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Rape Crisis Counseling: Trauma Contagion and Supervision

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Abstract

This study of rape crisis counselors considers whether increased exposure to victims' trauma is associated with increased supervision—believed necessary to combat trauma contagion—and whether such supervision will reduce the negative impact of such exposure. One hundred six women counselors in seven of nine rape crisis centers in Israel completed anonymous questionnaires documenting their work and trauma exposure. Trauma exposure was defined by counselors' number of victim-contact hours per week and their assessment of the trauma severity they experienced. Supervision was measured by the number of hours received. Counselors trauma outcome indicators included sexual intimacy, secondary traumatization (evidenced in posttraumatic stress disorder [PTSD]-type symptomology), and vicarious traumatization (expressed as a disturbance in cognitive schemes that undermine the self and others). Hypotheses were evaluated in fully recursive path analyses via ordinary least squares (OLS) regression. Participants' mean age was 43.4 years; 58% were married, 26% single, 13% divorced, and 3% widowed; 81% had a college degree or more; 18.9% reported being exposed to victims-trauma at a minimal level, 54.7% moderate and 26.4% extreme; and 43.4% were abused at some time

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in their lives. Job exposure to victims' trauma was significantly associated with increases in supervision time (β = .33, p = .002). Supervision time fully mediated the relationship between duration of exposure to victims' trauma and counselors' secondary traumatization reports such that increased supervision was associated with degrading sexual intimacy (β = .22; p = .032) and increased Secondary Trauma Scale scores (β = .44; p = .004) after taking into account counselors' education level, history of abuse, anger management in intimate relationship, and posttraumatic growth scores. The study results raise concern about counselors' mental health in that the supervision effect exacerbated the trauma contagion impacts. The study suggests a need for documenting the nature of the supervision and considering different types of supervision methods.

Keywords

rape crisis counseling, supervision, trauma contagion, sexual intimacy

Trauma is contagious, transmitted by association through the hearing or recalling a client's traumatic experience, and may affect counselors emotionally, physically, professionally, and interpersonally (Bride, 2004; Cook, Riggs, Thompson, Coyne, & Sheikh, 2004; Erez Shtark-Benyamin, 2011; Furlonger & Taylor, 2013; Ludick & Figley, 2017). The trauma contagious mechanism accounts for work-related stress experienced by professionals and nonprofessionals who directly assist the traumatized and others who live with them (Ludick & Figley, 2017). Anyone helping a rape survivor, even with the precautions taken by Rape Crisis Centers throughout the world, can be overwhelmed emotionally by what she hears and could even begin to experience, to a lesser degree, the same terror, rage, helplessness, and despair as the survivor of sexual violence (Rape Crisis Cape Town Trust, 2014). This study considers the efforts of Rape Crisis Centers in Israel to enable their counselors (volunteers and paid staff) to cope with such trauma contagion and its possible impacts via supervision.

There are different definitions to the negative impacts endured by counselors, which are used in an interlocking manner by many researchers (Tyre, Griffin, & Trippany-Simmons, 2016). Secondary traumatic stress is defined as the emotional and behavioral effect of experiencing the symptoms of post-traumatic stress disorder (PTSD) such as intrusiveness, avoidance behavior, and re-experiencing responses similar to the ones experienced by clients (Figley, 1995). While vicarious traumatization is more of a cognitive effect, defined as a transformation in cognitive schemes that undermine the self and

others due to empathetic engagement with trauma clients (McCann & Pearlman, 1990). Compassionate fatigue on the other hand is an emotional and physical exhaustion resulting from sustained empathic exposure to the pain of others (Bride & Figley, 2007; Figley, 1995); and burnout is described as emotional, physical, and psychological exhaustion that leaves counselors unable to provide ethical and competent services (Lambert & Lawson, 2013).

Among various traumatic events, sexual violence has been found to be the most pathogenic (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995). The consequences of trauma contagion related to sexual violence have been viewed as having an ever more encompassing negative impact on those who are recipients of their clients' stories (Figley, 1995, 2002; Schauben & Frazier, 1995). Such impacts include direct effects on secondary traumatic stress, vicarious traumatization, burnout, compassionate fatigue, and negative impacts on intimate relationships (Erez Shtark-Benyamin, 2011; Furlonger & Taylor, 2013; Lambert & Lawson, 2013; Ludick & Figley, 2017; Maltz, 1991; VanDeusen & Way, 2006). All of these experiences potentially affect counselors' professional performance (Jenkins & Baird, 2002). This study focuses on three forms of counselors' trauma contagion—secondary traumatic stress, vicarious traumatization, and particularly, given the nature of the reported trauma, on one aspect of intimate relationships, sexual intimacy.

Supervision and training provided to counselors has been well documented as a preventive measure of traumatization when assisting populations who endured direct trauma (Adams & Riggs, 2008; Courtois, Ford, & Cloitre, 2009; Dunkley & Whelan, 2006; Furlonger & Taylor, 2013; Harrison & Westwood, 2009). It has been widely recommended to provide adequate trauma-related supervision and training to counselors assisting trauma clients, as they have been identified as protective factors, especially for sexual violence counselors (Dunkley & Whelan, 2006; Follette, Polusny, & Milbeck, 1994; Harrison & Westwood, 2009; Schauben & Frazier, 1995; Sommer, 2008; Sommer & Cox, 2005; Trippany, White Kress, & Wilcoxon, 2004; Tyre et al., 2016).

Rape Crisis Center data in Israel (The Association of Rape Crisis Centers in Israel, 2016) suggest that one in three women experiences sexual assault during her lifetime. Because of this high prevalence, many professionals work with this population (Schauben & Frazier, 1995). Pearlman and Mac Ian (1995) found that sexual violence counselors experienced elevated levels of trauma symptoms. Schauben and Frazier (1995) report that counselors who encountered a higher percentage of sexual violence survivors experienced schema disturbance about themselves and others, PTSD symptoms, and self-reported vicarious trauma.

Studies have found that traumatized persons who suffer from PTSD may develop difficulties in intimate relationships (Cook et al., 2004). Their partners and close persons also appear to develop similar difficulties (Dekel & Solomon, 2006). Therapists who treat survivors of sexual violence experience higher levels of vicarious trauma compared with other trauma types (Cunningham, 2003), and show changes in their cognitive schemas related to trusting others and feeling intimate with others (Erez Shtark-Benyamin, 2011; VanDeusen & Way, 2006). Many therapists also experience difficulties in sexual intercourse (Pearlman & Mac Ian, 1995), where intrusive images of survivors' descriptions, or involuntary physical sensations, may invade as flashbacks during intercourse (Maltz, 1991).

