2015). Empathy: A review of the concept. *Emotion Review, 8*(2). https://doi.org/10.1177/1754073914558466

Dallam, S. J. (2001). Crisis or creation? A systematic examination of false memory syndrome. *Journal of Child Sexual Abuse, 9*(3-4), 9–36. https://doi.org/10.1300/j070v09n03_02

Dayan, J., & Olliac, B. (2010). From hysteria and shell shock to posttraumatic stress disorder: Comments on psychoanalytic and neuropsychological approaches.

*Journal of Physiology-Paris*, *104*(6), 296–302. https://doi.org/10.1016/j.jphysparis.2010.09.003

De Young, M. (2008). The day care ritual abuse moral panic: A sociological analysis. *Sociology Compass*, *2*(6), 1719–1733. https://doi.org/10.1111/j.1751-9020.2008.00169

Deblasio, L. (2022). Using reflexivity as a tool to validate feminist research based on personal trauma. *Feminist Legal Studies*, *30*, 355–365. Springer Link. https://doi.org/10.1007/s10691-022-09487-5

DelTosta, J. E., Ellis, M. V., & McNamara, M. L. (2019). Trainee vicarious traumatization: Examining supervisory working alliance and trainee empathy. *Training and Education in Professional Psychology*, *13*(4), 300–306. https://doi.org/10.1037/tep0000232

DePrince, A. P., Freyd, J., & Kimberling, R. (2002). The intersection of gender and betrayal in trauma. In R. Kimberling, P. Ouimette, & J. Wolfe (Eds.), *Gender and PTSD* (pp. 98–113). Guilford.

Devilly, G. J., Wright, R., & Varker, T. (2009). Vicarious trauma, secondary traumatic stress or simply burnout? Effect of trauma therapy on mental health professionals. *Australian & New Zealand Journal of Psychiatry*, *43*(4), 373–385. https://doi.org/10.1080/00048670902721079

DiCaccavo, A. (2002). Investigating individuals' motivations to become counselling psychologists: The influence of early caretaking roles within the family. *Psychology and Psychotherapy: Theory, Research and Practice*, *75*(4), 463–472. https://doi.org/10.1348/147608302321151943

Drake, J. R., Murdock, N. L., Marszalek, J. M., & Barber, C. E. (2015). Differentiation of Self Inventory—Short Form: Development and preliminary validation. *Contemporary Family Therapy*, *37*(2), 101–112. https://doi.org/10.1007/s10591-015-9329-7

Dube, S. R., Williamson, D. F., Thompson, T., Felitti, V. J., & Anda, R. F. (2004). Assessing the reliability of retrospective reports of adverse childhood experiences among adult HMO members attending a primary care clinic. *Child Abuse & Neglect*, *28*(7), 729–737. https://doi.org/10.1016/j.chiabu.2003.08.009

Edwards, K., & Konold, T. (2020). Moderated mediation analysis: A review and appliation to school climate research. *Practical Assessment, Research & Evaluation*, *25*(5), 1–17. ScholarWorks. https://doi.org/10.7275/16436623

Elliott, D. M., & Guy, J. D. (1993). Mental health professionals versus non-mental-health professionals: Childhood trauma and adult functioning. *Professional Psychology: Research and Practice*, *24*(1), 83–90. https://doi.org/10.1037/0735-7028.24.1.83

Erikson, E. H. (1968). *Identity: Youth and crisis*. W.W. Norton.

Esaki, N., & Larkin, H. (2013). Prevalence of adverse childhood experiences (ACEs) among child service providers. *Families in Society: The Journal of Contemporary Social Services*, *94*(1), 31–37. https://doi.org/10.1606/1044-3894.4257

Faber, D. P. (1997). Jean-Martin Charcot and the epilepsy/hysteria relationship. *Journal of the History of the Neurosciences*, *6*(3), 275–290. https://doi.org/10.1080/09647049709525714

*False Memory Syndrome Foundation*. (n.d.). Www.fmsfonline.org. Retrieved February 10, 2023, from http://www.fmsfonline.org/index.php?about=EarlyHistory

Feldman-Summers, S., & Pope, K. S. (1994). The experience of "forgetting" childhood abuse: A national survey of psychologists. *Journal of Consulting and Clinical Psychology*, *62*(3), 636–639. https://doi.org/10.1037/0022-006x.62.3.636

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., Koss, M. P., & Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. *American Journal of Preventive Medicine*, *14*(4), 245–258. https://doi.org/10.1016/s0749-3797(98)00017-8

Field, A. (2016). *Discovering statistics using IBM SPSS statistics* (4th ed.). Sage Pubns.

Figley, C. R. (1995). *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized*. Routledge.

Finkelhor, D., Shattuck, A., Turner, H., & Hamby, S. (2013). Improving the Adverse Childhood Experiences Study scale. *JAMA Pediatrics*, *167*(1), 70. https://doi.org/10.1001/jamapediatrics.2013.420

Finkelhor, D., Shattuck, A., Turner, H., & Hamby, S. (2015). A revised inventory of Adverse Childhood Experiences. *Child Abuse & Neglect*, *48*(48), 13–21. https://doi.org/10.1016/j.chiabu.2015.07.011

Foreman, T. (2018). Wellness, exposure to trauma, and vicarious traumatization: A pilot study. *Journal of Mental Health Counseling*, *40*(2), 142–155. https://doi.org/10.17744/mehc.40.2.04

Freud, S. (1962). Further remarks on the neuro-psychoses of defence. In J. Strachey (Ed.), & J. Strachey (Trans.), *The standard edition of the complete psychological works of Sigmund Freud (Vol. 3)* (pp. 159–188). Hogarth Press.Original work

published 1896.

Freyd, J. J. (2003). Memory for abuse: What can we learn from a prosecution sample? *Journal of Child Sexual Abuse*, *12*(2), 97–103. https://doi.org/10.1300/j070v12n02_05

Frie, R. (2000). The existential and the interpersonal: Ludwig Binswanger and Harry Stack Sullivan. *Journal of Humanistic Psychology*, *40*(3), 108–129. https://doi.org/10.1177/0022167800403009

Friedman, M. J. (2013). Finalizing PTSD in DSM-5: Getting here from there and where to go next. *Journal of Traumatic Stress*, *26*(5), 548–556. https://doi.org/10.1002/jts.21840

Frost, R. (2014). Challenges of conducting Bowen Family Systems research on differentiation of self. In P. Titelman (Ed.), *Differentiation of Self: Bowen Family Systems Theory Perspectives* (pp. 303–329). Routledge.

Fueshko, T. M. (2016). The intricacies of shell shock: A chronological history of The Lancet's Publications by Dr. Charles S. Myers and his contemporaries. *Peace & Change*, *41*(1), 38–51. https://doi.org/10.1111/pech.12171

Gaboury, K., & Kimber, M. (2022). Consequences of vicarious traumatization among mental health providers with a history of child maltreatment: A narrative review. *Psychological Trauma: Theory, Research, Practice, and Policy*, *15*(Suppl 2), 1–10. https://doi.org/10.1037/tra0001298

Garven, S., Wood, J. M., Malpass, R. S., & Shaw, J. S. (1998). More than suggestion: The effect of interviewing techniques from the McMartin Preschool case. *Journal of Applied Psychology*, *83*(3), 347–359. https://doi.org/10.1037/0021-

9010.83.3.347

Gelso, C. J., & Hayes, J. A. (2007). *Countertransference and the therapist's inner experience: perils and possibilities*. Routledge, Taylor & Francis Group.

