Traumatizing Aspects of Providing Counselling in Community Agencies to Survivors of Sexual Violence: A Concept Map

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ABSTRACT

Concept mapping (a combined qualitative/quantitative approach) was used to clarify and understand 72 Canadian professionals' experience of what they found to be traumatizing about their work with sexual violence survivors in community settings. A sample of 30 professionals providing community-based treatment to survivors of sexual violence sorted and rated 96 individual statements (generated by 72 professionals) regarding the traumatizing aspects of this clinical work to produce a visual representation, or concept map, of their experience. The final concept map generated eight distinct cluster themes: Witnessing and Responding to Therapeutic Content, Witnessing and Responding to Therapeutic Process, Challenging Countertransference Reactions, System Flaws and Inadequacies, Societal Injustice, Awareness of Human Cruelty, Feeling Helpless and Powerless, and Workplace Constraints and Deficiencies. The implications of these findings and suggestions for further areas of investigation are discussed.

RÉSUMÉ

La méthode du schéma conceptuel (une approche qualitative-quantitative combinée) a été utilisée pour clarifier et comprendre l'expérience de 72 professionnels canadiens de ce qu'ils trouvaient traumatisant dans leur travail avec des survivants de violence sexuelle dans un milieu communautaire. Un échantillon de 30 professionnels livrant un traitement basé dans la collectivité à des survivants de violence sexuelle a trié et évalué 96 énoncés individuels (produits par 72 professionnels) sur les aspects traumatisants de ce travail clinique afin de produire une représentation visuelle ou schéma conceptuel de leur expérience. Le schéma conceptuel définitif a identifié huit grappes de thèmes distincts : être témoin du contenu thérapeutique et y réagir; être témoin du processus thérapeutique et y réagir; remettre en question les réactions de contre-transfert; lacunes et insuffisances du système; injustice sociétale; conscience de la cruauté humaine; sentiment d'être démuni et impuissant; et contraintes et insuffisances du lieu de travail. Les répercussions de ces constatations et des suggestions d'autres domaines d'enquête sont discutées.

In the past decade growing attention has been given to investigating the phenomenon of vicarious trauma among counsellors working with survivors of sexual violence and other client populations who have experienced traumatic stressors (Adams, Matto, & Harrington, 2001; Baird & Jenkins, 2003; Brady, Guy, Poelstra, & Fletcher Brokaw, 1999; Pearlman & MacIan, 1995; Robinson, Clements, & Land, 2003; Schauben & Frazier, 1995; Steed & Downing, 1998). The term *vicarious trauma* was coined in 1990 by McCann and Pearlman and refers to the process by which helping professionals can experience traumatic stress symptoms

and significant internal changes to aspects of the self as a result of their clinical exposure to clients who have directly experienced traumatic stressors. Although the notion of vicarious trauma has had significant appeal for counsellors working with traumatized populations, empirical support for the construct has been inconsistent. There appear to be significant discrepancies both among quantitative investigations and between quantitative and qualitative investigations regarding the prevalence, severity, and risk factors for vicarious trauma (Kadambi & Ennis, 2004; SabinFarrell & Turpin, 2003). Qualitative investigations have yielded more consistent support for the assertions that the experience of being traumatized by working with survivors of sexual violence is both a common and personally significant experience among these professionals (Black & Weinreich, 2000; Iliffe & Steed, 2000; Steed & Downing). Quantitative investigations that have examined affective reactions, behavioural symptoms, and cognitive distortions associated with vicarious trauma, however, have yielded conflicting results regarding the scope, prevalence, and severity of vicarious trauma (Adams et al.; Baird & Jenkins; Kadambi & Truscott, 2003, 2004; SabinFarrell & Turpin).

The inconsistencies between these investigations are quite curious. It remains unclear whether the inconsistencies relate to construct validity, differences in operational definitions and subsequent measurement of the phenomena, or the types of research methods used. It seems as if there is something about the concept of vicarious trauma that resonates deeply with clinicians, but assessing and measuring their experience has proved to be quite challenging. In order to more fully understand the potential experience of vicarious trauma, the current study combined quantitative and qualitative approaches to investigating the experience among professionals working in the area of sexual violence.

RATIONALE FOR CURRENT STUDY

This investigation was initiated by the findings of an earlier study that investigated the differential impact of counselling/psychotherapy on Canadian professionals working in the areas of sexual violence, psycho-oncology, and general practice (Kadambi & Truscott, 2004). These three professional groups were expected to exhibit significant between-group differences on self-report measures including the Traumatic Stress Institute Belief Scale, Revision M (TSI; Pearlman, 1996), which measures cognitive disruption associated with vicarious trauma; the Impact of Events Scale (IES; Horowitz, Wilner, & Alvarez, 1980), which measures traumatic stress symptoms; and the Maslach Burnout Inventory (MBI; Maslach, Jackson, & Leiter, 1996), which assesses three aspects of burnout: emotional exhaustion, depersonalization, and professional accomplishment. It was hypothesized that professionals working with survivors of sexual violence would report higher levels of traumatic stress and cognitive disruptions associated with vicarious trauma.