Studies have identified a variety of risk factors for negative effects of trauma work, including female gender (Schauben & Frazier, 1995; Sprang, Clark, & Whitt-Woosely, 2007), personal trauma history (Adams & Riggs, 2008; Cunningham, 2003; Jenkins & Baird, 2002; Nelson-Gardell & Harris, 2003; VanDeusen & Way, 2006), particularly in childhood (Bride, 2004; Nelson-Gardell & Harris, 2003), exposure/high caseload of trauma clients (Cunningham, 2003; Pearlman & Mac Ian, 1995; Sprang et al., 2007), younger age of counselors (Arvay & Uhlemann, 1996; Sprang et al., 2007), and lack of experience or less experience in working with trauma clients (Bride, 2004; Cunningham, 2003; Devilly, Wright, & Varker, 2009; Sprang et al., 2007). It was also found that sexual violence counselors are survivors of various types of abuse themselves (VanDeusen & Way, 2006). Sexual violence counselors with a personal history of sexual abuse report higher levels of intrusive trauma-related images compared with counselors with no such history (Pearlman & Mac Ian, 1995).

Education of counselors has been noted as a potential resilience mechanism, buffering the negative impacts of PTSD, and vicarious traumatization (Finklestein, Stein, Greene, Bronstein, & Solomon, 2015; Tyre et al., 2016). In addition, trauma-related education and trainings are suggested to be protective in preparing counselors to cope with the consequences of vicarious trauma exposure (Calderón-Abbo, Kronenberg, Many, & Ososfsky, 2008; Trippany et al., 2004).

In contrast to the potential negative effects of trauma contagion, it has been clinically and empirically noted that trauma survivors also experience positive psychological changes, posttraumatic growth (PTG) following traumatic events (Cohen & Collens, 2013; Zoellner & Maercker, 2006). The more extreme the event a person experiences, the higher the prevalence of PTG (Tedeschi & Calhoun, 1996). Tedeschi, Park, and Calhoun (1998) describe these changes as including greater appreciation of life, identifying new opportunities, feeling internal strength, feeling closeness in relationships, and spiritual positive changes. Laufer and Solomon (2006) claim that

PTG is similar to PTSD in that it occurs in persons who have not experienced the trauma directly, such as therapists and care providers. Therefore, counselors can also experience a spectrum of feelings and emotions that include positive personal and professional outcomes (Ling, Hunter, & Maple, 2014). Both positive and negative impacts can be experienced and coexist in the same individual (Lambert & Lawson, 2013).

The Rape Crisis Centers in Israel provide diverse services to survivors of sexual violence and their families including: a 24-hour crisis intervention hotline (a prominent service), face-to-face counseling, and accompanying the survivors to the hospital and during the criminal process of pressing charges at police stations, confronting the perpetrator/s, and testifying in courts. These services are offered to survivors, their partners, and family members. All the services and other administrative activities at the centers are led by volunteer women counselors. Each counselor has to contribute at least three hours a week to center activities. The centers also provide survivors with group therapy and referrals to private therapists who are sexual violence specialists. In addition, as part of their educational programs, the centers train facilitators to conduct interactive workshops on sexual violence, and prevention programs to train professionals, educate and raise awareness of high school students and the general public.

To protect their counselors and paid staff and enable a positive environment for both the counselors and survivors, the centers base their practice on six principles. First, only counselors of 24 years of age and above are recruited to provide services to survivors so as to allow enough maturity to cope with the traumatic stories exposed by survivors. Second, prior to becoming counselors, women go through an intensive training course for 3 months, in which they learn how to provide services to survivors. Third, while volunteering, women are obligated to participate in supervision at least once a month, meetings where counselors share their experiences, thoughts and feelings with other counselors in addition to obtaining professional guidance on best practices. These supervision meetings are a mandatory requirement for providing services to survivors. Counselors start participating in the supervision meetings immediately after they start volunteering and assisting survivors of sexual violence. Fourth, counselors are encouraged to approach/reach out to staff members with challenges or difficulties they encounter during their interactions with survivors, especially if they cannot attend the group supervision. Fifth, counselors who do not attend supervision or seek individual assistance from staff members cannot continue volunteering. Finally, the centers provide services with "a woman for woman" feminist approach, meaning that a woman is the best person to understand sexual violence and violations conducted against other women, and therefore volunteering women have diverse professional backgrounds, not necessarily in a therapeutic field.

However, and despite all precautions undertaken by the centers, counselors are often overwhelmed, have ambiguous feelings, and need to avoid or distance themselves from providing services to survivors, to the extent of eventually leaving the centers, sometimes after a few months of their start date. This is why the centers have incorporated supervision meetings as part of their working setup, hoping to alleviate the psychological challenges and address counselors' distress when assisting survivors. It has been reported that counselors assisting populations in crisis may experience various emotions, such as anger, shock, confusion, ambiguity, demoralization, and traumatic responses (Dupre, Echterling, Meixner, Anderson, & Kielty, 2014). These emotions may interfere with counselors' judgment of best response to the needs of the client (Trippany et al., 2004; Tyre et al., 2016).

Knowing about the work potential for growth and the potential hazardous impacts in advance and being prepared to deal with them are critical to counselors' well-being (Sommer, 2008). Munroe (1999) encourages centers to warn counselors of the negative impact of trauma exposure and to train them to cope with it. Pearlman (1999) stresses the importance of continuous education pertaining trauma as a means of self-care. The American Counseling Association Code of Ethics (ACA; 2014) suggests that counselors should practice only after receiving relevant education, training, and supervision, when at the same time, supervisors must be appropriately trained. While Rosenbloom, Pratt, and Pearlman (1999) note that supervision for trauma counselors should be ongoing, Sommer and Cox (2005) recommend trauma-sensitive supervision that directly addresses vicarious traumatization and uses stories to facilitate meaning, making self-reflection a strength-based approach for trauma counselors.

This article addresses the potential of trauma contagion in the rape crisis interaction in an epidemiological framework. The structure of such contagion would involve transmission via exposure to survivors' traumatic experiences in the workplace—the Rape Crisis Centers. Exposure would be indicated by hours of exposure to traumatic stories and interactions, and the severity of trauma stories. The effects of exposure would be experienced in areas that are most related or proximate to the rape experience, such as sexual intimacy, as well as in secondary traumatic stress and vicarious traumatization. Given the Centers' operating principles, the risk of these negative outcomes is believed to be addressed by supervision assistance. Thus, the study considers two hypotheses. First, increased workplace exposure of counselors to their clients' trauma will result in increased supervision time. Second, supervision will mediate the negative effects of "trauma contagion," reducing its impact—reducing the potential impact on sexual intimacy, secondary traumatic stress, and vicarious traumatization.