Groesbeck, C. J. (1975). The archetypal image of the wounded healer. *Journal of Analytical Psychology*, *20*(2), 122–145. https://doi.org/10.1111/j.1465-5922.1975.00122.x

Hainlen, R. L., Jankowski, P. J., Paine, D. R., & Sandage, S. J. (2015). Adult attachment and well-being: Dimensions of differentiation of self as mediators. *Contemporary Family Therapy*, *38*(2), 172–183. https://doi.org/10.1007/s10591-015-9359-1

Halevi, E., & Idisis, Y. (2018). Who helps the helper? Differentiation of self as an indicator for resisting vicarious traumatization. *Psychological Trauma: Theory, Research, Practice, and Policy*, *10*(6), 698–705. https://doi.org/10.1037/tra0000318

Hayes, A. F. (2013). *Introduction to Mediation, Moderation, and Conditional Process Analysis: A Regression-Based Approach.* (1st ed.). Guilford Publications.

Heiden-Rootes, K. M., Brimhall, A. S., Jankowski, P. J., & Reddick, G. T. (2017). Differentiation of self and clinicians' perceptions of client sexual behavior as "problematic." *Contemporary Family Therapy*, *39*(3), 207–219. https://doi.org/10.1007/s10591-017-9412-3

Herman, J. (1992). *Trauma and recovery*. Pandora.

Herman, J. L., & Schatzow, E. (1987). Recovery and verification of memories of childhood sexual trauma. *Psychoanalytic Psychology*, *4*(1), 1–14. https://doi.org/10.1037/h0079126

Hiles Howard, A. R., Parris, S., Hall, J. S., Call, C. D., Razuri, E. B., Purvis, K. B., & Cross, D. R. (2015). An examination of the relationships between professional quality of life, adverse childhood experiences, resilience, and work environment in a sample of human service providers. *Children and Youth Services Review*, *57*(57), 141–148. https://doi.org/10.1016/j.childyouth.2015.08.003

History.com Editors. (2009, October 29). *Japanese internment camps*. History; A&E Television Networks. https://www.history.com/topics/world-war-ii/japanese-american-relocation

History.com Editors. (2017, November 15). *Eugenics*. History. https://www.history.com/topics/european-history/eugenics

History.com Editors. (2019a, January 15). *Native American History Timeline*. History; A&E Television Networks. https://www.history.com/topics/native-american-history/native-american-timeline

History.com Editors. (2019b, February 26). *Women's History Milestones: A Timeline*. HISTORY; A&E Television Networks. https://www.history.com/topics/womens-history/womens-history-us-timeline

Hoffman, D., Carter, D., Viglucci Lopez, C., Benzmiller, H. Guo, A., Latifi, S. Craig, D. (2015). *Independent review relating to APA ethics guidelines, national security interrogations, and torture*. https://www.apa.org/independent-review/revised-report.pdf

Holmstrom, L. L., & Burgess, A. W. (1975). Assessing trauma in the rape victim. *The American Journal of Nursing*, *75*(8), 1288. https://doi.org/10.2307/3423598

Hooshang Nayebi. (2021). *Advanced Statistics for Testing Assumed Causal*

*Relationships*. Springer Nature.

Hovdestad, W. E., & Kristiansen, C. M. (1996). A field study of "false memory syndrome": Construct validity and incidence. *The Journal of Psychiatry & Law*, *24*(2), 299–338. https://doi.org/10.1177/009318539602400208

Jackson, K. C. (2022). *The story of violence in America*. American Academy of Arts & Sciences. https://www.amacad.org/publication/story-violence-america

Janet, P. (1904). Amnesia and the dissociation of memories by emotions. *Journal de Psychologie, 1*, 417–453.

Jankowski, P. J., & Hooper, L. M. (2012). Differentiation of self: A validation study of the Bowen theory construct. *Couple and Family Psychology: Research and Practice*, *1*(3), 226–243. https://doi.org/10.1037/a0027469

Jenkins, S. M., Buboltz, W. C., Schwartz, J. P., & Johnson, P. (2005). Differentiation of self and psychosocial development. *Contemporary Family Therapy*, *27*(2), 251–261. https://doi.org/10.1007/s10591-005-4042-6

Jenkins, S. R., & Baird, S. (2002). Secondary traumatic stress and vicarious trauma: A validational study. *Journal of Traumatic Stress*, *15*(5), 423–432. https://doi.org/10.1023/a:1020193526843

Johnson, P., Buboltz, W. C., & Seemann, E. (2003). Ego identity status: A step in the differentiation process. *Journal of Counseling & Development*, *81*(2), 191–195. https://doi.org/10.1002/j.1556-6678.2003.tb00241.x

Kapel Lev-Ari, R., Solomon, Z., & Horesh, D. (2020). Far away, so close: The role of self-differentiation in psychopathology among spouses of ex-POWs and comparable combatants. *Journal of Clinical Psychology*, *76*(10), 1904–1922.

https://doi.org/10.1002/jclp.22965

Karatekin, C., & Hill, M. (2018). Expanding the original definition of adverse childhood experiences (ACEs). *Journal of Child & Adolescent Trauma*, *12*(3). https://doi.org/10.1007/s40653-018-0237-5

Kardiner, A., & Spiegel, H. (1947). *War stress and neurotic illness*. Paul B. Hoeber.

Kendall, J. (2021, February 7). *The false memory syndrome at 30: How flawed science turned into conventional wisdom*. Mad in America. https://www.madinamerica.com/2021/02/false-memory-syndrome/

Kerr, M. E., & Bowen, M. (1988). *Family evaluation: an approach based on Bowen Theory*. Norton.

Kessler, R. C., & Merikangas, K. R. (2004). The National Comorbidity Survey Replication (NCS-R): Background and aims. *International Journal of Methods in Psychiatric Research*, *13*(2), 60–68. https://doi.org/10.1002/mpr.166

Kilpatrick, D. G., Resnick, H. S., Freedy, J. R., Pelcovitz, D., Resick, P. A., & Roth, S. (1998). Posttraumatic stress disorder field trial: Evaluation of the PTSD construct—Criteria A through E. In T. A. Widiger, A. J. Frances, H. A. Pincus, R. Ross, M. B. First, & W. David (Eds.), *DSM-IV Sourcebook* (pp. 803–844). American Psychiatric Press.