Surprisingly, no significant differences were evident between groups. A significant difference was found, however, between professional groups' perceptions

of their work as traumatizing. Eighty-four percent of professionals working in the area of sexual violence indicated their work was traumatizing or potentially traumatizing, as compared to 50% of psycho-oncology professionals and 36% of professionals in general practice settings (Kadambi & Truscott, 2004).

The intent of this follow-up investigation was to further understand this apparent discrepancy between quantitative measures of traumatic stress and the perception of clinical work as traumatizing among professionals working with survivors of sexual violence. While quantitative measures did not yield expected results in the primary study, we sought to obtain a deeper understanding of how professionals may experience their clinical work with this population as traumatizing by undertaking a concept mapping investigation. Using the qualitative data that was collected along with the aforementioned quantitative measures, we developed a concept map of what professionals working with survivors of sexual violence found traumatizing about their work.

Within this study, concept mapping was used to further our understanding of the underlying dimensions of what aspects of providing counselling/psychotherapy to survivors of sexual violence professionals perceive as personally traumatizing or potentially traumatizing. Concept mapping is a research method that combines qualitative and quantitative approaches to research. It is an approach that is increasingly being used by social science researchers for exploring the structure and content of a phenomenon of interest as it is experienced by a group of participants (Bedi, 2006; Brown & Calder, 2000; Donnelly, Donnelly, & Grohman, 2000; Gol & Cook, 2004; Goodyear, 2002; Goodyear, Tracey, Claiborn, Lichtenberg, & Wampold, 2005; Paulson & Worth, 2002; Shewchuk & O'Connor, 2002). While this approach is most commonly used nomothetically to understand knowledge structures that are held by a group of people, it can also be used ideographically to understand how individuals uniquely conceptualize their experience (Goodyear et al.). Concept mapping has been suggested as a particularly good research method to deal with text generated from open-ended questions (Jackson & Trochim, 2002). Concept mapping investigations involve (a) the generation of thoughts, ideas, or experiences by participants when posed a specific question; (b) the grouping and rating of these thoughts, ideas, or experiences via sorting and rating tasks conducted by participants; and (c) statistical analysis of sorting tasks across participants' wherein a multidimensional scaling procedure depicts the organizational structure underlying participants' sorting and cluster analysis that then groups together conceptually similar sorted items.

The approach actively involves the research participants in each stage of data collection and analysis (Trochim, 1989b, 1993). Using statistical techniques to analyze sorting and rating data across participants, a concept map is generated that visually depicts participants' ideas/concepts and how these ideas/concepts may be related (Davison, Richards, & Rounds, 1986). As participants sort and group the data, bias that may result from researchers sorting and grouping qualitative data is reduced.

METHOD

Participants

Professionals currently providing counselling to sexual violence survivors across eight Canadian provinces were contacted in two phases to participate in this study. In the first phase, 260 individual survey packages that were part of a larger primary research project were sent to 44 Canadian sexual assault centres that were in the community or attached to an institution (e.g., university or hospital). Survey packages contained a demographic questionnaire, quantitative measures from the primary research project, and several open-ended questions, one of which was "What aspects of clinical work with your primary client population [survivors of sexual violence] do you feel are traumatizing and/or contribute to the potential of traumatization?" Participants were informed that the data they provided for the primary research project would also be used for additional research projects. Although 102 surveys were initially returned, 16 of those surveys were not included in the primary research project sample as they were missing data or did not meet the screening criteria of the primary study (Kadambi & Truscott, 2004). Eighty-six participants ultimately returned usable survey measures. However, 14 (16%) indicated that they did not feel their work with survivors of sexual violence was traumatizing and were excluded from the sample for this project, resulting in a response rate of 27.6%. The final sample consisted only of participants who indicated they perceived their work was traumatizing or potentially traumatizing and who also responded to the open-ended question.

The final sample in the first phase of data collection consisted of 72 participants: 3 male and 69 female. Participants' mean age was 39.7 years (SD = 9.01), with a range of 22–62 years. Of the sample, 15% had a diploma or certificate, 31% had bachelor's degrees, 50% had masters' degrees, 1% had doctorate degrees, and 3% had an education background that fell into an "other" category (e.g., medical degree). The participants in this Phase 1 sample had a range of 1–22 years working with sexual violence. The average number of years providing counselling to survivors of sexual violence among participants was 7.54 years (SD = 5.21). Seventy-two percent of participants in this sample indicated they themselves had experienced some type of "traumatic stressor." Participants were given the *Diagnostic and Statistical Manual of Mental Disorders Fourth Edition* (*DSM-IV*; American Psychiatric Association, 1994) criterion A1 for post-traumatic stress disorder as a guideline of what constituted a "traumatic stressor" for the purposes of this research study.

