Journal of
FORENSIC NURSING
THE OFFICIAL JOURNAL OF THE INTERNATIONAL ASSOCIATION OF FORENSIC NURSES

REVIEW ARTICLE

Vicarious traumatization: Concept analysis

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Keywords
Burn out; compassion fatigue; forensic nursing; post-traumatic stress disorder; secondary traumatic stress; vicarious traumatization.

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Received: November 11, 2010; accepted: April 5, 2011

doi: 10.1111/j.1939-3938.2011.01115.x

Abstract

There is growing knowledge of the effects of stress on professionals, including various negative symptoms that may mirror the biopsychosocial effects exhibited by the victims of trauma. Multiple concepts including burn out, compassion fatigue, post-traumatic stress disorder (PTSD), and secondary traumatic stress, are terms that have been incorrectly interchanged with the term vicarious traumatization (VT). Clarity of vicarious victimization and understanding contributing factors is imperative in order to facilitate future research and implement timely and effective interventions, as well as sculpt evidence based practice. This concept anaylsis, complete with a concept map, discusses VT; related terminology; symptomology; prevention and relevant interventions; and discusses opportunities for personal/professional growth for nurses and especially forensic nurses working with victims of violence.

Introduction

Vicarious traumatization (VT), with repetitive invasion of another's trauma, affects the sense of belonging, relationships, and perspective on life. VT negatively alters personal feelings, beliefs, values, and judgments. It may also affect sense of survival, safety and security, cognitive functioning, sense of love and belonging, self-esteem and self actualization (United States Department of Justice, 2007). Nurses face numerous stressors every day, as do law enforcement workers, mental health providers, and social workers; the stress coupled with the unique nature of being responsible for a consistently high level of functioning and decision making may prove to be psychologically overwhelming. Understanding the concept of VT is essential for persons working with victims of trauma in order to educate and intervene when necessary. The term VT first appeared in a study conducted by McCann and Pearlman (1990) and was used to capture the therapist's reaction to a "client's traumatic events" (p. 131). The term describes the negative changes experienced by mental health clinicians dealing with survivors of sexual abuse and favors trauma theory (Bell, Kulkarni, & Dalton, 2003; VanDeusen & Way, 2006). Given the elevated levels of exhaustion from the cumulative, repeated, persuasive, long-term stress from working with the victims of violence, VT becomes a risk for some nurses. Thus, VT is a type of empathetic engagement or occupational hazard of working with the victims of violence (Bell et al., 2003; Dunkley & Whelan, 2006; Tunajek, 2006; Way, VanDeusen, & Cottrell, 2007). The cumulative effects of VT include an altered worldview and changes in psychological and emotional needs, trust and dependence, control, intimacy, self esteem, altered beliefs and cognitions, and sense of safety that parallel those of post-traumatic stress disorder (PTSD) (Dunkley & Whelan, 2006; Hernandez, Gangsei, & Engstrom, 2007; Salston & Figley, 2003; VanDeusen & Way, 2006). Furthermore, there may be a buildup of negative visual imagery, based on the violent accounts that have been disclosed, and this may result in permanent or temporary alteration of memory (Dunkley & Whelan, 2006). There are numerous other terms that are related and used interchangeably, albeit incorrectly, with VT. Including, but not limited to the key words that were searched, including, but not limited to empathetic strain, emotional labor, and secondary victimization. Due to the numerous associated terminologies the four most common terms were chosen with the intent of clarifying the concept of VT (burn out, compassion fatigue, secondary traumatic stress and PTSD).

Method

This paper reviews the literature on VT based on an electronic search of Ovid, PubMed and the Cumulative Index of Nursing of Allied Health (CINHAL) and results in a concept analysis of VT. The search terms used included burn out, compassion fatigue, PTSD, secondary traumatic stress, and VT. Twenty-three resources were identified and 12 journal articles (published between 1990 and 2007), two websites and two books (published in 2000 and 2006) were selected for review based on their applicability to forensic nursing. Sources were selected for differentiation and clarification of the concept of VT. The resulting concept anaylsis is cummulative, based on current literature while avoiding redundancy seen throughout the literature. The concept map supports implications in practice, education, and research.