Kilpatrick, D. G., Resnick, H. S., Milanak, M. E., Miller, M. W., Keyes, K. M., & Friedman, M. J. (2013). National estimates of exposure to traumatic events and PTSD prevalence using DSM-IV and DSM-5 criteria. *Journal of Traumatic Stress*, *26*(5), 537–547. https://doi.org/10.1002/jts.21848

Kucmin, T., Kucmin, A., Nogalski, A., Sojczuk, S., & Jojczuk, M. (2016). History of

trauma and posttraumatic disorders in literature. *Psychiatria Polska*, *50*(1), 269–281. https://doi.org/10.12740/pp/43039

Lamb, N. B. (2017). The witch-hunt narrative: Turning a blind eye to the evidence in the so-called name of justice. *Journal of Interpersonal Violence*, *32*(6), 948–955. https://doi.org/10.1177/0886260516657356

Lambert, J. E., & Friedlander, M. (2008). Relationship of differentiation of self to adult clients' perceptions of the alliance in brief family therapy. *Psychotherapy Research*, *18*(2), 160–166. https://doi.org/10.1080/10503300701255924

Lampis, J., & Cataudella, S. (2019). Adult attachment and differentiation of self-constructs: A possible dialogue? *Contemporary Family Therapy*, *41*(3), 227–235. https://doi.org/10.1007/s10591-019-09489-7

Lampis, J., Cataudella, S., Busonera, A., & Skowron, E. A. (2017). The role of differentiation of self and dyadic adjustment in predicting codependency. *Contemporary Family Therapy*, *39*(1), 62–72. https://doi.org/10.1007/s10591-017-9403-4

Lanius, R. A., Brand, B., Vermetten, E., Frewen, P. A., & Spiegel, D. (2012). The dissociative subtype of posttraumatic stress disorder: Rationale, clinical and neurobiological evidence, and implications. *Depression and Anxiety*, *29*(8), 701–708. https://doi.org/10.1002/da.21889

Loftus, E. F. (1993). The reality of repressed memories. *American Psychologist*, *48*(5), 518–537. https://doi.org/10.1037/0003-066x.48.5.518

Loftus, E. F., & Pickrell, J. E. (1995). The formation of false memories. *Psychiatric Annals*, *25*(12), 720–725. https://doi.org/10.3928/0048-5713-19951201-07

Loftus, E. F., Polonsky, S., & Fullilove, M. T. (1994). Memories of childhood sexual abuse: Remembering and repressing. *Psychology of Women Quarterly*, *18*(1), 67–84. https://doi.org/10.1111/j.1471-6402.1994.tb00297.x

Macleod, A. (Sandy). (2018). Abrupt treatments of hysteria during World War I, 1914–18. *History of Psychiatry*, *29*(2), 187–198. https://doi.org/10.1177/0957154x18757338

Makadia, R., Sabin-Farrell, R., & Turpin, G. (2017). Indirect exposure to client trauma and the impact on trainee clinical psychologists: Secondary traumatic stress or vicarious traumatization? *Clinical Psychology & Psychotherapy*, *24*(5), 1059–1068. https://doi.org/10.1002/cpp.2068

Maloni, J. (2014). Bowen Theory as a guide to defining a self over a life cycle. In P. Titelman (Ed.), *Differentiation of self: Bowen Family Systems Theory perspectives* (pp. 203–216). Routledge.

McCann, I. L., & Pearlman, L. A. (1992). Constructivist self-development theory: A theoretical framework for assessing and treating traumatized college students. *Journal of American College Health*, *40*(4), 189–196. https://doi.org/10.1080/07448481.1992.9936281

McCann, L., & Pearlman, L. A. (1990a). *Psychological trauma and adult survivor: theory, therapy, and transformation.* Routledge.

McCann, L., & Pearlman, L. A. (1990b). Vicarious traumatization: A framework for understanding the psychological effects of working with victims. *Journal of Traumatic Stress*, *3*(1), 131–149. https://doi.org/10.1007/bf00975140

McCann, L., Pearlman, L. A., Sakheim, D. K., & Abrahamson, D. J. (1988). Assessment

and treatment of the adult survivor of childhood sexual abuse within a schema framework. In *Vulnerable populations, Vol. 1 Evalutation and treatment of sexually abused children and adult survivors* (pp. 77–101). Lexington Books/D.C. Heath and Com.

McCauley, J. (1997). Clinical characteristics of women with a history of childhood abuse. *JAMA*, *277*(17), 1362. https://doi.org/10.1001/jama.1997.03540410040028

McIntyre, S. L., & Samstag, L. W. (2021). Promoting an empathic dialectic for therapeutic change: An integrative review. *Journal of Contemporary Psychotherapy*, *52*(2), 127–136. https://doi.org/10.1007/s10879-021-09516-5

McLennan, J. D., MacMillan, H. L., & Afifi, T. O. (2020). Questioning the use of adverse childhood experiences (ACEs) questionnaires. *Child Abuse & Neglect*, *101*, 104331. https://doi.org/10.1016/j.chiabu.2019.104331

McOmber, J. B. (1996). Silencing the patient: Freud, sexual abuse, and "the etiology of hysteria." *Quarterly Journal of Speech*, *82*(4), 343–363. https://doi.org/10.1080/00335639609384162

Mersky, J. P., Choi, C., Plummer Lee, C., & Janczewski, C. E. (2021). Disparities in adverse childhood experiences by race/ethnicity, gender, and economic status: Intersectional analysis of a nationally representative sample. *Child Abuse & Neglect*, *117*, 105066. https://doi.org/10.1016/j.chiabu.2021.105066

Mersky, J. P., Janczewski, C. E., & Topitzes, J. (2016). Rethinking the measurement of adversity. *Child Maltreatment*, *22*(1), 58–68. https://doi.org/10.1177/1077559516679513

Messina, K. C., Kolbert, J. B., Bundick, M. J., Crothers, L. M., & Strano, D. A. (2018).

The impact of counseling on Bowen's differentiation of self. *The Family Journal: Counseling and Therapy for Couples and Families*, *26*(2), 150–155. Sage.

Michel, S. (2011, January 19). *The history of child care in the U.S.* Social Welfare History Project. https://socialwelfare.library.vcu.edu/programs/child-care-the-american-history/

Mitchell, S. A., & Black, M. J. (1995). *Freud and beyond: a history of modern psychoanalytic thought*. Basic Books, A Member Of The Perseus Books Group.

Mordeno, I. G., Go, G. P., & Yangson-Serondo, A. (2017). Examining the dimensional structure models of secondary traumatic stress based on DSM-5 symptoms. *Asian Journal of Psychiatry*, *25*(25), 154–160. https://doi.org/10.1016/j.ajp.2016.10.024

Mosley-Johnson, E., Garacci, E., Wagner, N., Mendez, C., Williams, J. S., & Egede, L. E. (2018). Assessing the relationship between adverse childhood experiences and life satisfaction, psychological well-being, and social well-being: United States Longitudinal Cohort 1995–2014. *Quality of Life Research*, *28*, 907–914. https://doi.org/10.1007/s11136-018-2054-6

Nathan, D., & Snedeker, M. R. (1995). *Satan's silence: The making of a modern American witch-hunt*. Basic Books.