In the second phase of data collection, sexual assault centres that were approached initially to obtain Phase 1 participants were re-contacted and asked to participate in the second phase of the study, which involved a sorting/rating task. A total of 75 individual research packages were sent to 17 sexual assault centres across Canada. Forty percent of packages were completed and returned for a final sample of 30 participants. Commonly, the recommended sample size is 15 participants (recommended minimum is 10 participants) for concept mapping investigations (Trochim, 1993).

Independent sample *t*-tests revealed participants in Phase 2 did not differ significantly from Phase 1 participants in terms of age, $t = (100) = -1.038$, $p = .302$, or in the length of time they had worked with survivors of sexual violence, $t = (41.66) = -.703$, $p = 0486$. Chi-square analysis suggested no differences between the percentage of participants in each group who reported experiencing a traumatic stressor, $\chi^2 = (1) = .051$, $p = .821$. Gender composition did appear to differ between participants in Phase 1 and Phase 2 of the study. There was a larger percentage of men who completed the second phase sorting/rating task (10% of Phase 2 sample) compared with men in Phase 1 of the study who responded to the survey (4% of Phase 1 sample). The small number of men in both samples prevented meaningful chi-square analysis.

Procedure

During the first data-gathering phase, participants were asked to respond to the following open-ended question: "What aspects of clinical work with your primary client population [survivors of sexual violence] do you feel are traumatizing and/or contribute to the potential of traumatization?" The question was designed to draw out participants' perspectives on their experience without confining their responses.

The research team used Giorgi's (1985) four-level scheme as a procedural guideline for dealing with participant responses. The research team first met to review participants' raw responses and to separate responses (using grammatical rules that marked separate sentences) into statements that represented discrete ideas. The statements were then examined by the research team and contextual or irrelevant material was removed. Next, the team identified statements that preserved participants' language and reflected the domain of their experience as it related to what they found traumatizing about working with survivors of sexual violence. Finally, each of the statements was compared with the others for redundancies and the research team chose statements that best represented participants' ideas. Once this level of analysis was complete, the research team had extracted an inclusive set of 96 statements that reflected the essence of participants' experience while retaining their language.

In the second data-gathering phase, 30 participants completed the sorting and rating task. For the sorting task, each of the 96 statements derived from the qualitative analysis was printed on a card, so that each card represented one qualitative description of what participants found traumatizing or potentially traumatizing about their clinical work with survivors of sexual violence. Participants were asked to place the 96 cards in piles according to "how they seem to go together." Participants were not given any restrictions in their sorting instructions other than that they not place each item card alone in a pile or place all cards in one pile (Rosenberg & Kim, 1975).

For the rating task, the 96 rewarding items from the qualitative analysis were compiled into a questionnaire in which the 30 participants rated each on a five-point scale ranging from 1 (*not important*) to 5 (*extremely important*). The intent of this

procedure was to enable identification of the relative importance of the traumatizing aspects of providing counselling/psychotherapy to survivors of sexual violence.

RESULTS

Using Concept Systems Software (Trochim, 1993), the researchers performed a nonmetric multidimensional scaling (MDS) procedure on the data from the sorting task. The MDS procedure arranges points representing individual statements along X and Y axes. Since the primary purpose of the MDS analysis is to display clustering results visually, two-dimensional solutions are often appropriate, as three-dimensional solutions are visually more challenging to interpret (Kruskal & Wish, 1978). Statements that were sorted more frequently together across participants' sorts are spatially depicted closer to one another. Thus, the distance between points represents the frequency with which the statements were sorted together. The MDS procedure resulted in a final stress value of .1745 for a two-dimensional solution, which is reasonably stable (Kruskal & Wish). The stress value is an index of the stability of an MDS solution and ranges from 0 (*perfectly stable*) to 1 (*perfectly unstable*).

Hierarchical cluster analysis was then applied to the MDS similarity matrix. The cluster analysis groups individual statements into clusters of statements that reflect similar concepts (Trochim, 1989a, 1989b). Ward's (1963) algorithm for cluster analysis was used to optimize distinctiveness across clusters (Borgen & Barnett, 1987). This algorithm combines two clusters until, at the end, all of the statements are in a single cluster. It is the task of the research team to decide how many clusters the statements should be grouped in for the final solution. Several potential cluster solutions (ranging from 3 to 19) were examined. The researchers took into account that participants on average sorted the statements into 9.86 piles (Range = 3–37, SD = 7.74). It has been suggested that greater consideration be given to cluster solutions that are close in raw number to the average number of piles selected by participants (Bedi, 2006). Cluster solutions between 8 and 10 for this study were considered most in line with participants' conceptualizations.