Method

Between 2008 and 2011, 106 (24%) women of the 440 counselors at seven of the nine rape crisis centers for women in Israel anonymously completed study questionnaires on assessing exposure to survivors' trauma through work activity and its consequences. Two nonparticipating centers were located in northern Israel (Galil-Golan) and in Jerusalem (a center serving exclusively Jewish religious women). No incentives were provided for participation. Questionnaires were made available in a common area and returned to a secure location.

Scales were translated, back-translated, and validated in their Hebrew versions. The study was approved by the Tel-Aviv University and the Berkeley Campus Committees for the Protection of Human Subjects and experienced no problems in its implementation.

Procedure

Initial contacts with the directors of each center took place in which the aims of the study were explained via phone calls and formal emails. These contacts were followed by referrals and requests to the volunteers' coordinators to assist in recruiting participants. The researchers distributed the questionnaires among counselors in group or individual meetings at the centers after obtaining signed consent forms. Additional empty questionnaires were left in envelopes for potential participants at each center, at the hotline desk. Some counselors only reached the centers for the night shifts, making it impossible for the researchers to meet every woman in person. A note was attached to the empty questionnaires and consentt forms, requesting the counselors' participation at their convenience. Upon completion of the questionnaires, participants sealed the envelopes and left them in a secured box.

Prior to their participation, it was clarified to the counselors that their participation is anonymous and voluntary and that the data collected is for research purposes only and will not be utilized for the centers' purposes. Every three months, the researchers visited the centers and collected the sealed envelopes from the secured box. Data were protected in a secured alarmed office at the University of California, Berkeley during the data analysis and dissemination.

Theoretical Model: Concepts and Measurement

The following describes a causal model of trauma contagion and the potential mediation by agency supervision. It contains three trauma outcomes which

follow in time sequence a mediator (amount of supervision) influenced by two potential vectors and four confounders.

A. Trauma-contagion outcomes potentially associated with delivering rape crisis counseling:

- Sexual intimacy, a disrupted ability to be emotionally close in sexual interactions herein considered as a potential outcome of rape crisis counseling. The Sexual Intimacy Scale consisted of three items, rated from 1 "totally agree" to 6 "totally disagree." These items were originally generated as part of the Intimate Relationship Scale (Hershaleg, 1984). Higher scores indicated less capacity of an individual to have an intimate relationship with a partner. In the current study, the Sexual Intimacy Scale had an Alpha reliability = .36.

- Secondary traumatic stress was assessed with the Secondary Trauma Scale (STS; Motta, Kefer, Hertz, & Hafeez, 1999). The scale is derived from the delineation of symptomology for PTSD from the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; *DSM-5*; American Psychiatric Association, 2013) and from The Compassion Fatigue Self-Test for Psychotherapists (Figley, 1995). It has 20 Likert-type scale items (scored: 1 = "*disagree strongly*" to 5 = "*agree strongly*") reflecting the major PTSD criteria: re-experiencing the trauma (the emotional distress of the person who had been traumatized); avoidance (of thoughts, feelings, images, and situations that remind the person of the negative effect of the traumatic event); and, increase arousal (evidenced as irritability, difficulty falling asleep, and hypervigilance). Higher scores indicate increased secondary traumatic stress. Herein, the scale's Alpha reliability was .91. Only 54 assessments using the Secondary Traumatic Stress Scale were obtained as this scale was added to the questionnaire halfway through the data gathering.

- Vicarious traumatization was assessed with the Trauma and Attachment Beliefs Scale (TABS; Pearlman, 2003). The scale assesses beliefs and perceptions around five issues: feeling safe from harm, feeling connected, being able to depend on or trust, managing feelings and behaviors, and feeling valued and valuing oneself and others. The scale comprises 84 Likert-type-scale items (scored: 1 = "*disagree strongly*" to 6 = "*agree strongly*"). Higher scores reflect greater vicarious traumatization, meaning, greater disturbance in cognitive schemes that undermine the self and others in the above five dimensions. Scale Alpha in the current sample was .94.

B. Potential vectors of trauma contagion associated with providing rape crisis counseling are as follows:

- Time of exposure to client's trauma, that is, the average number of hours per week the counselor was exposed to victims' descriptions of their trauma.
- Severity of client's trauma story rated as "Minimal" = 1; "Moderate" = 2; or "Extreme" = 3.

C. Potential confounders: Factors that may account for observed trauma contagion that are not job related or may serve as a protection against trauma contagion.

- Past history of trauma: Did the counselor have a history of personally experiencing trauma (Yes = 1; No = 0) based on a response to a modified version of The Traumatic Events Questionnaire (TEQ; Varna & Lauterbach, 1994). The TEQ contains 17 traumatic events, each asking whether the participant had or had not experienced the event. In this study, we did not use the full 17 items, but rather the following events: child sexual abuse, child physical abuse, child emotional abuse, adult sexual abuse, and adult partner abuse.
- Anger Management in Intimate Relationship Scale, also generated from the Intimate Relationship Scale (Hershaleg, 1984), measures the ability of dealing with anger in intimate relationships: The openness to express anger and frustration to the partner and the ability to receive those from the partner. It was included as a control in that sexual relationships may be significantly affected by how individuals cope with consequent anger following exposure to sexual violence of survivors. The scale consists of four items, rated from 1 "*totally agree*" to 6 "*totally disagree*." Higher scores indicate less capacity for anger management. Herein, the reliability of the scale was Alpha = .55.
- Education: Did the counselor have at least a college education? (Yes = 1; No = 0)
- Posttraumatic Growth Inventory (PTGI; Tedeschi & Calhoun, 1996): This scale has 21 six-category Likert-type items (scored "did not experience" = 0 to "experienced to a great degree" = 5) that measure the salutary impacts of the exposure to traumatic events and the positive changes they might engender in participants. The scale's dimensions are appreciation of life, identifying new opportunities in life and pursued goals, internal strength that

participants attribute to themselves, relationships and relating to others, and spiritual change and assessment of spiritual life. The scale herein has a reliability of Alpha = .94.

D. Potential Mediator—that is, the rape crisis centers' means of helping their counselors in teaching them self-care skills and provide a supportive space, are hoped to defend them against trauma contagion.

- Frequency of Supervision scored as "Once a week" = 5; "Twice a month" = 4; "Once a month" = 3; "Less than once a month" = 2; "None" = 1.

It should be clear that questionnaire items ask about previous supervision and that the outcomes assessed are at the time of the individual's response to the questionnaire items.