National Association of Social Workers. (2021). *NASW Code of Ethics*. National Association of Social Workers. https://www.socialworkers.org/About/Ethics/Code-of-Ethics/Code-of-Ethics-English

National Center on Child Abuse and Neglect. (1995). *Characteristics and sources of allegations of ritualistic child abuse.* U.S. Department of Justice.

https://www.ojp.gov/pdffiles1/Digitization/154415NCJRS.pdf

National Conference of State Legislatures. (2017, May 30). *State civil statutes of limitations in child sexual abuse cases*. https://www.ncsl.org/human-services/state-civil-statutes-of-limitations-in-child-sexual-abuse-cases

National Human Genome Research Institute. (2021, December 1). *Eugenics and scientific racism*. Genome.gov; National Human Genome Research Institute. https://www.genome.gov/about-genomics/fact-sheets/Eugenics-and-Scientific-Racism

Negriff, S. (2020). ACEs are not equal: Examining the relative impact of household dysfunction versus childhood maltreatment on mental health in adolescence. *Social Science & Medicine*, *245*, 112696. https://doi.org/10.1016/j.socscimed.2019.112696

Neumann, D. A., & Gamble, S. J. (1995). Issues in the professional development of psychotherapists: Countertransference and vicarious traumatization in the new trauma therapist. *Psychotherapy: Theory, Research, Practice, Training*, *32*(2), 341–347. https://doi.org/10.1037/0033-3204.32.2.341

Nikčević, A. V., Kramolisova-Advani, J., & Spada, M. M. (2007). Early childhood experiences and current emotional distress: What do they tell us about aspiring psychologists? *The Journal of Psychology*, *141*(1), 25–34. https://doi.org/10.3200/jrlp.141.1.25-34

Otgaar, H., Howe, M. L., & Patihis, L. (2021). What science tells us about false and repressed memories. *Memory*, *30*(1), 1–6. https://doi.org/10.1080/09658211.2020.1870699

Otgaar, H., Howe, M. L., Patihis, L., Merckelbach, H., Lynn, S. J., Lilienfeld, S. O., & Loftus, E. F. (2019). The return of the repressed: The persistent and problematic claims of long-forgotten trauma. *Perspectives on Psychological Science*, *14*(6), 1072–1095. https://doi.org/10.1177/1745691619862306

Oxford University Press. (n.d.). *Trauma*. Oxford English Dictionary. Retrieved December 10, 2022, from https://www-oed-com.huaryu.kl.oakland.edu/view/Entry/205242?redirectedFrom=trauma#eid

Pack, M. (2014). Vicarious resilience. *Affilia: Journal of Women and Social Work*, *29*(1), 18–29. https://doi.org/10.1177/0886109913510088

Pamplona, F. (2022, July 28). *Post Hoc Analysis: Process and types of tests*. Mind the Graph Blog. https://mindthegraph.com/blog/post-hoc-analysis/

Patihis, L., Frenda, S. J., & Loftus, E. F. (2018). False memory tasks do not reliably predict other false memories. *Psychology of Consciousness: Theory, Research, and Practice*, *5*(2), 140–160. https://doi.org/10.1037/cns0000147

Pearlman, L. A. (2003). *Trauma and attachment belief scale*. Western Psychological Services.

Pearlman, L. A., & Mac Ian, P. S. (1995). Vicarious traumatization: An empirical study of the effects of trauma work on trauma therapists. *Professional Psychology: Research and Practice*, *26*(6), 558–565. https://doi.org/10.1037/0735-7028.26.6.558

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

Pinto, R., Correia, L., & Maia, Â. (2014). Assessing the reliability of retrospective reports of adverse childhood experiences among adolescents with documented childhood maltreatment. *Journal of Family Violence*, *29*(4), 431–438. https://doi.org/10.1007/s10896-014-9602-9

Preacher, K. J., Rucker, D. D., & Hayes, A. F. (2007). Addressing moderated mediation hypotheses: Theory, methods, and prescriptions. *Multivariate Behavioral Research*, *42*(1), 185–227. https://doi.org/10.1080/00273170701341316

Quirk, S. A., & DePrince, A. P. (1996). Childhood trauma: Politics and legislative concerns for therapists. In S. Contratto & M. J. Gutfreund (Eds.), *A feminist clinician's guide to the memory debate* (pp. 19–30). Haworth.

Raunick, C. B., Lindell, D. F., Morris, D. L., & Backman, T. (2015). Vicarious trauma among sexual assault nurse examiners. *Journal of Forensic Nursing*, *11*(3), 123–128. https://doi.org/10.1097/jfn.0000000000000085

Richardson, J. T. (1997). The social construction of satanism: Understanding an international social problem. *Australian Journal of Social Issues*, *32*(1), 61–85. https://doi.org/10.1002/j.1839-4655.1997.tb01292.x

Richardson, J. T., Reichert, J., & Lykes, V. (2009). Satanism in America: An update. *Social Compass*, *56*(4), 552–563. https://doi.org/10.1177/0037768609345976

Rogers, C. R. (1975). Empathic: An unappreciated way of being. *The Counseling Psychologist*, *5*(2), 2–10. https://doi.org/10.1177/001100007500500202

Rogers, C. R. (2007). The necessary and sufficient conditions of therapeutic personality change. *Psychotherapy: Theory, Research, Practice, Training*, *44*(3), 240–248. https://doi.org/10.1037/0033-3204.44.3.240

Romano, A. (2021, March 31). *Demonic rituals, false confessions, ruined lives: Satanic panic is still alive and well*. Vox. https://www.vox.com/culture/22358153/satanic-panic-ritual-abuse-history-conspiracy-theories-explained

Rucker, D. D., Preacher, K. J., Tormala, Z. L., & Petty, R. E. (2011). Mediation analysis in social psychology: Current practices and new recommendations. *Social and Personality Psychology Compass*, *5*(6), 359–371. https://doi.org/10.1111/j.1751-9004.2011.00355.x

Russell, D. E. H. (1984). *Sexual exploitation: Rape, child sexual abuse, and sexual harrassment*. Sage.

*SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach Prepared by SAMHSA's Trauma and Justice Strategic Initiative*. (2014). http://store.samhsa.gov/system/files/sma14-4884.pdf

Satir, V. (1987). The therapist story. *Journal of Psychotherapy & the Family*, *3*(1), 17–25. https://doi.org/10.1300/j287v03n01_04

Scalabrini, A., Mucci, C., Esposito, R., Damiati, S., & Northoff, G. (2020). Dissociation as a disorder of integration – On the footsteps of Pierre Janet. *Progress in Neuropsychopharmacology & Biological Psychiatry*, *101*, 109928. Elsevier. https://doi.org/10.1016/j.pnpbp.2020.109928

Schauben, L. J., & Frazier, P. A. (1995). Vicarious trauma: The effects on female counselors of working with sexual violence survivors. *Psychology of Women Quarterly*, *19*(1), 49–64. https://doi.org/10.1111/j.1471-6402.1995.tb00278.x

Schauss, E., Zettler, H., Patel, M., Hawes, K., Dixon, P., Bartelli, D., Ellmo, F., Naik, S., Suchomelly, F., Cogdal, P., & West, S. (2021). Exploring the test-retest

differences of self-reported adverse childhood experiences among adolescents in residential treatment. *Journal of Family Trauma, Child Custody & Child Development*, *18*(3), 263–278. https://doi.org/10.1080/26904586.2021.1918037

Schreiber, N., Bellah, L. D., Martinez, Y., McLaurin, K. A., Strok, R., Garven, S., & Wood, J. M. (2006). Suggestive interviewing in the McMartin Preschool and Kelly Michaels daycare abuse cases: A case study. *Social Influence*, *1*(1), 16–47. https://doi.org/10.1080/15534510500361739

Schuman, J., & Galvez, M. (1996). A meta/multi-discursive reading of `false memory syndrome'. *Feminism & Psychology*, *6*(1), 7–29. https://doi.org/10.1177/0959353596061002

Shannon, P. J., Simmelink, J., Im, H., Becher, E., & Crook-Lyon, R. E. (2014). Exploring the experiences of survivor students in a course on trauma treatment. *Psychological Trauma: Theory, Research, Practice, and Policy*, *6*(Suppl 1), S107–S115. https://doi.org/10.1037/a0032715