As the cluster solution is based on the MDS solution (the point map of individual statements), the cluster solution is used as a secondary guide to interpreting the map. The MDS solution is given primary consideration. The research team then met to review the MDS solution and reach consensus on the final cluster number based on examination of the location of the individual statements. The final cluster solution was overlaid on the MDS point map. Clusters were then assigned names after the researchers considered individual items within the cluster, items contributing most to the uniqueness of the cluster, and the relative distance of each item from other items on the map.

The concept map of the 96 traumatizing or potentially traumatizing aspects of providing treatment to survivors of sexual violence is presented in Figure 1. Each of the 96 statements derived from the participants' phenomenological response is represented as a point on the map. The relative position of the points from one another is derived from the MDS solution and reflects the frequency with which

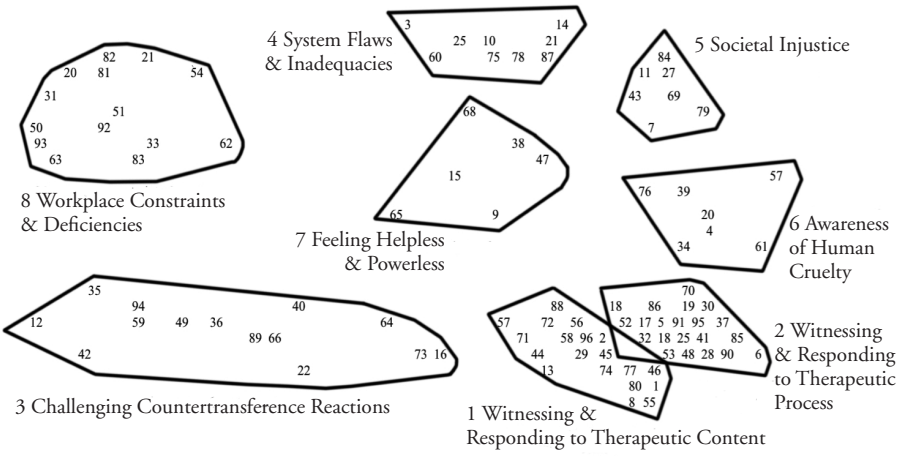
the statements were sorted together by participants; points that are closer together represent statements that were more frequently sorted together than were statements represented by points farther apart. The cluster boundaries around groups of points represent statements that were more frequently sorted together in the same pile and less often sorted with statements in other piles.

Bridging values can range from 0 to 1 and depict how frequently statements were sorted together. Based upon estimated distances between statements from the MDS two-dimensional solution, lower bridging values are indicative of statements sorted together more frequently and higher values indicate statements sorted together less frequently. Statements with a high bridging value indicate that a statement bridges two or more clusters to which it is related. Statements with a bridging value of 1 suggest that the item could potentially be sorted with every cluster. A low bridging value means that the statements in that cluster were more frequently sorted with statements within the cluster than with statements in other clusters. Rating values range from 1 to 5 and represent the importance participants placed on each statement. Low values reflect statements experienced as less important and higher values reflect correspondingly more important traumatizing aspects of working with survivors of sexual violence.

Interpretation of the concept map involves the research team speculating about the potential structure that participants imposed to sort individual items (Kunkel

Figure 1

Concept map of 96 elements of what 72 treatment providers found traumatizing about their work, derived from qualitative analysis of their response to the probe "What aspects of clinical work with your primary client population [survivors of sexual violence] do you feel are traumatizing and/or contribute to the potential of traumatization?" (based on multidimensional scaling and cluster analysis of 30 participants' open-card sort of these elements)



& Newsom, 1996) and the identification of conceptual dimensions around which points may be organized (Buser, 1989). Examination of the individual statements and overall clusters in terms of their placement and adjacency can help guide interpretation to identify distinct regions of the map and potentially related concepts. Clusters and individual statements that are close together visually on the map reflect participants' perceptions of them as similar. The final concept map generated eight distinct cluster themes: Witnessing and Responding to Therapeutic Content, Witnessing and Responding to Therapeutic Process, Challenging Countertransference Reactions, System Flaws and Inadequacies, Societal Injustice, Awareness of Human Cruelty, Feeling Helpless and Powerless, and Workplace Constraints and Deficiencies. A statement key, statements within each cluster, and descriptive statistics for each statement and cluster are presented in Table 1.

