Mental Health Professionals’ Experiences of Vicarious Traumatization in Post–Hurricane Katrina New Orleans

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Mental health professionals in a variety of work settings regularly encounter clients who are trauma victims. This secondary exposure to trauma often results in the professionals experiencing the effects of trauma themselves, known as vicarious traumatization (VT). The present descriptive, sequential mixed-method study explored VT experienced by mental health professionals in the post–Hurricane Katrina New Orleans region using the Vicarious Traumatization Questionnaire (VTQ). The study also examined the impact of VT on the professional and personal functioning of mental health professionals through interviews with agency directors. Results indicated notable VT impact. Prevention and treatment implications are discussed.

The term “vicarious traumatization” (VT) was first offered in 1990 by McCann and Pearlman to describe the process by which an individual experiences profound negative psychological effects as a result of working with trauma victims. Through repeated exposures to clients’ traumas, mental health professionals may experience significant adverse effects in core aspects of themselves, including their perception of themselves, others, and the world (Rasmussen, 2005; Trippany, White Kress, & Wilcoxon, 2004). “VT

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emphasizes the way the therapist’s experience of the self is altered in terms of identity, world view, spirituality, self capacities, ego resources, psychological needs, and the sensory system” (Rasmussen, 2005, p. 20). Mental health professionals may experience other disruptions to their sense of safety, trust, power, esteem, independence, intimacy, and frame of reference (McCann & Pearlman, 1990). Symptoms of vicarious traumatization include anxiety, suspiciousness, depression, somatic symptoms, intrusive thoughts and feelings, avoidance, emotional numbing and flooding, and increased feelings of personal vulnerability (Adams & Riggs, 2008).

The purpose of this study was to (a) document quantitatively the extent and occurrence of vicarious traumatization experienced by mental health professionals and (b) determine qualitatively the unique nature of VT and its impact on the professional and personal functioning of mental health providers in the particularly susceptible region of post-Katrina New Orleans.

METHOD

The basic approach is both quantitative and qualitative: a mixed-methods design as described by Tashakkori and Teddlie (1998) wherein the analysis is multilevel with quantitative data at one level (obtained from the mental health provider) and qualitative data at a higher level (obtained from the agency director). For Phase 1, mental health professionals were surveyed to explore the effects of VT. For Phase 2, agency directors were interviewed to examine the impact of VT on the personal and professional functioning of mental health professionals. Prior to recruitment, internal University of New Orleans review board approval was obtained.

Participants

The participants for Phase 1 were recruited from mental health agencies located in the post–Hurricane Katrina New Orleans area, including the parishes of Orleans, Jefferson, St. Bernard, St. Tammany, and Plaquemines, an area of more than 1 million residents. In the more than 4 years since the hurricane, evidence of substantial and severe emotional disorders and collateral mental health issues of its residents has been well documented (e.g., Faust et al., 2008; Lamberg, 2008). It seemed a safe assumption that such an obviously traumatized area would be a fertile developing ground and singular clinical exemplar for VT among those most closely exposed to treating trauma: the mental health providers of the region.

A solicitation e-mail was sent to 33 agency directors in the region requesting participation from their clinicians in an electronic survey as well as an interview invitation for the agency director. It was estimated that each agency employed between 2 and 10 mental health professionals, yielding an
estimated region-wide population of approximately 200 participants. Out of the 30 participants who completed the survey, there were 24 females and 6 males, 90% of whom were Caucasian, with the remaining 10% African American, Hispanic, and Native American. Participants ranged in age from 24 to 71 ($M = 42.48, SD = 13.6$). Participants reported a variety of educational backgrounds, including a master’s in counseling (40%), a master’s in social work (34%), a doctoral degree in social work (3%), and other (21%; JD and MSW, MDiv and ThM, bachelor in liberal arts, bachelor in psychology). Clinicians had worked in the mental health field between 1 and 34 years ($M = 9.98, SD = 9.01$). All participants provided direct clinical services to clients at mental health agencies in the New Orleans region. Two participants who reported that they had not worked with trauma clients were included in the sample characteristics data but not the trauma results data.

Five agency directors from the region volunteered to participate in structured interviews for Phase 2. Out of the five participants who completed the interview, there were four females and one male. Four were Caucasian and one was Hispanic. All participants provided direct clinical and administrative supervision to mental health professionals employed at their agency.

**Instrumentation**

A 29-item electronic questionnaire, the Vicarious Traumatization Questionnaire (VTQ), was developed by the researchers with item content based on the current conceptual literature on vicarious trauma (e.g., McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995; Rasmussen, 2005; Tehrani, 2007). The questionnaire was designed to assess anonymously a mental health professional’s self-reported experiences of VT. A panel of five mental health professionals screened items for content validity as well as ease of understanding and administration. The final instrument was pilot tested on 10 mental health professionals, and minor modifications were made upon completion of the pilot study.

Items 1–8 were used to gather demographic information about participants, including gender, age, ethnicity, income, education level, professional licensure and certification, present employment, and years working in the mental health field. Items 9–11 asked for an estimate of the number of trauma victims worked with each week and specification about the types of traumatic material that clients reported (e.g., childhood sexual abuse, domestic violence, natural disaster). Items 12–14 were used to explore changes in perceptions of self, others, and the world. Item 15 was used to explore negative psychological effects experienced. Items 12–15 required a response on a 7-point Likert scale ranging from “always” (1) to “never” (7). Items 16–18 asked participants to indicate all symptoms and changes experienced from VT (e.g., anxiety, suspiciousness, intrusive thoughts and feelings, sense of safety, frame of reference).