Analyses

Data were analyzed using SPSS version 23. Univariate descriptive statistics were computed as well as Alpha reliabilities for major scales. Hypotheses were evaluated in fully recursive path analyses via ordinary least squares (OLS) regression where supervision frequency was regressed on client-exposure-time, severity-of-exposure, and the four confounders and/or protective factors: education, having a history of experiencing personal abuse, posttraumatic growth, and ability to manage anger in an intimate relationship. The three trauma outcome criteria were then regressed on all these variables including supervision time.

Results

Participants had a mean age of 43.4 years (ranging from 24 to 69; $n = 106$); 26% ($n = 28$) were single, 58% ($n = 61$) married, 13% ($n = 14$) divorced, and 3% ($n = 3$) widowed; 81.1% ($n = 86$) had a college degree or more education. They mostly, 80.0% ($n = 84$), described themselves as secular in their religious beliefs.

In all, 43.4% ($n = 46$) of the participating women were abused in one or more of the following ways either by child sexual abuse 12% ($n = 13$), child physical abuse 8% ($n = 8$), child emotional abuse 21% ($n = 22$), adult sexual abuse 22% ($n = 23$), adult partner abuse 2% ($n = 2$); 55.6% ($n = 59$) were not abused in this way.

Table 1 describes the rape crisis center experience of the counselors. Most of the counselors were volunteers (90.6%, $n = 96$). They had been at the rape crisis center for an average of 3.1 years ($SD \pm 2.7$). They attended to less than

Table 1. Counselors Experience in the Rape Crisis Centers.

Variable	M (SD)	n
Years at Center	3.07 (2.66)	106
Center Position		
Volunteer	90.6%	96
Coordinator	9.4%	10
Severity of Victim Trauma Exposure on Job		
Minimal	18.9%	20
Moderate	54.7%	58
Extreme	26.4%	28
Hours of Victim Trauma Exposure on Job		
Under 3 hr	76%	81
Above 3 hr	24%	25
Frequency of Supervision		
Once a week	3.8%	4
Twice a month	17.0%	18
Once a month	62.3%	66
Less than once a month	13.2%	14
None	3.8%	4

10 calls from survivors per week (84.9%, $n = 90$)and were exposed to traumatic experiences of survivors between 1 and 3 hours (76%, $n = 81$)–the content of which was most likely to be viewed as moderately severe (54.7%, $n = 58$). All counselors received supervision (a majority once each month (62.3%, $n = 66$). Only four participants did not report on the frequency of received supervision.

Table 2 includes the bivariate correlation between all variables included in the theoretical models.

Two of the three path models were significant—the model predicting sexual intimacy ($R = .46$, $R^2 = .21$, Adj. $R^2 = .16$, $F = 3.62$, $df = 7, 93$, $p = .002$) and the one predicting secondary traumatic stress ($R = .55$, $R^2 = .30$, Adj. $R^2 = .19$, $F = 2.73$, $df = 7, 44$, $p = .019$); the model predicting vicarious traumatization was not significant. Table 3 includes the six regressions supporting the mediation effect of "frequency of supervision" for these two criterion variables. The path model describing the sexual intimacy outcomes is illustrated in Figure 1. The model indicates that the effect of hours of exposure to victims' trauma on the job was completely mediated by supervision. Increases in hours of exposure to survivors' trauma lead to increased access to supervision ($\beta = .33$, $t = 3.13$, $p = .002$). Increased supervision time significantly degraded sexual intimacy ($\beta = .22$, $t = 2.18$, $p = .032$). In addition, poorer anger

Table 2. Bivariate Correlations Between All Variables Included in the Theoretical Models.

	Sexual Intimacy (N = 106)	Anger Management (N = 106)	History of Abuse (N = 105)	Duration of Victim Report Exposure on Job (N = 106)	Posttraumatic Growth (N = 106)	Severity of Victim Reports (N = 106)	Education (N = 106)	Frequency of Supervision (N = 102)	Secondary Traumatic Stress (N = 54)
Sexual Intimacy	1								
Anger Management	.272	1							
History of Abuse	.166	−.015	1						
Duration of Victim Report Exposure on Job	.064	−.261	−.028	1					
Posttraumatic Growth	−.150	−.062	.158	.156	1				
Severity of Victim Reports	−.053	−.106	.014	.349	−.122	1			
Education	.101	.033	−.158	−.040	−.176	.090	1		
Frequency of Supervision	.145	−.176	−.124	.359	.132	.046	.158	1	
Secondary Traumatic Stress	.253	.151	.168	.266	.039	.037	.026	.408	1

Table 3. Factors in Rape Crisis Counseling Associated With Sexual Intimacy and Secondary Traumatic Stress.

Model Criterion	Sexual Intimacy[a]					Frequency of Supervision[b]					Sexual Intimacy[c]				
Variable	B	SE	β	t	Sig.	b	SE	β	t	Sig.	b	SE	β	t	Sig.
Anger Management	.24	.07	.31	3.25	.002	−.04	.03	−.10	−1.05	.298	.25	.07	.33	3.47	.001
History of Abuse	.68	.28	.28	2.44	.017	−.12	.13	−.09	−.95	.345	.57	.27	.20	2.10	.039
Duration of Victim Report Exposure on Job	.49	.22	.23	2.23	.028	.34	.11	.33	3.13	.002	.11	.24	.05	.48	.629
Posttraumatic Growth	−.02	.01	−.19	−1.96	.053	.00	.00	.10	1.04	.301	−.02	.01	−.21	−2.14	.035
Severity of Victim Reports	−.31	.22	−.14	−1.40	.165	−.08	.10	−.08	−.78	.437	−.20	.22	−.09	−.92	.362
Education	.45	.36	.12	1.28	.205	.28	.17	.16	1.67	.098	.44	.35	.12	1.25	.214
Frequency of Supervision	—					—					.47	.21	.22	2.18	.032
Model Statistics	$R = .43$, Adj. $R^2 = .13$, $F_{(6, 98)} = 3.67$, $p = .003$					$R = .43$, Adj. $R^2 = .13$, $F_{(6, 94)} = 3.49$, $p = .004$					$R = .46$, Adj. $R^2 = .16$, $F_{(7, 93)} = 3.62$, $p = .002$				