Skowron, E. A. (2000). The role of differentiation of self in marital adjustment. *Journal of Counseling Psychology*, *47*(2), 229–237. https://doi.org/10.1037/0022-0167.47.2.229

Skowron, E. A., & Dendy, A. K. (2004). Differentiation of self and attachment in adulthood: Relational correlates of effortful control. *Contemporary Family Therapy*, *26*(3), 337–357. https://doi.org/10.1023/b:coft.0000037919.63750.9d

Skowron, E. A., & Friedlander, M. L. (1998). The Differentiation of Self Inventory: Development and initial validation. *Journal of Counseling Psychology*, *45*(3), 235–246. https://doi.org/10.1037/0022-0167.45.3.235

Skowron, E. A., Holmes, S. E., & Sabatelli, R. M. (2003). Deconstructing differentiation: Self regulation, interdependent relating, and well-being in adulthood. *Contemporary Family Therapy*, *25*(1), 111–129. Springer Link. https://doi.org/10.1023/A:1022514306491

Skowron, E. A., & Schmitt, T. A. (2003). Assessing interpersonal fusion: Reliability and validity of a new DSI fusion with others subscale. *Journal of Marital and Family Therapy*, *29*(2), 209–222. https://doi.org/10.1111/j.1752-0606.2003.tb01201.x

Skowron, E. A., Stanley, K. L., & Shapiro, M. D. (2008). A longitudinal perspective on differentiation of self, interpersonal and psychological well-being in young adulthood. *Contemporary Family Therapy*, *31*(1), 3–18. https://doi.org/10.1007/s10591-008-9075-1

Sleater, A. M., & Scheiner, J. (2019). Impact of the therapist's "use of self." *The European Journal of Counselling Psychology*, *8*(1), 118–143. PsychOpen.

Sledjeski, E. M., Speisman, B., & Dierker, L. C. (2008). Does number of lifetime traumas explain the relationship between PTSD and chronic medical conditions? Answers from the National Comorbidity Survey-Replication (NCS-R). *Journal of Behavioral Medicine*, *31*(4), 341–349. https://doi.org/10.1007/s10865-008-9158-3

Smith, M., & Pazder, L. (1981). *Michelle remembers.* Pocket Books.

Soper, D. (n.d.). *Free Significance of the Difference between Two Correlations Calculator - Free Statistics Calculators*. Www.danielsoper.com. Retrieved February 13, 2024, from https://www.danielsoper.com/statcalc/calculator.aspx?id=104

Stein, D. J., Koenen, K. C., Friedman, M. J., Hill, E., McLaughlin, K. A., Petukhova, M.,

Ruscio, A. M., Shahly, V., Spiegel, D., Borges, G., Bunting, B., Caldas-de-Almeida, J. M., de Girolamo, G., Demyttenaere, K., Florescu, S., Haro, J. M., Karam, E. G., Kovess-Masfety, V., Lee, S., & Matschinger, H. (2013). Dissociation in posttraumatic stress disorder: Evidence from the World Mental Health surveys. *Biological Psychiatry*, *73*(4), 302–312. https://doi.org/10.1016/j.biopsych.2012.08.022

Titelman, P. (2014). The concept of differentiation of self in Bowen Theory. In Peter Titelman (Ed.), *Differentiation of self: Bowen Family Systems Theory perspectives* (pp. 3–64). Routledge.

Tracey, M. (2022). *Older and wiser*. Apa.org. https://www.apa.org/gradpsych/2006/03/wiser

Turner, R. J., & Lloyd, D. (1995). Lifetime traumas and mental health: the significance of cumulative adversity. *Journal of Health and Social Behavior*, *36*(4), 360–376. ProQuest.

U.S. Department of Health and Human Services, National Center on Child Abuse and Neglect. (1992). *Child Maltreatment 1992: Reports From the States to the National Center on Child Abuse and Neglect*. https://www.ojp.gov/pdffiles1/Digitization/149527NCJRS.pdf

Van der Kolk, B. (2000). Posttraumatic stress disorder and the nature of trauma. *Posttraumatic Stress Disorder*, *2*(1), 7–22. https://doi.org/10.31887/dcns.2000.2.1/bvdkolk

van der Kolk, B. (2014). *The body keeps the score: Mind, brain and body in the transformation of trauma*. Penguin Books.

van der Kolk, B. A., Roth, S., Pelcovitz, D., Sunday, S., & Spinazzola, J. (2005). Disorders of extreme stress: The empirical foundation of a complex adaptation to trauma. *Journal of Traumatic Stress, 18*(5), 389–399. https://doi.org/10.1002/jts.20047

Van der Kolk, B., & Van der Hart, O. (1990). Pierre Janet and the breakdown of adaptation in psychological trauma. *The American Journal of Psychiatry, 146*(12), 1530–1540. https://doi.org/10.1176/ajp.146.12.1530.

VanDeusen, K. M., & Way, I. (2006). Vicarious trauma: An exploratory study of the impact of providing sexual abuse treatment on clinicians' trust and intimacy. *Journal of Child Sexual Abuse, 15*(1), 69–85. https://doi.org/10.1300/j070v15n01_04

Varra, E. M., Pearlman, L. A., Brock, K. J., & Hodgson, S. T. (2008a). Factor analysis of the Trauma and Attachment Belief Scale: A measure of cognitive schema disruption related to traumatic stress. *Journal of Psychological Trauma, 7*(3), 185–196. https://doi.org/10.1080/19322880802266813

Varra, E. M., Pearlman, L. A., Brock, K. J., & Hodgson, S. T. (2008b). Factor analysis of the Trauma and Attachment Belief Scale: A measure of cognitive schema disruption related to traumatic stress. *Journal of Psychological Trauma, 7*(3), 185–196. https://doi.org/10.1080/19322880802266813

Watson, M. F., Bacigalupe, G., Daneshpour, M., Han, W., & Parra-Cardona, R. (2020). COVID-19 interconnectedness: Health inequity, the climate crisis, and collective trauma. *Family Process, 59*(3), 832–846. https://doi.org/10.1111/famp.12572

Way, I., VanDeusen, K., & Cottrell, T. (2007). Vicarious trauma: Predictors of clinicians'

disrupted cognitions about self-esteem and self-intimacy. *Journal of Child Sexual Abuse*, *16*(4), 81–98. https://doi.org/10.1300/j070v16n04_05

Weathers, F. W., Blake, D. D., Schnurr, P. P., Kaloupek, D. G., Marx, B. P., & Keane, T. M. (2013). *Life Events Checklist for DSM-5 (LEC-5) - PTSD: National Center for PTSD*. Va.gov. https://www.ptsd.va.gov/professional/assessment/te-measures/life_events_checklist.asp

Williams, A., Helm, H., & Clemens, E. (2012). The effect of childhood trauma, personal wellness, supervisory working alliance, and organizational factors on vicarious traumatization. *Journal of Mental Health Counseling*, *34*(2), 133–153. https://doi.org/10.17744/mehc.34.2.j3l62k872325h583

Williams, L. M. (1994). Recall of childhood trauma: A prospective study of women's memories of child sexual abuse. *Journal of Consulting and Clinical Psychology*, *62*(6), 1167–1176. https://doi.org/10.1037/0022-006x.62.6.1167

Wolfgang Gunther Plaut. (1981). *The Torah : A modern commentary = Tôrā*. New York Union Of American Hebrew Congregations.