Vicarious traumatization

VT is unique to those working with trauma/violent crime survivors and the subsequent potential effects that the professional may experience on an individual basis (Dunkley & Whelan, 2006). Common terms related to VT include burn out, compassion fatigue, empathetic stress, secondary victimization, secondary traumatic stress, secondary survivor, emotional contagion, rape-related family crisis, proximity effects, traumatic countertransference, emotional labor, and indirect traumatization (Figley, 2003; Hernandez et al., 2007; Polin, 1996; Salston & Figley, 2003; Tunajek, 2006). In order to clarify and differentiate VT from other potential outcomes it is helpful to examine, burn out, compassion fatigue, PTSD and secondary traumatic stress, and look at ways in which VT is distinct. Vicarious victimization has been seen in multidisciplinary settings, including counselors, mental health workers/therapists and law enforcement as well as healthcare workers. By the virtual nature of forensic nursing and associated patient populations that are cared for it is essential that forensic nurses are cognizant of the unique potential consequences of VT to themselves as well as family and peers (Figure 1).

Burn out

Burn out is related to the job environment and may be related to a lack of personal and/or organizational support. The United States Department of Justice (2007) describes burn out as "emotional, mental and physical exhaustion. . .may show up in work performance through absenteeism, tardiness or delayed productivity" (Chapter 18, Section 2, ¶1). Factors contributing to burn out include professional isolation; emotional and physical drain; erosion of idealism (cynicism); ambiguous success and lack of expected rewards or accomplishment (Dunkley & Whelan, 2006; Salston & Figley, 2003; United States Department of Justice, 2007). Burn out can occur in persons not working with survivors of traumatic events and is more closely aligned to working with difficult populations (Bell et al., 2003; Dunkley & Whelan, 2006; Salston & Figley, 2003). For example, a nurse who works in clinical settings with patients whom she perceives as noncompliant and begins to feel frustrated and isolated may experience burn out, resulting in tardiness and absenteeism.

Compassion fatigue

Compassion fatigue reflects deep feelings of suffering, sorrow, or sympathy to the point of exhaustion, associated with a deep desire to alleviate the pain or suffering of another person (Polin, 1996; Tunajek, 2006). Compassion fatigue is called the "cost of caring" (Figley, 2003) or an evolving consequence of caring. It is thought to be an emerging form of burn out or long-term stress (Figley, 2003; Hernandez et al., 2007; Polin, 1996; Tunajek, 2006). Compassion fatigue has a faster onset and recovery period than VT (Salston & Figley, 2003). Compassion fatigue differs from VT in that it is not necessarily associated with working with victims of violence. An example would be a nurse working with diabetic patients that are suffering the consequences of a long-term, depilating disease process. Or it may be seen in a correctional nurse that must keep incarceration the priority over healthcare.

Secondary traumatic stress

Secondary traumatic stress can occur when a person is repeatedly exposed to a single traumatic event and is a form of revictimization. For example a rape victim may experience secondary traumatic stress while testifying about the incident or a child who discloses abuse to an adult may experience secondary traumatic stress while describing the incident. (Dunkley & Whelan, 2006). PTSD is associated with VT, and understanding of this diagnosis is imperative for recognizing and treating VT (Bell et al., 2003; Dunkley & Whelan, 2006; VanDeusen & Way, 2006). The Diagnostic and Statistical Manual of Mental Disorders—Fourth Edition (DSM-IV) of The American Psychiatric Association (1989) states that PTSD includes "experiencing, witnessing, or confrontation with an event or events that involve actual or threatened death or serious injury, or a threat to the physical integrity of self or others" and involves "intense fear, helplessness, or horror" (p. 463). PTSD includes exposure to a traumatic event; persistently re-experiencing the traumatic event;