Model Criterion	Secondary Traumatic Stress[a]					Frequency of Supervision[d]					Secondary Traumatic Stress[c]				
Variable	B	SE	β	t	Sig.	b	SE	β	t	Sig.	b	SE	β	t	Sig.
Anger Management	1.32	.88	.21	1.50	.141	−.04	.06	−.08	−.60	.553	1.54	.83	.25	1.86	.069
History of Abuse	4.97	3.38	.21	1.47	.149	−.15	.23	−.09	−.64	.526	5.87	3.18	.24	1.85	.071
Duration of Victim Report Exposure on Job	5.65	2.48	.35	2.28	.027	.40	.17	.35	2.37	.022	3.20	2.45	.20	1.30	.199
Posttraumatic Growth	.03	.14	.03	.21	.836	.01	.01	.20	1.36	.181	−.05	.14	−.05	−.38	.707
Severity of Victim Reports	−1.43	2.60	−.08	−.55	.586	−.08	.18	−.06	−.46	.650	−.923	2.49	−.05	−.37	.713
Education	4.06	5.26	.11	.77	.445	.49	.36	.19	1.38	.174	1.03	5.00	.03	.21	.838
Frequency of Supervision	—					—					6.126	2.04	.44	3.00	.004
Model Statistics	$R = .40$, Adj. $R^2 = .05$, $F_{(6, 48)} = 1.47$, $p = .209$					$R = .50$, Adj. $R^2 = .15$, $F_{(6, 45)} = .47$, $p = .038$					$R = .55$, Adj. $R^2 = .19$, $F_{(7, 44)} = 2.73$, $p = .019$				

[a]Sexual Intimacy and Secondary Traumatic Stress. Models *without* mediation of Frequency of Supervision.
[b]Frequency of Supervision Model with $N = 101$.
[c]Sexual Intimacy and Secondary Traumatic Stress. Models *with* mediation of Frequency of Supervision.
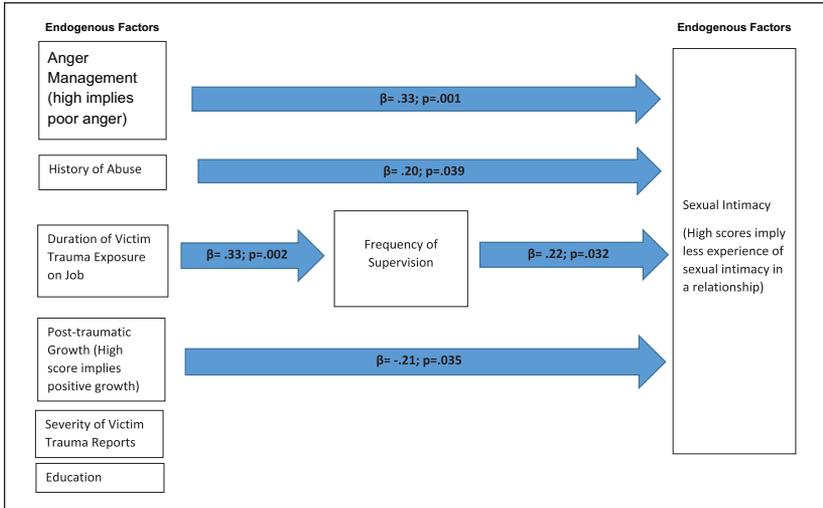[d]Frequency of Supervision Model with $N = 51$.

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Figure 1. Factors affecting the experience of sexual intimacy mediated by the amount of supervision received by rape crisis counselors.
Note. Equation 1: $R = .55$, $R^2 = .30$, Adj. $R^2 = .19$; $F = 2.73$; $df = 7, 94$; $p = .019$.
Equation 2: $R = .46$, $R^2 = .21$, Adj. $R^2 = .16$; $F = 3.62$; $df = 6, 93$; $p = .002$.

management ($\beta = .33$, $t = 3.47$, $p = .001$) and having been abused had negative impacts on sexual intimacy ($\beta = .20$, $t = 2.10$, $p = .039$). Posttraumatic growth had a positive impact on sexual intimacy ($\beta = -.21$, $t = -2.14$, $p = .035$).

The path model describing secondary traumatic stress outcomes is illustrated in Figure 2. This model indicates that the hours of exposure to survivors' trauma on the job significantly increased supervision time ($\beta = .35$, $t = 2.37$, $p = .022$). Supervision time mediated the relationship between job exposure and secondary traumatic stress. Increased supervision time was associated with increased secondary traumatic stress ($\beta = .44$, $t = 3.00$, $p = .004$).

Discussion

Therapists of sexual violence victims demonstrate a wide range of mental distress (Schauben & Frazier, 1995). This study addressed the issue of the range of such effects on counselors at the Rape Crisis Centers in Israel by considering three criteria, each of which appeared with reflect a potentially broader impact of trauma exposure to sexual violence—that is, sexual intimacy, secondary traumatic stress, and vicarious traumatization, when frequency of supervision is a mediating variable. The study's main finding is
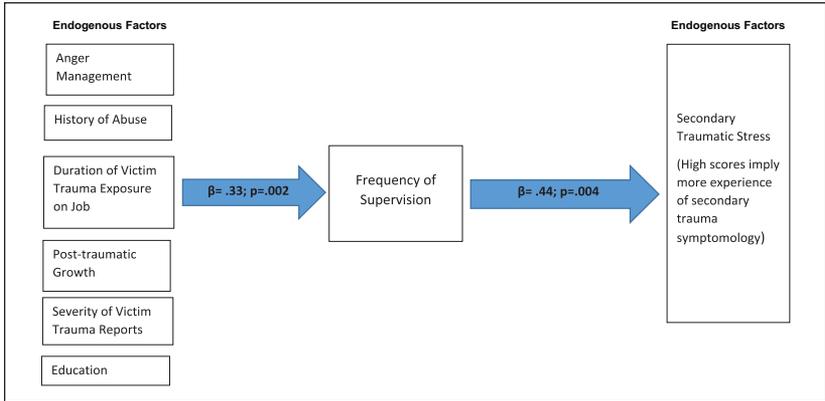
Figure 2. Factors affecting the experience of secondary traumatic stress mediated by the amount of supervision received by rape crisis counselors.
Note. Equation 1: $R = .55$, $R^2 = .30$, Adj. $R^2 = .19$; $F = 2.73$; $df = 7, 94$; $p = .019$.
Equation 2: $R = .43$, $R^2 = .18$, Adj. $R^2 = .13$; $F = 3.49$; $df = 6, 93$; $p = .004$.

that increased supervision was associated with counselor's experience of decreased sexual intimacy and increased secondary traumatic stress even after taking into account the level of anger management, the counselor's history of being abused, the duration and severity of exposure to client's trauma, posttraumatic growth and their level of education. One might be tempted to interpret this finding differently—for example, one might wish to conclude that participants were looking for more supervision because of the level of secondary traumatic stress and decreased sexual intimacy they were experiencing and that this was a good thing. Unfortunately, given the time ordering of the assessment, the participants got the supervision before the reported secondary traumatic stress and sexual intimacy problems.