Within the map, Cluster 1 (Witnessing and Responding to Therapeutic Content) and Cluster 2 (Witnessing and Responding to Therapeutic Process) were spatially located very close together and partially overlapped one another. This indicates that the items in these two clusters were frequently sorted with one another, suggesting conceptual similarities. Statements within Cluster 1 tended to reflect traumatizing aspects relating to the content of clinical work (e.g., "Explicit details of violence," "Graphic descriptions of abuse"). Cluster 2 contained statements that appeared to be slightly more related to the counsellors' experience of the process of providing counselling to survivors of sexual violence (e.g., "Witnessing clients' despair and hopelessness," "Dealing with extremely complex clients"). These two clusters had the lowest bridging values compared to other clusters within the map, suggesting that the traumatizing aspects represented within these clusters were quite distinct from the other cluster themes.

Average rating values reflect how important participants felt the statements within each cluster were as they related to the experience of being traumatized or potentially traumatized. Although participant rating values had little variation (Range = 3.25–3.75) between cluster ratings (suggesting that all cluster themes were considered important), there were slight differences that the authors felt could be important to understanding the experience of this unique sample. The average rating values for Clusters 1 and 2 ranked fifth and sixth in terms of importance compared to the other cluster themes.

Cluster 3 was labeled Challenging Countertransference Responses. Statements within this cluster seemed to be connected to counsellors' cognitive and emotional responses to clients' material (e.g., "Hearing client stories that trigger an emotional response in me," "Disturbing visual images of what my clients have shared") and specific client behaviour (e.g., "A client's suicide"). This cluster had the second highest average rating relative to all other clusters.

System Flaws and Inadequacies was the name given to Cluster 4. Statements within this cluster seemed to reflect the traumatizing aspects of witnessing client experiences and counsellors having their own experiences interacting with existing social systems commonly accessed by survivors of sexual violence (e.g., "The disinterest shown by authorities when offered information about sexual violence,"

"The failure of the justice system to protect victims," "When helping professionals cause further harm"). In essence, the statements within this cluster appeared to describe what is commonly referred to as "re-victimization" by professionals working with survivors of violence. Cluster 4 average rating value was ranked third relative to other cluster rating values.

Table 1
Clusters and Items From Concept Map of What Aspects of Providing Counselling/Psychotherapy to Survivors of Sexual Violence Participants Found Traumatizing

Cluster and Item	Bridging value	Rating (mean)
Cluster 1: Witnessing and Responding to Therapeutic Content	**0.12**	**3.36**
1. Graphic descriptions of abuse	0.10	3.47
46. Dealing with clients who are feeling suicidal or who have attempted suicide	0.08	3.53
8. Witnessing young children in therapy re-enacting their abuse	0.20	3.76
55. Working with clients in the immediate aftermath of a sexual assault	0.19	3.28
2. Surprise events/disclosures in therapy	0.08	3.00
80. Explicit details of violence	0.13	3.40
74. Clients often have issues that require immediate attention	0.15	3.45
96. Working with clients who are emotionally "frozen"	0.08	2.77
13. Providing support to people who are in crisis much of the time	0.14	3.60
44. Sitting with the agony of another person	0.11	3.47
71. Seeing the terror of others	0.14	3.40
29. Being exposed to clients' anger	0.14	2.87
58. Descriptions of incest	0.08	3.17
56. Children's disclosure of their abuse	0.08	3.76
45. Dealing with clients who self injure	0.02	3.27
77. Seeing the pain of parents whose children have been abused	0.08	3.53
57. Accompanying clients to the hospital, courts, etc.	0.23	3.10
72. Constant exposure to traumatic details and violence	0.17	3.79
88. Lack of progress in therapy	0.17	3.27
Cluster 2: Witnessing and Responding to Therapeutic Process	**0.08**	**3.32**
5. The degree of pain and suffering experienced by some victims	0.03	3.70
32. Repeated disclosures of trauma	0.05	3.48
17. Graphic descriptions of violence to children	0.05	3.73
52. Dealing with extremely complex clients	0.05	3.73
18. Concern for the safety of clients who are currently being abused	0.16	4.20
86. The severity of violence experienced by some clients	0.08	3.40
19. Hearing harmful things that parents and others can do to children	0.18	3.70
70. Witnessing the impact of violence on people's lives	0.17	3.21
30. Clients' experience of disempowerment	0.10	2.93
95. Clients' denial of the impact of abuse/violence	0.09	2.67
37. Clients who have lost hope because of their past	0.12	3.03
6. The changes in the victim's personality as a result of the abuse	0.23	3.03
85. Working with clients who have clinical disorders	0.22	3.07
25. Witnessing clients' despair and hopelessness	0.00	3.60