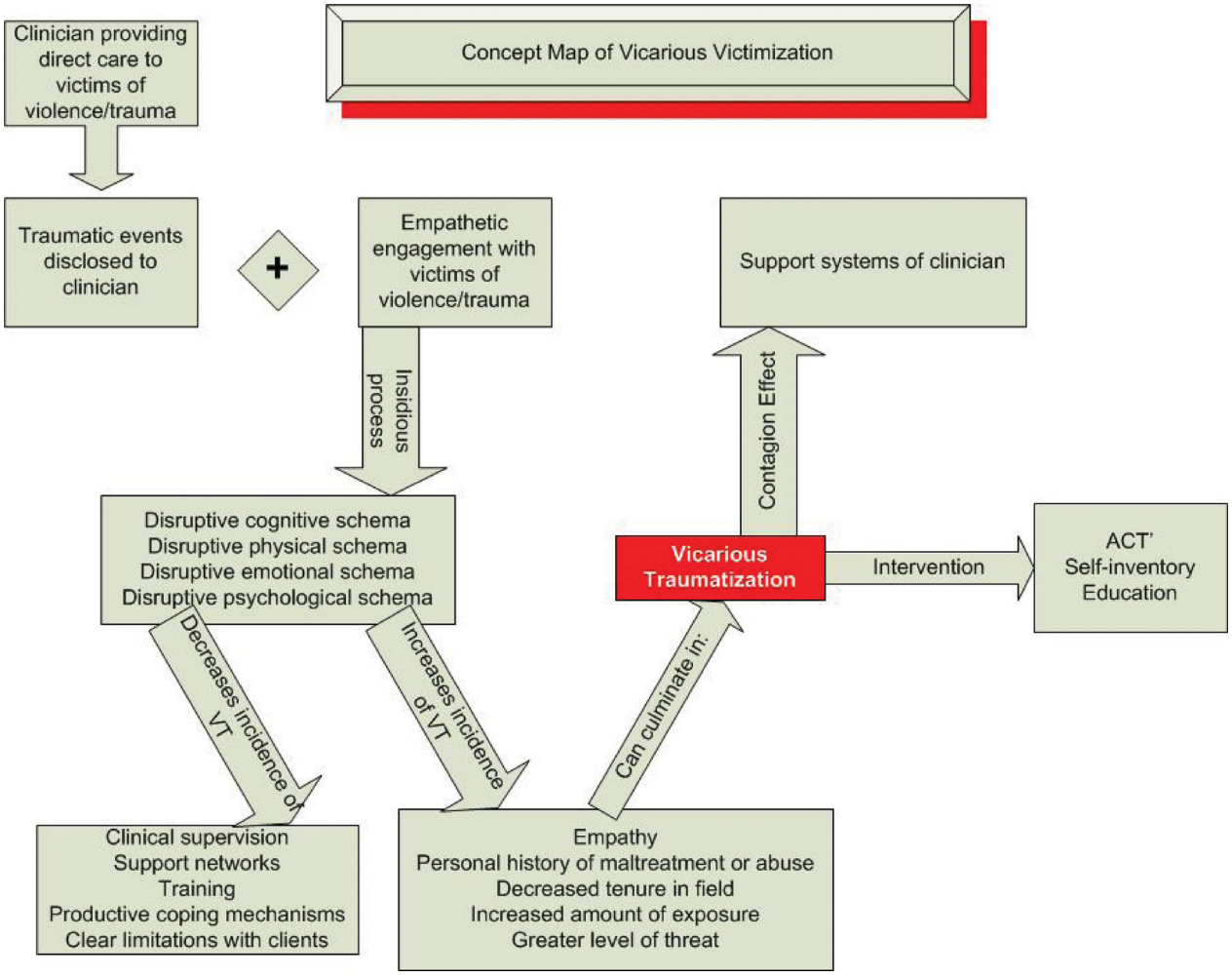

Figure 1. Concept map of vicarious victimization.

relentless avoidance of stimuli associated with the trauma; numbing of general responsiveness; and unrelenting symptoms of increased arousal (e.g., hypervigilance, anger, exaggerated startle response); the duration of the disturbance is more than 1 month; and the disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning. (Polin, 1996). Vicaious traumatization may present itself with PTSD-like symptomology, however, the main difference is that VT occurs without directly experiencing or witnessing the violence. Through comparison of related concepts the parameters of VT have been identified (Table 1).

Vicarious traumatization

VT appears to have an insidious onset and builds across time as providers repeatedly encounter traumatic and violent events over the course of their career (Bell et al., 2003; United States Department of Justice, 2007; VanDeusen & Way, 2006; Way et al., 2007). Figley (2003) notes that "these effects are cumulative and permanent" (p. 4). However, Figley is the only author who considers them permanent (Figley, 2003). Multiple factors are associated with VT including a personal history of trauma, caseload, level of experience, coping strategies, and gender differences. There has been little research on the effects of a person having a personal history of trauma, and the results are conflicting as to whether this increases the risk of VT or has little or no impact (Dunkley & Whelan, 2006; VanDeusen & Way, 2006; Way et al., 2007). A few studies have found a correlation between a history of childhood emotional neglect and VT (VanDeusen & Way, 2006; Way et al., 2007). One study conducted on law enforcement personnel, with a personal history of childhood abuse, found that VT was more common when working with survivors of sexual assault (Bell et al., 2003). However, traumatic events occur