Despite the prevalence of telephone counseling services, we found no studies that addressed the most direct potential effect of exposure to sexual violence on sexual intimacy. Only a small number of studies considered the exposure effects of secondary traumatic stress and vicarious traumatization of telephone counseling (Dunkley & Whelan, 2006; Furlonger & Taylor, 2013; Mauldin, 2001) and only one study addressed therapist sexual attitudes (Erez Shtark-Benyamin, 2011). This study showed significant effects on decreased sexual intimacy and, in concordance with the literature, associated increases in symptoms of secondary traumatic stress (Schauben & Frazier, 1995).

Supervision is believed to potentially provide a safe environment within which counselors can process their responses to trauma work and develop

self-awareness, self-efficacy, and enhance professional competence, enabling better trauma responses, and mechanisms of self-care (Adams & Riggs, 2008; Bride & Figley, 2007; Courtois et al., 2009; Finklestein et al., 2015; Follette et al., 1994; Harrison & Westwood, 2009). While supervision has been clinically linked to acting as a preventive measure for secondary trauma stress through enhancing counselors' awareness of their internal process of recognizing potential negative responses when involved in trauma work, and consequently enabling engagement in positive coping strategies (Adams & Riggs, 2008; Courtois et al., 2009; Dunkley & Whelan, 2006; Harrison & Westwood, 2009; Wheeler, 2007), the positive effect of supervision has been inconsistently supported in the trauma literature (Bober & Regehr, 2006; Furlonger & Taylor, 2013; Sabin-Farrell & Turpin, 2003). There is also little research that supports the presumption that supervision improves the effects of vicarious traumatization on telephone and online counselors (Furlonger & Taylor, 2013; Mauldin, 2001). Counselors often avoid receiving supervision (Dunkley & Whelan, 2006; Wheeler & Richards, 2007) due to feelings of anxiety and shame. They also doubt their professional qualifications in dealing with trauma clients (Finklestein et al., 2015; Furlonger & Taylor, 2013; Munroe, 1999).

Vicarious traumatization is supposed to have an impact on the well-being of telephone counselors (Dunkley & Whelan, 2006; Mauldin, 2001). Nonetheless, in this study, we did not find a significant correlation between vicarious traumatization and other variables in the study. The findings herein are not concordant with the theoretical framework on vicarious traumatization (McCann & Pearlman, 1990), but in line with other studies that documented similar results when not finding significant correlations between vicarious traumatization and other variables. Studies have also failed to find counselors with high levels of vicarious trauma among those providing assistance to survivors of sexual violence (Brady, Guy, Polestra, & Brokaw, 1999; Mauldin, 2001). Similar to the current study, Brady et al. (1999) found that while female counselors with high exposure to sexually abused clients reported significant posttraumatic symptoms, they did not show significant disruptions in cognitive schemas. Two other studies found levels of vicarious traumatization to be average to low among telephone counselors (Dunkley & Whelan, 2006; Mauldin, 2001). It thus appears that while their personal lives are disrupted by secondary trauma stress, we find no reason to believe that their exposure has created in them the disturbance in cognitive schemes that is thought to be the defining characteristic of vicarious traumatization.

Furlonger and Taylor (2013) investigated the effects of supervision on the management of vicarious traumatization among telephone and online counselors in Australia. They did not find significant correlations between supervision and vicarious traumatization, though the size of counselors' trauma

caseload was found to be strongly related to both vicarious traumatization and negative coping styles. Trauma caseload has been also associated with negative coping styles and vicarious traumatization in other studies (Arvay & Uhlemann, 1996; Bride, 2004; Schauben & Frazier, 1995). Furlonger and Taylor claim that such findings may occur due to the fact that only 44% of the counselors work with trauma cases and that vicarious traumatization may be associated with the clients' type of trauma. However, Mauldin (2001) who studied only sexual assault workers (trauma cases) still reported low scores of vicarious traumatization.

Another significant finding of this study is that posttraumatic growth appears to have a positive direct effect on sexual intimacy. This finding is concordant with theoretical framework and empirical studies related to the positive outcomes of working with survivors of trauma (Pearlman & Mac Ian, 1995) and survivors of sexual trauma (Schauben & Frazier, 1995). Most studies reported positive changes on counselors' perspective about life, significance of their work, improvement in interpersonal skills, higher spirituality, compassion, and sensitivity (Arnold, Calhoun, Tedeschi, & Cann, 2007; Pearlman & Mac Ian, 1995). To our knowledge, none of these studies have findings related to sexual intimacy.

In acknowledging the impact of their work on their mental health and personal lives, this research holds great importance to counselors and other professionals working with survivors of sexual violence. Such acknowledgment can support them in reflecting that "they are not alone," especially when feeling deluge, overwhelmed by survivors' experiences and exhaustion. Rape crisis centers, while attempting to provide emotional support to counselors, need to find different strategies of helping them cope with the consequences of their interactions with survivors. The study's findings also may help explain the diverse feelings counselors have during the job performance as secondary traumatic stress (i.e., avoidance, overwhelmed, ambiguous feelings), and enable the centers to better address their high volunteer turnover rate, increase counselors' continuity and decrease centers training costs. Successively, survivors of sexual violence could benefit from a higher quality of provided services and more experienced and capable counselors.

Traumatization of therapists can affect not only their lives but also those of their clients. Effected therapists function less effectively and professionally (Arvay & Uhlemann, 1996). Many studies have stressed that there is a need for professional training, trauma-sensitive supervision and debriefing for trauma counselors (Mauldin, 2001; Sommer, 2008). The supervision in the rape crisis centers is usually a supportive group setting where counselors share their thoughts and feelings, in addition to survivors' trauma stories, with the rest of the women in the group and a group facilitator. Sommer (2008) stresses

the importance of providing counselors with trauma-sensitive supervision. The Prolonged Exposure Therapy (Foa, Hembree, & Rothbaum, 2007) based on cognitive behavioral therapy (CBT) is designed to help PTSD patients emotionally process traumatic events and reduce trauma-induced psychological disturbances. Although most clinicians do not usually use CBT (Rosen et al., 2004) meta-analytic findings indicate that it has the greatest effects (Bradley, Greene, Russ, Dutra, & Westen, 2005; Van Etten & Taylor, 1998). Prolonged exposure therapy is characterized by re-experiencing the traumatic event in a safe environment through remembering and engaging with it (Foa et al., 2007). In the process, a patient is asked to vividly recount a traumatic event repeatedly until the patient's emotional response decreases to gradually confront safe but fear-evoking trauma triggers (Foa & Rothbaum, 1998).