48. Working with angry and abusive clients	0.02	3.27
53. Witnessing clients' flashbacks	0.00	3.20
28. The grief and sorrow of clients	0.02	3.30
91. Clients who have survived repeated or chronic trauma	0.03	3.27
41. Hearing client stories of neglect	0.05	3.03
90. The range of emotions experienced and released by my clients	0.03	2.87
Cluster 3: Challenging Countertransference Reactions	**0.61**	**3.63**
12. Working with victims when my own trauma history has not been resolved	1.00	4.34
42. Dealing with my personal feelings of anger, outrage, grief, and powerlessness	0.87	3.93
59. Nightmares I experience relating to clients' stories	0.74	3.37
35. Fear of harm happening to my own children	0.92	3.10
94. Fear for my own personal safety	0.77	3.57
16. Empathizing with clients' experiences	0.32	3.53
73. A client's suicide	0.36	4.69
64. Hearing about incidents of sexual abuse that are in familiar contexts	0.35	3.13
40. The overwhelming sense of helplessness in hearing the trauma that children and adults have endured	0.44	3.40
22. Hearing client stories that trigger an emotional response in me	0.51	4.00
36. Disturbing visual images of what my clients have shared	0.55	3.53
89. Graphic descriptions of abuse give me pictures in my head that become part of my experience	0.54	3.47
49. Dealing with client issues that relate to my own past experience	0.62	3.40
66. Hearing clients' stories that I can relate to on an "it could have happened to me" basis	0.60	3.30
Cluster 4: System Flaws and Inadequacies	**0.45**	**3.44**
3. Stories of carelessness by other professionals or bureaucrats	0.59	3.33
10. Descriptions of racist, sexist treatment of victims by police and the courts	0.44	3.57
23. Workers who don't fight for children's rights	0.52	3.27
60. When the helping profession causes further harm	0.53	3.59
75. The inadequacy of laws relating to child protection	0.39	3.17
78. The disinterest shown by authorities when offered information about sexual violence	0.39	3.50
87. Lack of justice shown from the criminal justice system	0.39	3.27
14. Society's unwillingness to address issues that perpetuate violence against women	0.42	3.63
24. The failure of the justice system to protect victims	0.38	3.63
Cluster 5: Societal Injustice	**0.48**	**3.40**
7. The scope of the problem of violence and domestic violence	0.48	3.40
43. Hearing about how the justice system has let down victims of violence	0.46	3.60
69. The re-victimization of women by various institutions	0.46	3.37
79. Knowing the world is not safe for women and children	0.58	3.17
11. Dealing with the lack of support for victims	0.46	3.30
27. The injustice of our society	0.43	3.40
84. Societal attitudes that are victim-blaming	0.47	3.57
Cluster 6: Awareness of Human Cruelty	**0.44**	**3.28**
4. The realization that unimaginable horrors are perpetrated on children	0.37	3.97
34. Hearing about the attitudes of clients' abusers	0.30	3.07

26. The reality of how cruel some people are	0.39	3.47
61. The increasing number of women who identify as both victim and abuser	0.45	3.00
39. The awareness of how cruel we can be as human beings	0.46	3.23
76. Knowing that people continue to abuse	0.45	3.10
67. The degree of poverty and marginalization of my clients	0.64	3.10
Cluster 7: Feeling Helpless and Powerless	**0.50**	**3.25**
9. Knowing that children are living in unstable, unsafe situations	0.42	3.87
15. The time-limited role of therapy in clients' lives	0.55	2.67
65. Knowledge that a member of my immediate community is an abuser	0.53	3.50
38. Having knowledge of perpetrators still in the community going unpunished for their offences	0.50	3.23
47. Assisting clients to cope with the lack of responsiveness of the criminal justice system	0.48	3.17
68. Feeling helpless about the conviction rate of sexual abusers	0.51	3.07
Cluster 8: Workplace Constraints and Deficiencies	**0.58**	**3.75**
20. The lack of support in the workplace	0.45	4.10
31. Work circumstances that discourage effective self-care	0.45	3.79
81. Working with unethical management and coworkers	0.54	4.20
21. The lack of opportunity to get specialized training	0.49	3.57
82. Working with unprofessional management and coworkers	0.57	4.10
54. Lack of adequate financial compensation for the services I provide	0.64	3.07
33. Too many back-to-back trauma clients	0.66	3.53
83. Witnessing the impact of this work on my coworkers	0.70	3.17
62. Feeling unable to offer adequate services to women in crisis	0.68	3.37
50. Lack of opportunity for regular debriefing	0.58	4.07
51. Lack of balanced caseload	0.54	3.87
92. Lack of qualified clinical supervision	0.55	3.77
63. Being overwhelmed by a large caseload of trauma survivors	0.69	3.90
93. Working in isolation	0.65	4.07

Note. Participants rated each item according to its importance, using a 5-point scale ranging from 1 (*not important*) to 5 (*extremely important*).