World Health Organisation. (2022). *ICD-11*. Www.who.int. https://www.who.int/standards/classifications/classification-of-diseases

World Health Organization. (1992). *International statistical classification of diseases and related health problems.* (10th ed.). World Health Organization.

Young, A. (1997). *The harmony of illusions: Inventing post-traumatic stress disorder*. Princeton University Press.

Yuhas, A. (2021, March 31). It's time to revisit the satanic panic. *The New York Times*. https://www.nytimes.com/2021/03/31/us/satanic-panic.html

Zarse, E. M., Neff, M. R., Yoder, R., Hulvershorn, L., Chambers, J. E., & Chambers, R. A. (2019). The adverse childhood experiences questionnaire: Two decades of research on childhood trauma as a primary cause of adult mental illness, addiction, and medical diseases. *Cogent Medicine*, *6*(1). https://doi.org/10.1080/2331205x.2019.1581447

## Appendix A

## Institutional Review Board Approval

**Date**: November 21, 2023

**Study #**: IRB-FY2024-103

**Study Tile**: The Relationship Between Therapist Differentiation of Self and Vicarious Traumatization

**Submission Type**: Initial

**IRB Decision**: Exempt

**Research Team**:
Barbara Shaya
James Hansen

Based on applicable federal regulations, the above referenced study has been determined to be Exempt, with the following categories:
Category 2.(i). Research that only includes interactions involving educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures, or observation of public behavior (including visual or auditory recording) if at least one of the following criteria is met:
The information obtained is recorded by the investigator in such a manner that the identity of the human subjects cannot readily be ascertained, directly or through identifiers linked to the subjects;

**Notes for Researcher(s):**
This submission includes the following approved documents:

- Email Recruitment
- Information Sheet (Date-Stamped Version 11/21/23)
- Survey Questionnaires

**Letter and Consent Document:**
This letter along with the IRB approved (date-stamped) consent document can be found in Cayuse in the Submission Details page under Letters and Attachments, respectively. Please make sure to use the most recent IRB approved version of the

consent form in consenting participants.

**Permission from Research Site(s):**
Please note the following:

- This IRB exemption determination letter means that this research has met one or more of the federal criteria for exemption per 45 CFR 46.104- Exempt Research.
- Before the research is initiated, permission to conduct research at a given site must be obtained from all research locations listed in the IRB submission. You must keep copies of all such permission letters for your files.
- It is the responsibility of each researcher to follow all applicable policies and procedures of any outside institution where the research will be conducted.

**Modifications:**
Any changes to this exempt project must be reviewed by the IRB prior to initiation by submitting a MODIFICATION request. Do not collect data while the changes are being reviewed. Data collected during this time cannot be used in research.

**Record Retention:**
Exempt projects will be retained by the IRB office for three years after the last action on the project.

You are approved to start the research. Please retain a copy of this notification for your records.

If you have any questions, please contact the IRB office.

Thank you.

The Oakland University IRB

# Appendix B

## Instrument Approvals

from: **DVP Inquiries (CDC)** <dvpinquiries@cdc.gov>

to: Barbara Shaya <bshaya@oakland.edu>

date: Apr 3, 2023, 9:42 AM

subject: RE: ACES Questionnaire

Thank you for your inquiry.
General text information, publications available for download, and graphs developed by CDC and presented on CDC's website are works of the United States Government and are in the public domain. This means that they are meant for public use and are not subject to copyright law protections. Permission is not required for use of public domain items. But we do ask that you credit CDC as the original source whenever the items are used in any publicly distributed media.
We appreciate receiving copies of any research that uses the ACEs questionnaires, although this is not a requirement for their use.
The Family Health History and Health Appraisal questionnaires were used to collect information on child abuse and neglect, household challenges, and other socio-behavioral factors in the original CDC-Kaiser ACE Study. The questionnaires are not copyrighted, and there are no fees for their use. You can download them as pdfs using the following links.
Family Health History Questionnaires:
Male Version: http://www.cdc.gov/violenceprevention/acestudy/pdf/fhhmlorna.pdf
Female Version: http://www.cdc.gov/violenceprevention/acestudy/pdf/fhhflorna.pdf

Health Appraisal Questionnaire
Male Version: http://www.cdc.gov/violenceprevention/acestudy/pdf/haqmweb.pdf
Female Version: http://www.cdc.gov/violenceprevention/acestudy/pdf/haqfweb.pdf

Please see the references below for more information about the reliability and validity of these scale items.

- Wyatt, G. E. (1985). The sexual abuse of Afro-American and White-American women in childhood. *Child Abuse & Neglect*, 9, 507–519.
- Bernstein, D. P., Fink, L., Handelsman, L., Foote, J., Lovejov, M., Wenzel, K., Ruggiero, J. (1994). Initial reliability and validity of a new retrospective measure of child abuse and neglect. *American Journal of Psychiatry*, 151, 1132-1136.
- Straus, M. A., & Gelles, R. J. (1990). Physical Violence in American Families: Risk Factors and Adaptations to Violence in 8,145 Families. New Brunswick, NJ: Transaction Press

Additionally, it is important to note that while the original ACEs questions (referenced above) were used in the 1998 CDC-Kaiser ACEs study, this study is not ongoing. There are similar ACEs questions in the ACEs module of the Behavioral Risk Factor Surveillance Surveys (BRFSS). The BRFSS ACE module was adapted from the original CDC-Kaiser ACE Study and is used to collect information on child abuse and neglect and household challenges. Please see the BRFSS Questionnaires website for the most up-to-date versions of the BRFSS ACE Modules.

It is important to note that CDC does not endorse the use of the ACE score in any sort of diagnosis process. Many organizations use ACE study questions and other screening tools at their discretion.

Again, thank you for your inquiry and we hope you find this information helpful.

from: **Barbara Shaya** <bshaya@oakland.edu>

to: eskowron@uoregon.edu

date: Aug 27, 2023, 8:53 PM

subject: Request to Use DSI-R in Dissertation Research

Hello Dr. Skowron:  My name is Barbara Shaya, and I am a doctoral student at Oakland University in Rochester, Michigan. I am in the process of writing my dissertation proposal and my topic is The Relationship Between Differentiation of Self and Vicarious Traumatization in Therapists Who Work with Traumatized Populations.

I would like to request permission, as the developer of this instrument, to use the Differentiation of Self Inventory-Revised (DSI-R) in my quantitative dissertation research design. Please let me know if you have any questions or need me to provide any additional information.

Thank you for your consideration.