When compared with other supportive therapy techniques, Prolonged Exposure was found to be greater in reduction of PTSD symptoms (Schnurr et al., 2007). Prolonged exposure included education about reactions to trauma, breathing skills, repeated recounting of trauma memories during sessions, homework, and discussion of thoughts and feelings related to exposure exercises, all in a structured manual with specific content (Foa & Rothbaum, 1998).

Supervision that includes sharing of traumatic experiences of survivors in a group setting might re-expose counselors to additional traumatic experiences of each other, especially if not emotionally processed in an adequate manner, and therefore lead to additional secondary traumatic stress. This may explain in part the results of the decreased sexual intimacy and increased secondary traumatic stress of counselors who consumed increased supervision. Supervision based on Prolonged Exposure or CBT might have a different impact on counselors; however, such supervision methods need to be empirically studied.

The study findings are based on correlation and do not establish causation. The study is cross-sectional and thus relies on time ordering in the assessment to establish causal direction—most notably the fact that the trauma indicator assessments were made *after* the supervision had been experienced. The sexual intimacy scale was based on only three items, consequently yielding a low internal consistency score. Further scale development on the measurement of sexual intimacy would be useful in this area of research. This research area could also benefit from experimentation with new models of intervention that would enable counselors of rape crisis centers to better cope with exposure to their clients' trauma—especially studies that were longitudinal in nature and more focused on proximate outcomes associated with the quality of the counselors' sexual relationships.

In summary, rape crisis centers need to find different preventive strategies to protect their paid staff and volunteers from the traumatizing effects of exposure to clients' sexual violence experiences.

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Declaration of Conflicting Interests

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References

Adams, S. A., & Riggs, S. A. (2008). An exploratory study of vicarious trauma among therapist trainees. *Training and Education in Professional Psychology*, *2*, 26-34.

American Counseling Association. (2014). *ACA code of ethics*. Alexandria, VA: Author.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: American Psychiatric Publishing.

Arnold, D., Calhoun, L., Tedeschi, R., & Cann, A. (2007). Vicarious posttraumatic growth in psychotherapy. *Journal of Humanistic Psychology*, *45*, 239-263.

Arvay, M. J., & Uhlemann, M. R. (1996). Counsellor stress in the field of trauma: A preliminary study. *Canadian Journal of Counselling and Psychotherapy*, *30*, 193-210.

The Association of Rape Crisis Centers in Israel. (2016). Retrieved from http://www.1202.org.il/en/union/info/statistics/general-statistics

Bober, T., & Regehr, C. (2006). Strategies for reducing secondary or vicarious trauma: Do they work? *Brief Treatment and Crisis Intervention*, *6*, 1-9.

Bradley, R., Greene, J., Russ, E., Dutra, L., & Westen, D. (2005). A multidimensional meta-analysis of psychotherapy for PTSD. *The American Journal of Psychiatry*, *162*, 214-227.

Brady, J. L., Guy, J. D., Polestra, P. L., & Brokaw, B. F. (1999). Vicarious traumatization, spirituality, and the treatment of sexual abuse survivors: A national survey of women psychotherapists. *Professional Psychology Research & Practice*, *30*, 386-393.

Bride, B. E. (2004). The impact of providing psychosocial services to traumatized populations. *Stress, Trauma, and Crisis*, *7*, 29-46.

Bride, B. E., & Figley, C. R. (2007). The fatigue of compassionate social workers: An introduction to the special issue on compassion fatigue. *Clinical Social Work Journal*, *35*, 151-153.

Calderón-Abbo, J., Kronenberg, M., Many, M., & Ososfsky, H. (2008). Fostering healthcare providers' post-traumatic growth in disaster areas: Proposed additional core competencies in trauma-impact management. *American Journal of the Medical Sciences*, *336*, 208-214.

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*, 570-580.

Cook, J. M., Riggs, D. S., Thompson, R., Coyne, J. C., & Sheikh, J. I. (2004). Posttraumatic stress disorder and current relationship functioning among World War II ex-prisoners of war. *Journal of Family Psychology*, *18*, 36-45.

Courtois, C. A., Ford, J. D., & Cloitre, M. (2009). Best practices in psychotherapy for adults. In C. A. Courtois & J. D. Ford (Eds.), *Treating complex traumatic stress disorders: An evidence-based guide* (pp. 202-224). New York, NY: Guildford Press.

Cunningham, M. (2003). Impact of trauma work on social work clinicians: Empirical findings. *Social Work*, *48*, 451-459.

Dekel, R., & Solomon, Z. (2006). Secondary traumatization among wives of Israeli POWs: The role of POWs' distress. *Social Psychiatry and Psychiatric Epidemiology*, *41*, 27-33.

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*, 373-385.

Dunkley, J., & Whelan, T. A. (2006). Vicarious traumatization in telephone counsellors: Internal and external influences. *British Journal of Guidance & Counselling*, *34*, 451-469.

Dupre, M., Echterling, L. G., Meixner, C., Anderson, R., & Kielty, M. (2014). Supervision experiences of professional counselors providing crisis counseling. *Counselor Education and Supervision*, *53*, 82-96.

Erez Shtark-Benyamin, K. (2011). *The relations between treatment of sexual violence victims, level of empathy and the therapist's sexual attitudes* (Master's thesis). Tel-Aviv University, Tel-Aviv, Israel.

Figley, C. R. (1995). Compassion fatigue as secondary traumatic stress disorder: An overview. In C. R. Figley (Ed.), *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized* (pp. 1-20). New York, NY: Brunner/Mazel.

Figley, C. R. (2002). Introduction. In C. R. Figley (Ed.), *Treating compassion fatigue* (pp. 1-14). New York, NY: Brunner-Routledge.

Finklestein, M., Stein, E., Greene, T., Bronstein, I., & Solomon, Z. (2015). Posttraumatic stress disorder and vicarious trauma in mental health professionals. *Health & Social Work*, *40*(2), e25-e31.

Foa, E. B., Hembree, E. A., & Rothbaum, B. O. (2007). *Prolonged Exposure Therapy for PTSD: Emotional processing of traumatic experiences* (Therapist Guide). New York, NY: Oxford University Press.

Foa, E. B., & Rothbaum, B. O. (1998). *Treating the trauma of rape: Cognitive-behavioral therapy for PTSD*. New York, NY: Guilford.

Follette, V. M., Polusny, M. M., & Milbeck, K. (1994). Mental health and law enforcement professionals: Trauma history, psychological symptoms, and impact of providing services to child sexual abuse survivors. *Professional Psychology: Research and Practice*, *25*, 275-282.

Furlonger, B., & Taylor, W. (2013). Supervision and the management of vicarious traumatisation among Australian telephone and online counsellors. *Australian Journal of Guidance and Counselling*, *23*, 82-94.