Cluster 5, Societal Injustice, also contained statements that related to survivor re-victimization, but the statements in this cluster reflected more pervasive societal issues that were experienced as traumatizing aspects of working with survivors (e.g., "Societal attitudes that are victim blaming," "The injustice of our society," "Dealing with the lack of support for victims"). Relative to other clusters, Cluster 5 ranked fourth in terms of its average rating value.

Cluster 6 was labelled Awareness of Human Cruelty. The statements in this cluster related to participants' awareness and discomfort associated with human cruelty (e.g., "The reality of how cruel some people are," "The realization that unimaginable horrors are perpetrated onto children"). Cluster 7, Feeling Helpless and Powerless, contained statements that appeared to reflect participants' feelings of helplessness and powerlessness in response to various aspects of clinical work with survivors (e.g., "Feeling helpless about the conviction rate of sexual abusers," "Knowing that children are living in unstable, unsafe situations"). The average

rating values for Clusters 6 and 7 received the two lowest average rating values compared to all other clusters.

The eighth and final cluster, Workplace Deficiencies and Constraints, was an interesting cluster within the map. The visual depiction of this cluster in Figure 1 indicates that this was an aspect of participants' experience that was quite distinct from other identified themes. The statements in this cluster related to workplace stressors, such as heavy trauma caseloads and lack of workplace support for professional development and self care (e.g., "Too many back to back trauma clients," "Lack of qualified supervision," "Working with unprofessional management and coworkers"). Quite unexpectedly, this cluster obtained the highest average rating value compared to other cluster themes, suggesting participants felt it was the most important theme relating to their experience of their work as traumatizing.

Examinations of concept maps also occur along conceptual axes on which the clusters may be located. Looking at the map from another perspective shows that if the map were examined top to bottom and right to left, the clusters in each of the four resulting quadrants would suggest that participants' experience of traumatization or potential traumatization could be considered a complex interaction between four factors. Micro- and macro-levels of the context in which counselling to survivors of sexual violence is conducted seem to be represented in the upper left corner of the map representing workplace-related factors, and the upper right corner reflecting broader perceptions of the systemic and social context in which their clinical work occurs. The lower quadrants add an additional two factors, counsellor-related variables and factors associated with survivor clientele. In the middle of this conceptualization, Cluster 7, Feeling Helpless and Powerlessness, seems to bridge themes that relate to the context in which their clinical work is provided and the themes that related to the counsellor and clientele.

DISCUSSION

Participants in this follow-up investigation clearly articulated aspects of their work with survivors that were perceived as traumatizing, despite the lack of significant differences on quantitative measures of traumatic stress among the sample in a primary research study. Ultimately eight cluster themes within this concept map depicted traumatizing or potentially traumatizing aspects of working with survivors of sexual violence. Several identified themes within the concept map were highly specific to working with survivors of sexual violence. While the authors are unable to speak to how common the experience of feeling traumatized is among Canadian professionals working with sexual violence, we can, due to the design of this study, speak to how participants in this particular sample experienced and conceptualized feeling traumatized by their work. When viewed in its entirety, the map seemed to suggest that participants' experience of trauma or potential trauma from their clinical work was composed of an interaction between the specifics of clinical interaction with survivors, workplace variables, counsellor responses to their work, and the larger social/political context in which their work is conducted.

Importance of Workplace and Sociopolitical Context

A particularly interesting aspect of the concept map was participants' inclusion and rated importance of workplace factors and larger social influences as contributing factors in their experience of their work as traumatizing or potentially traumatizing. Previous attempts to assess these professionals' experience of traumatization may have underestimated the importance of social/political context and workplace variables in determining professionals' responses to clinical work with this client population. Although the ranking values suggested that participants felt all cluster themes were important, Cluster 8 (Workplace Constraints and Deficiencies) had the highest rating value. This seems to be in keeping with the findings of other researchers who suggest that supportive work environments and socially supportive work relationships can help offset the effects of workplace stress (Baker, Israel, & Schurman, 1996; Bradley & Cartwright, 2002; Terry, Nielsen, & Perchard, 1993).

The pragmatic applications of these findings are similar to the recommendations made by other researchers who have emphasized the importance of clinical supervision, managing case loads, professional development, creating supportive work environments, and cultivating a work climate of collegiality and respect (Iliffe & Steed, 2000; Neumann & Gamble, 1995; Pearlman & MacIan, 1995; Pearlman & Saakvitne, 1995; Robinson et al., 2003; Schauben & Frazier, 1995; Sexton, 1999). These findings also offer much in the way of prevention in that participants in this sample identified that the most important aspects of feeling traumatized by their work were related to issues largely under institutional/agency control.