Kind regards,

Barbara Shaya, LPC
PhD Candidate, Oakland University

from: **Elizabeth Skowron** <eskowron@uoregon.edu>

to: Barbara Shaya <bshaya@oakland.edu>

date: Aug 28, 2023, 12:29 PM

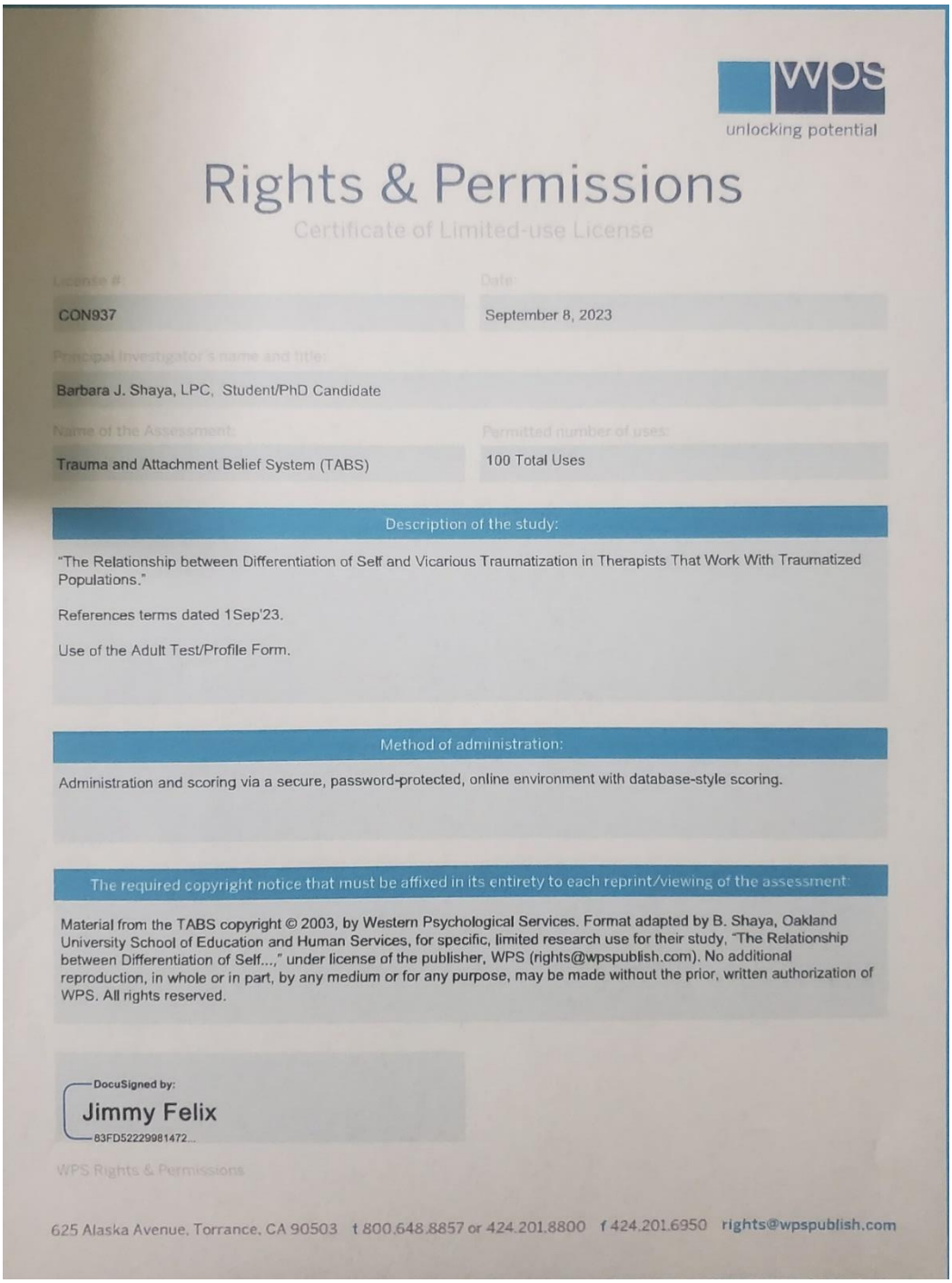
subject: Re: Request to Use DSI-R in Dissertation Research

Dear Barbara,

You are welcome to use our DSI in your research.

Sincerely,

Elizabeth



unlocking potential

# Rights & Permissions

## Certificate of Limited-use License

License #: CON937

Date: September 8, 2023

Principal Investigator's name and title: Barbara J. Shaya, LPC, Student/PhD Candidate

Name of the Assessment: Trauma and Attachment Belief System (TABS)

Permitted number of uses: 100 Total Uses

**Description of the study:**

"The Relationship between Differentiation of Self and Vicarious Traumatization in Therapists That Work With Traumatized Populations."

References terms dated 1Sep'23.

Use of the Adult Test/Profile Form.

**Method of administration:**

Administration and scoring via a secure, password-protected, online environment with database-style scoring.

**The required copyright notice that must be affixed in its entirety to each reprint/viewing of the assessment:**

Material from the TABS copyright © 2003, by Western Psychological Services. Format adapted by B. Shaya, Oakland University School of Education and Human Services, for specific, limited research use for their study, "The Relationship between Differentiation of Self...," under license of the publisher, WPS (rights@wpspublish.com). No additional reproduction, in whole or in part, by any medium or for any purpose, may be made without the prior, written authorization of WPS. All rights reserved.

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## Appendix C

## Participant Recruitment Letter

*The Relationship Between Therapist Differentiation of Self and Vicarious-Traumatization*

My name is Barbara Shaya, and I am a doctoral student from Oakland University in Rochester, Michigan. I am conducting a non-experimental quantitative research study as part of my doctoral degree requirements. The purpose of this research study is to a) explore the relationship between therapist level of self-differentiation and vulnerability to vicarious traumatization, and b) explore potential therapist factors that may increase or decrease vulnerability to vicarious traumatization.

I am recruiting individuals who are:

- Licensed clinical mental health therapists (e.g. counselors, marriage and family therapists, social workers, psychologists, psychiatrists) *or* pre-licensed graduate students in one of these disciplines currently enrolled in an internship course;
- 25 years of age or older;
- English-language fluent;
- Actively providing therapy to a minimum of 5 clients per week.

(Excluded from this study are licensed mental health professionals whose primary work setting is in-patient hospitalization, intensive out-patient, rehabilitation, education or career counseling.)

Your participation in this study is voluntary. The research study will take place online. The survey will take approximately 20-30 minutes to complete. Once you have submitted your survey, your participation will be complete.

Please click here https://oakland.az1.qualtrics.com/jfe/form/SV_b4rPpzso1LzzBKC to view the consent form and begin the survey. Please forward this invitation letter to anyone you know who meets the requirements listed above.

If you have any questions about this study, please contact me at bshaya@oakland.edu or my dissertation chair, Dr. James T. Hansen at jthansen@oakland.edu. The IRB approval number for this dissertation study is IRB-FY2024-103.

Thank you for your consideration,

*Barbara J. Shaya, LPC*

## Appendix D

## Variables

| Variable | ID | # Items | Items Included |
|---|---|---|---|
| Differentiation of Self-Overall | DOS | 46 | INTRA; INTER |
| DOS Intrapersonal Dimension | INTRA | 22 | IP; ER |
| I-Position | IP | 11 | |
| Emotional Reactivity | ER | 11 | |
| DOS Interpersonal Dimension | INTER | 24 | EC; FO |
| Emotional Cutoff | EC | 12 | |
| Fusion With Others | FO | 12 | |
| Vicarious Traumatization-Overall | VT | 84 | VTSelf; VTOther |
| VT Self-Oriented | VTSelf | 45 | SS; SE; SI; ST; SC |
| Self-Safety | SS | 13 | |
| Self-Esteem | SE | 9 | |
| Self-Intimacy | SI | 7 | |
| Self-Trust | ST | 7 | |
| Self-Control | SC | 9 | |
| VT Other-Oriented | VTOther | 39 | OS; OE; OI; OT; OC |
| Other-Safety | OS | 8 | |
| Other-Esteem | OE | 8 | |
| Other-Intimacy | OI | 8 | |
| Other-Trust | OT | 8 | |
| Other-Control | OC | 7 | |
| Personal Trauma History | PTH | 28 | ACESR; ATR |
| ACES-Revised | ACESR | 14 | |
| Adult Traumatic Events | ATR | 14 | |
| Personal Therapy | THPY | 1 | # of years |
| Work Experience | WE | 1 | # of years |
| Trauma-Specific Training | TT | 1 | Category levels 0-4 defined |
| Professional Support | SUPP | 1 | Satisfaction levels 0-10 |

## Appendix E

## Background Information Questionnaire

Which of the following best describes how you identify or would describe your gender?