Table 1 Comparison and contrast of terminology

Concept	Mirrors the bio-psychosocial effects exhibited by victim's of trauma	Trauma personally experienced or witnessed	Repeatedly exposed to a single traumatic event	Aligned with working with difficult patient population	Shorter duration and quicker recovery than VT	Predominately related to job environment; including inability to feel that interventions are helpful	Negatively alters' personal perceptions	Repetitive invasion of another's trauma	Associated exclusively with working with victims of violence or trauma
Burn out				X		X			
Compassion fatigue					X	X			
PTSD		X					X		
Secondary traumatic stress		X	X				X		
Vicarious trauma-tization	X						X	X	X

Burn out and compassion fatigue is associated with working environments, job related factors, and is not restricted to caring for victims of violence. PTSD and secondary trauma encompasses those who have been victims of violence. Vicarious traumatization shares common characteristics with all of these manifestations.

in varying forms (emotional, physical, and psychological) over time, and correlations are extremely difficult to establish.

Research conducted with counselors has shown an increased risk of VT as the number of clients with a history of trauma increased (Bell et al., 2003; Dunkley & Whelan, 2006). Greater diversity in the types of patients counseled was related to a lower occurrence of VT (Bell et al., 2003). It is not clear whether experience helps or hinders the development of VT (Australian Commonwealth, 2007; Dunkley & Whelan, 2006). However, since VT is an insidious process, there must be some exposure to traumatized patients over time which requires time in practice. Younger, less seasoned clinicians show higher levels of negative self-cognition, intimacy and other effects of VT (Bell et al., 2003; VanDeusen & Way, 2006; Way et al., 2007). Also, new personnel have been found to be more adversely effected by disruption of self-esteem and intimacy (Way et al., 2007). Lack of supervision, especially for new personnel, has been shown to increase VT, while continuing education decreased the occurrence of VT (Australian Commonwealth, 2007; Dunkley & Whelan, 2006; VanDeusen & Way, 2006).

Coping strategies have been found to have negative or positive effects in relation to VT. Positive coping strategies include expression of feelings, emotional support, humor, good physical health, hobbies, spiritual activities, and seeking peer support. Negative coping strategies include alcohol, drugs, denial, and disengagement (Dunkley & Whelan, 2006).

Comparisons of male and female clinicians treating survivors have found a greater amount of VT in females. Although there was a greater negative impact on males' self-cognition and intimacy (Way et al., 2007).

According to McCann and Pearlman (1990), when professionals are engaged in empathetic listening in client situations in which there are "emotionally shocking images of horror and suffering that are characteristic of serious trauma," they are at risk of developing VT (p. 134). However, conflicting findings and small sample sizes in the relationships of clinicians' level of experience, coping strategies, gender, caseload, past history of childhood trauma and supervision to VT, indicates further research is required (Australian Commonwealth, 2007; Bell et al., 2003; Dunkley & Whelan, 2006; Way et al., 2007).

Once VT is experienced by a person it may spill over to collateral individuals, such as peers, family, and friends. Since VT can disrupt cognitive, physical, emotional, and/or psychological schemas in individuals, it can potentially affect their interactions with others in a negative manner (Figure 1).

Prevention of vicarious traumatization

Prevention may be primary (prevention of occurrence); secondary (early detection and intervention); or tertiary (rehabilitation and improvement in the quality-of-life) (Lynch, 2006). The overall plan should be to educate and increase awareness; implement early identification and recognition, and develop tools and strategies to combat and eradicate VT. Unfortunately, studies that have dealt with the prevention of VT are limited by their small sample sizes. One of the keys to prevention is a self-inventory that involves development of self-awareness of one's own strengths, weaknesses, and vulnerabilities.

Education, research, and outreach have been found to help mitigate the effects of VT (Australian Commonwealth, 2007; Bell et al., 2003). Outreach measures and education on the potential of developing VT have resulted in the decreased occurrence of symptoms (Bell et al., 2003). Education should emphasize that distress is not a sign of weakness and overwhelming circumstances may elicit normal reactions to abnormal situations or events.