Harrison, R., & Westwood, M. (2009). Preventing vicarious trauma of mental health therapists: Identifying protective practices. *Psychotherapy Theory, Research, Practice, Training*, *46*, 203-219.

Hershaleg, A. (1984). *Intimacy and mutual familiarity of emotions among married couples in the city and Kibbutz* (Master's thesis). Haifa University, Haifa, Israel.

Jenkins, S. R., & Baird, S. (2002). Secondary traumatic stress and vicarious trauma: A validational study. *Journal of Traumatic Stress*, *15*, 423-432.

Kessler, R., Sonnega, A., Bromet, E., Hughes, M., & Nelson, C. (1995). Posttraumatic stress disorder in the national comorbidity survey. *Archives of General Psychiatry*, *52*, 1048-1060.

Lambert, S. F., & Lawson, G. (2013). Resilience of professional counselors following hurricanes Katrina and Rita. *Journal of Counseling & Development*, *91*, 261-268.

Laufer, A., & Solomon, Z. (2006). Posttraumatic symptoms and posttraumatic growth among Israeli youth exposed to terror incident. *Journal of Social & Clinical Psychology*, *25*, 429-447.

Ling, J., Hunter, S. V., & Maple, M. (2014). Navigating the challenges of trauma counseling: How counselors thrive and sustain their engagement. *Australian Social Work*, *67*, 297-310.

Ludick, M., & Figley, C. R. (2017). Toward a mechanism for secondary trauma induction and reduction: Reimagining a theory of secondary traumatic stress. *Traumatology*, *23*, 112-123.

Maltz, W. (1991). Caution: Treating sexual abuse can be hazardous to your love life. *Treating Abuse Today*, *2*, 20-24.

Mauldin, A. L. (2001). *Vicarious traumatization among sexual assault hotline workers* (Doctoral dissertation). University of Memphis, Tennessee.

McCann, I. L., & Pearlman, L. A. (1990). Vicarious traumatization: A framework for understanding the psychological effects of working with victims. *Journal of Traumatic Stress*, *3*, 131-149.

Motta, R. W., Kefer, J. M., Hertz, M. D., & Hafeez, S. (1999). Initial evaluation of the secondary trauma questionnaire. *Psychological Reports*, *85*, 997-1002.

Munroe, J. (1999). Ethical issues associated with secondary trauma in therapists. In B. H. Stamm (Ed.), *Secondary traumatic stress: Self-care issues for clinicians, researchers, and educators* (2nd ed., pp. 211-229). Lutherville, MD: Sidran Press.

Nelson-Gardell, D., & Harris, D. (2003). Childhood abuse history, secondary traumatic stress, and child welfare workers. *Child Welfare*, *82*, 5-26.

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

Pearlman, L. A. (2003). *The trauma attachment belief scale manual*. Los Angeles, CA: 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*, 558-565.

Rape Crisis Cape Town Trust. (2014). Retrieved from http://rapecrisis.org.za/infor-mation-for-survivors/vicarious-trauma/

Rosen, C. S., Chow, H. C., Finney, J. F., Greenbaum, M. A., Moos, R. H., Sheikh, J. I., & Yesavage, J. A. (2004). VA practice patterns and practice guidelines for treating posttraumatic stress disorder. *Journal of Traumatic Stress*, *17*, 213-222.

Rosenbloom, D., Pratt, A., & Pearlman, L. (1999). Helpers' responses to trauma work: Understanding and intervening in an organization. In B. H. Stamm (Ed.), *Secondary traumatic stress: Self-care issues for clinicians, researchers, and edu-cators* (2nd ed., pp. 65-79). Lutherville, MD: Sidran Press.

Sabin-Farrell, R., & Turpin, G. (2003). Vicarious traumatization: Implications for the mental health of health workers? *Clinical Psychology Review*, *23*, 449-480.

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*, 49-64.

Schnurr, P. P., Friedman, M. J., Engel, C. C., Foa, E. B., Shea, M. T., Chow, B. K., . . . Bernardy, N. (2007). Cognitive behavioral therapy for posttraumatic stress dis-order in women: A randomized controlled trial. *Journal of the American Medical Association*, *297*, 820-830.

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

Sommer, C. A., & Cox, J. (2005). Elements of supervision in sexual violence coun-selors' narratives: A qualitative analysis. *Counselor Education and Supervision*, *45*, 119-134.

Sprang, G., Clark, J. J., & Whitt-Woosely, A. (2007). Compassion fatigue, compas-sion satisfaction, and burnout factors impacting a professional's quality of life. *Journal of Loss and Trauma*, *12*, 259-280.

Tedeschi, R. G., & Calhoun, L. G. (1996). The Posttraumatic Growth Inventory: Measuring the positive legacy of trauma. *Journal of Traumatic Stress*, *9*, 455-471.

Tedeschi, R. G., Park, C. L., & Calhoun, L. G. (1998). Posttraumatic growth: Conceptual issues. In R. G. Tedeschi, C. L. Park, & L. G. Calhoun (Eds.), *Posttraumatic growth: Positive changes in the aftermath of crisis* (pp. 1-22). Mahwah. NJ: Lawrence Erlbaum.

Trippany, R., White Kress, V., & Wilcoxon, S. (2004). Preventing vicarious trauma: What counselors should know when working with trauma survivors. *Journal of Counseling & Development*, *81*, 31-37.

Tyre, Y., Griffin, M., & Trippany-Simmons, R. (2016). Building resiliency in counselors in training for counselors educators. *Alabama Counseling Association Journal*, *41*, 25-44.

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*, 69-85.

Van Etten, M. L., & Taylor, S. (1998). Comparative efficacy of treatments for posttraumatic stress disorder: A meta-analysis. *Clinical Psychology & Psychotherapy*, *5*, 126-144.

Varna, S., & Lauterbach, D. (1994). Prevalence of traumatic events and post-traumatic psychological symptoms in a non-clinical sample of college students. *Journal of Traumatic Stress*, *7*, 289-302.

Wheeler, S. (2007). What shall we do with the wounded healer? The supervisor's dilemma. *Psychodynamic Practice: Individuals, Groups and Organizations*, *13*, 245-256.

Wheeler, S., & Richards, K. (2007). The impact of clinical supervision on counsellors and therapists, their practice and their clients. A systematic review of the literature. *Counselling & Psychotherapy Research*, *7*, 54-65.

Zoellner, T., & Maercker, A. (2006). Posttraumatic growth in clinical psychology—A critical review and introduction of a two component model. *Clinical Psychology Review*, *26*, 626-653.

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