- Cisgender woman
- Cisgender man
- Transgender women (trans feminine; male to female)
- Transgender man (trans masculine; female to male)
- Nonbinary, agender, or other

How do you describe your racial identity?

- White or Caucasian
- Black or African American
- Asian or Pacific Islander
- Native American, American Indian, First Nations, or otherwise Indigenous
- Hispanic or Latino/a/x
- Other_____

What is your age? (enter #)

What is your current licensure status?

- Full Licensure
- Limited Licensure
- Not licensed
- Previously licensed and eligible, but currently inactive

In which mental health discipline are you licensed?

- Counseling
- Social Work
- Marriage and Family Therapy
- Psychology
- Psychiatry
- Other _____

How many years (post-licensure) of work experience do you have? (enter #)

Which best describes your current work setting?

- Private Practice (solo)
- Private Practice (group)
- Community health agency
- Non-profit agency

- Outpatient hospital or clinic
- Other _____

Where do you provide therapeutic services?
- Within the United States (USA) only
- Outside of the United States only (please indicate where)
- Both within and outside the United States (please indicate where outside of the USA you practice, and what percentage of time is spent outside of the USA)

What is your self-identified primary theoretical orientation?
- Humanistic/Client Centered
- Psychodynamic/Psychoanalytic
- Cognitive Behavioral Therapy
- Feminist Multicultural
- Family Systems
- Integrative/Eclectic
- Other _____

Approximately how many hours (on average) of individual therapy do you provide per week?
Enter #

Approximately how many hours (on average) of group therapy do you provide per week? (include couples, families, and groups)
Enter #

In your current caseload, what percentage of clients have a history of trauma?
Provide slide scale 0% - 100%

Did your coursework leading to licensure include a trauma-specific course?
- Yes
- No

How much trauma-specific training have you obtained since receiving licensure?
- None
- Some (a workshop or two, some conference presentations, one semester course during graduate program)
- A good amount (workshops, conference presentations, and at least one full-day minimum trauma-focused course, more than one semester course during graduate program)
- Advanced (Several full-day minimum trauma-focused courses in addition to workshops and presentations, trauma certification during graduate program)
- Substantial (certified in at least one trauma-specialty)

How much personal therapy have you participated in throughout your life? (Select the response that best fits your total cumulative amount of therapy received)

- None
- Minimal as required by my graduate program
- Some, 6 months – 1 year
- 1-3 years
- More than 3 years

Do you participate in regular (minimum 1x month) individual supervision/consultation?

- No
- Yes

Do you participate in regular (minimum 1x month) group supervision/consultation?

- No
- Yes

Do you participate in regular peer supervision/consultation?

- No
- Yes, 1x month or less
- Yes, a few times a month
- 1x per week minimum

How satisfied are you with the quantity and quality of overall professional support you receive (including supervision, peer consultation, access to necessary resources and training)?
Provide slide scale 0 (not at all satisfied) – 10 (completely satisfied)

What trauma populations do/have you work with? Check all that apply.

- Childhood sexual abuse
- Childhood physical abuse
- Childhood neglect
- Childhood emotional abuse (includes peer victimization, bullying)
- Adult sexual abuse/assault (includes human trafficking)
- Adult physical assault
- Adult psychological/emotional abuse
- Intimate Partner violence
- Homicide
- Suicide
- Military
- Terrorism/War
- Refugee/Displaced individuals

- Poverty
- Organized/Ritual Abuse
- Spiritual Abuse
- Natural Disaster
- Other

Have you ever discontinued working with a certain population because it was causing you excessive distress?

- No
- Yes (If yes, please describe_____)

## Appendix F

## Adverse Childhood Experiences – Revised Items

For each numbered item, respond with yes (1 pt) or no (0). Total possible score 0-14.
All items are preceded by "prior to your 18th birthday…)

1. Did a parent or other adult in the household **often** or **very often**…
    - Swear at you, insult you, put you down, or humiliate you? **or**
    - Act in a way that made you afraid you might be physically hurt?
2. Did a parent or other adult in the household **often** or **very often**…
    - Push, grab, slap, or throw something at you? **or**
    - **Ever** hit you so hard that you had marks or were injured?
3. Did an adult or person at least 5 years older than you **ever**…
    - Touch or fondle you or have you touch their body in a sexual way? **or**
    - Attempt or actually have oral, anal, or vaginal intercourse with you?
4. Did you **often or very often** feel that …
    - No one in your family loved you or thought you were important or special? **or**
    - Your family didn't look out for each other, feel close to each other, or support each other?
5. Did you **often or very often** feel that …
    - You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? **or**
    - Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
6. Was a biological parent **ever** lost to you through divorce, abandonment, or other reason?
7. Was your mother or stepmother…
    - **Often or very often** pushed, grabbed, slapped, or had something thrown at her?
    - **Sometimes, often, or very often** kicked, bitten, hit with a fist, or hit with something hard? **or**
    - **Ever** repeatedly hit over at least a few minutes or threatened with a gun or knife?
8. Did you live with anyone who was a problem drinker or alcoholic, or who used street drugs?
9. Was a household member depressed or mentally ill, or did a household member attempt suicide?
10. Did a household member go to prison?
11. Did other kids, including brothers or sisters, **often or very often** hit you, threaten you, pick on you or insult you?
12. Did you **often or very often** feel lonely, rejected or that nobody liked you?
13. Did you live for 2 or more years in a neighborhood that was dangerous, or where you saw people being assaulted?
14. Was there a period of 2 or more years when your family was very poor or on public assistance?

(Finkelhor et al., 2015)

## Appendix G

### Adult Traumatic Experiences*

Did any of the following difficult or stressful events **happen to you personally** in adulthood (since your 18th birthday)?

1. Natural disaster (tornado, flood, earthquake, hurricane)?
2. Fire or explosion?
3. Transportation accident (car, boat, plane, train)?
4. Serious accident at home, work, or during recreational activities?
5. Physical assault (being hit, slapped, kicked, beaten up, choked)?
6. Assaulted with a weapon (being stabbed, shot or threatened with a knife, gun or bomb)?
7. Sexual assault (rape or attempted rape, made to perform a sexual act through force, threat or harm)?
8. Sexual harassment (unwanted or uncomfortable sexual experience such as taunting, threatening, made to hear about or watch sexual activity)?
9. Held captive (being abducted or kidnapped, held hostage, prisoner of war, restrained from free movement for extended period of time)?
10. Combat or exposure to a war zone (military or civilian)?
11. Life-threatening illness or injury?
12. Witnessed or heard about a sudden violent death (homicide, suicide)?
13. Witnessed or heard about a sudden accidental death of a loved one?
14. Caused serious injury, harm, or death to someone else?

*Adapted from the Life Events Checklist for DSM-5 (Weathers et al., 2013).