Intervention in vicarious traumatization

Interventions should be specifically aimed at preventing long-term sequelae, including management of stress, anxiety, and pervasive negative attitudes with detrimental personal and professional consequences (Lynch, 2006). Interventions can increase the quality of the individual's work and preserve the overall effectiveness of the organization (Dunkley & Whelan, 2006). Detachment from clients, decreased empathy and lack of interaction with peers are cumulative effects of VT that should be diagnosed and intervened on before the professional becomes debilitated (VanDeusen & Way, 2006). Early recognition and intervention are crucial when there are significant warning signs, such as drug, food or alcohol abuse; anger; chronic tardiness or over-working; depression; exhaustion; frequent somatic complaints; hopelessness; inability to balance objectivity and empathy; hedonism; low self-esteem; or sleep disturbances (Tunajek, 2006). Positve coping strategies include: acknowledging and discussing emotions; humor; emotional support; hobbies; spiritual activities; emotional and peer support. Negative coping stratagies include: alcohol/drug use/abuse; denial and disengagement. (Dunkley & Whelan, 2006). Positive and negative coping strategies should be further studied to understand how they decrease or increase VT (Bell et al., 2003).

Clark and Giorro (1998) suggested an acronym for use in the prevention of VT in nurses, called ACT: acknowledge, connect and talk. First comes acknowledgment that VT exists and that nurses' work can be restorative in nature. Connection must occur at professional and personal levels. Peers should be encouraged to openly discuss among themselves encounters with clients experiencing traumatic events.

There should be a focus on increasing the rewardable aspects of nursing, including witnessing the resilience of patients as well as feeling a sense of fulfillment and appreciation through the services provided (Salston & Figley, 2003). Additionally, there should be more stringent observation of those with a personal history of trauma for early warning indicators of VT (Salston & Figley, 2003). Effective use of peer support, supervision and consultation, training, personal therapy, maintenance of a balanced life, and establishment of boundaries between self and the client are all positive interventions (Australian Commonwealth, 2007; Hernandez et al., 2007; Salston & Figley, 2003). A study by Kanter (2007) found that social workers who had inadequate professional training and unrealistic expectations experienced more negative effects (Kanter, 2007).

Opportunities for forensic nursing

There has been a great deal of conceptual confusion pertaining to VT and a variety of research agendas across multiple disciplines. The prudent approach for nurses, especially those that work with traumatized patients, are to have a clear understanding of VT. One of the greatest areas for forensic nursing is in research that focuses specifically on nurses. The lack of research done exclusively on nurses hampers our ability to garner an empirical or theoretical understanding of the impact of VT on nurses. Furthermore, forensic nurses can hone the research into addressing specificity to nursing practice as well as screening and intervening across disciplines. Much of the information we have comes from mental health clinicians. Training provided by forensic nurses should revolve around early intervention for VT and accentuate positive coping strategies while minimizing negative coping. Recognition of vicarious resilience as well as implementation of mirroring techniques could also mitigate occurrence of VT. Future studies should seek to find what helps individual nurses develop vicarious resilience through examining adaptive processes, stress reduction, coping mechanisms and debriefing (Australian Commonwealth, 2007; Hernandez et al., 2007). Vicarious resilience brings conscious attention to the problem and is a process that has positive effects secondary to the traumatized clients' resilience (Hernandez et al., 2007).

Future endeavors should bring acknowledgment that VT exists and invades the lives of even the strongest

and bravest. The American Nurses Association and The International Association of Forensic Nurses could be consulted in the development of an eclectic approach that serves nurses through implementation of a holistic biopsychosocial approach.

Programs should implement direct and applicable screening procedures, schedule screenings at realistic intervals, and provide follow-up counseling and other supplemental coping strategies. Current screening tools include Trauma Assessment Inventories; Trauma Attachment and Belief Scale (TABS); Traumatic Life Events Questionnaire (TLEQ); Traumatic Stress Institute Belief Scale (TSIBS-R-L); and Trauma-Related Guilt Inventory (TRGI) (Salston & Figley, 2003; VanDeusen & Way, 2006; Way et al., 2007). These screening/evaluation tools should be implemented in trauma related work environments.

Forensic nurses should also focus attention on decreasing the dearth of terminology; concept clarification; development of guidelines and validation of symptomology; implementation of screening flowcharts; and formulation of problem focused interventions.

Nurses are human and not immune to job related trauma and therefore they need to take care of their professional family as much as they take care of their clients. Nurses enter their profession in order to care for others; however, that must be combined with caring for themselves and their peers. If nurses approach health as helping others survive, they should have the goal of helping persons, including themselves, from being victimized by VT and increase the development of resilience.

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