Elements of Congruence and Incongruence with Theory Behind Vicarious Trauma

A frequent criticism/comment of studies investigating vicarious trauma is that quantitative measures used to assess aspects of vicarious trauma show high correlations with measures designed to assess burnout (Adams et al., 2001; Kadambi & Truscott, 2003, 2004). The constructs have been proposed to be interrelated yet distinct (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995), and this psychometric overlap has been interpreted as problematic in terms of the construct validity of vicarious trauma (Adams et al.; Kadambi & Truscott, 2003, 2004). It is interesting within this qualitative study that when participants are asked to report on aspects of what is "traumatizing," they also report on aspects of their experience and work variables that are quite commonly associated with the experience of burnout. This was evident in participants' statements comprising Clusters 4 (System Flaws and Inadequacies) and 8 (Workplace Constraints and Deficiencies). This congruence between qualitative and quantitative results may once again suggest that vicarious trauma and burnout may not be highly distinct. These constructs may be inextricably connected in ways that have yet to be determined by researchers. Alternatively, this finding could be the result of participants' utilizing subjective, and therefore discrepant, definitions for "traumatizing." Participants may have interpreted "traumatizing" to mean aspects of their work that were negative, difficult, or stressful. Although allowing participants to define what was

"traumatizing" about their experience resulted in rich data, the resulting map may be more inclusive of experiences other than that of vicarious trauma.

Conversely, there were aspects of this map that were quite congruent with principles behind the theory of vicarious trauma as proposed by McCann and Pearlman (1990). When considered in its entirety, the map supports their contention that the experience of vicarious trauma results from the unique interaction between the counsellor, their clinical work and the larger context in which their work occurs. Moreover, the three conditions that McCann and Pearlman propose are necessary to produce vicarious trauma, (a) exposure to graphic details of abuse, (b) exposure to human cruelty, and (c) participation in traumatic re-enactments, are well reflected in the statements that participants generated and among the cluster themes.

Limitations

Several cautions should be made in generalizing the findings of this study. As sampling from both the initial primary study (Kadambi & Truscott, 2004) and the current investigation was not based on random selection, it is possible that sampling biases occurred. It is important to consider that the samples are not representative of Canadian professionals providing counselling in community settings to survivors of sexual violence. For example, potential participants who perceived themselves to be traumatized by their clinical work may have been more likely to complete and respond to the survey in the primary study and more likely to participate in this study for the sorting/rating tasks. Moreover, the participants involved in the primary study who generated the meaning units and the participants who then sorted/rated the meaning units were almost all women. Generalizing these results to male professionals' experience working with survivors of sexual violence would be highly premature. Further research needs to be conducted to investigate the experience of male professionals.

It is also important to consider the workplace setting of the participant populations. Both samples of participants were limited to Canadian professionals providing treatment within sexual assault centres to survivors of sexual violence. Within this type of work setting, this sample may have been more likely to experience workplace stressors (e.g., limited resources, heavy caseloads, limited support for training and professional development) compared to professionals providing clinical services to survivors in other settings (e.g., private practice). Moreover, in addition to providing direct counselling services to survivors of violence, many Canadian sexual assault centres have mandates of public education and promoting social change. This workplace emphasis on promoting social justice may also have influenced how participants in this study contextualized the traumatizing aspects of their clinical work and the importance given to the sociopolitical environment in which their work occurs. It remains unclear if professionals working primarily with survivors of sexual violence in other work settings would have identified different aspects of their work that they felt were traumatizing and the importance they would have given to different themes that would be generated.

CONCLUSION

The results from this study appear to highlight the need for more comprehensive assessment in determining the impact of working with traumatized populations on helping professionals. Richer examinations of professionals' experience of being impacted by their clinical work are likely to require a combination of qualitative and quantitative approaches that assess multiple facets of the experience of feeling traumatized. These facets may include looking at (a) symptoms of traumatic stress, (b) changes in world view, (c) workplace stressors, (d) personal variables, and (e) assessments of perceptions of the sociopolitical context in which their work is conducted.

Researchers conducting quantitative investigations may benefit from considering the context they provide participants when asking them to report on their experiences. In this study, for example, the word "traumatizing" was completely left to the participant to define in order to attempt to fully capture their experiences. Their reported experiences seemed to encapsulate a range of experiences not necessarily congruent with what quantitative researchers may be attempting to determine or assess. It may be helpful to include more definitional information to participants regarding specific constructs or experiences on which they may be asked to report.

Debate regarding the prevalence and severity of traumatic stress responses among professionals working with survivors of sexual trauma is likely to continue. What remains both hopeful and conveniently pragmatic is that, within this study, participants identified workplace variables as the most important in their experience of what they defined as feeling "traumatized." These aspects of clinical work with survivors of sexual violence are the most amenable to immediate intervention and alteration for both individuals and agencies. Until researchers establish a clearer picture of these professionals' experiences and the factors that shape them, it appears that for clinicians, the customary recommendations of attending to and addressing workplace and workload issues as well as personal self-care may be well in order.

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