Items 19–21 were used to explore the extent educational training prepared participants to work with trauma victims. Item 19 required a response
on a 7-point Likert scale ranging from “exceptionally well” (1) to “not at all” (7). Items 22–24 were used to determine the extent fieldwork prepared participants to work with trauma victims. Item 22 required a response on a 7-point Likert scale ranging from “exceptionally well” (1) to “not at all” (7). Item 25 was used to explore the extent participants used coping mechanisms to cope with effects of VT and required a response on a 7-point Likert scale ranging from “always” (1) to “never” (7). Items 26–29 gathered additional information related to coping mechanisms using free form fields.

Quantitative data derived from Phase 1 were used to develop qualitative questions for Phase 2. The structured interview consisted of 14 open-ended questions to explore agency directors’ perceptions of the effects of VT on personal and professional functioning of their mental health staff. Participants provided information about their role and agency. Open-ended, structured questions were used to gather qualitative information (e.g., What has your experience been like working with mental health professionals working with trauma victims and how has the morale of the staff been affected?).

Procedure

For Phase 1, the VTQ was electronically sent via e-mail to mental health agency directors in the five selected parishes of the New Orleans area. Agency directors were invited to distribute the questionnaire to mental health professionals employed at their agency. Two follow-up e-mails were sent to encourage participation. Ultimately, 30 mental health providers out of an estimated 200 total possible respondents completed the survey.

For Phase 2, agency directors were solicited in the initial e-mail for voluntary participation in an interview. Follow-up phone calls were made as necessary to agency directors for participation. Two doctoral-level research assistants (coauthors of this study) trained in qualitative research techniques conducted 60-minute videotaped structured interviews in a private office setting. Open-ended questions were used to facilitate a rich understanding of directors’ experiences. Interviews were videotaped to allow for an audit trail that could be used to validate data accuracy as well as adherence to interview protocols. Data were analyzed for common themes by researchers and then coded for each interview. Peer examination was utilized to ensure internal validity (Creswell, 2007).

RESULTS

For Phase 1, data were initially prescreened for missing values and outliers, and descriptive statistics were obtained. Next, Pearson’s $r$ was used to look for relevant relationships among the key variables. Descriptive statistics
revealed that 96% of participants reported working with between 1 and 20 trauma victims weekly ($M=5.17$, $SD=.75$). The most common type of trauma reported was domestic violence, and natural disaster was the fourth most common type of trauma. Those data are reported in Table 1.

The clinicians who worked with trauma victims reported many negative psychological symptoms, including anxiety ($n=19$; 73%), suspiciousness ($n=16$; 62%), and increased vulnerability ($n=12$; 46%). Additionally, participants reported their sense of safety ($n=17$; 71%) and frame of reference ($n=12$; 50%) were disrupted due to working with trauma victims. Participants reported esteem as least disrupted ($n=2$; 8%). A significant association was found between participants working with trauma victims and altered perceptions of self ($r=.436$, $p<.05$). An altered perception of self was significantly correlated with participants experiencing negative psychological effects ($r=.671$, $p<.01$).

Coursework and fieldwork were investigated to determine to what extent participants found either experience prepared them to work with trauma victims. Participants indicated that fieldwork experiences were more

<table>
<thead>
<tr>
<th>Trauma category</th>
<th>Responses</th>
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<tbody>
<tr>
<td>Domestic violence</td>
<td>28</td>
</tr>
<tr>
<td>Childhood sexual abuse</td>
<td>26</td>
</tr>
<tr>
<td>Physical assault</td>
<td>24</td>
</tr>
<tr>
<td>Natural disaster</td>
<td>24</td>
</tr>
<tr>
<td>Sexual assault</td>
<td>23</td>
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<tr>
<td>Loss</td>
<td>22</td>
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<tr>
<td>Bullying</td>
<td>18</td>
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<tr>
<td>School violence</td>
<td>10</td>
</tr>
<tr>
<td>Man-made disaster</td>
<td>9</td>
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<tr>
<td>Other</td>
<td>6</td>
</tr>
<tr>
<td>Work-related violence</td>
<td>5</td>
</tr>
<tr>
<td>Total percentage</td>
<td>100</td>
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<table>
<thead>
<tr>
<th>Symptom experiences</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety</td>
<td>19</td>
</tr>
<tr>
<td>Suspiciousness</td>
<td>16</td>
</tr>
<tr>
<td>Increased feelings of personal vulnerability</td>
<td>12</td>
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<tr>
<td>Avoidance</td>
<td>11</td>
</tr>
<tr>
<td>Depression</td>
<td>9</td>
</tr>
<tr>
<td>Emotional numbing and flooding</td>
<td>9</td>
</tr>
<tr>
<td>Intrusive thoughts and feelings</td>
<td>8</td>
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<tr>
<td>Hopelessness</td>
<td>7</td>
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<tr>
<td>Somatic symptoms</td>
<td>6</td>
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<tr>
<td>Lack of motivation</td>
<td>5</td>
</tr>
<tr>
<td>Other</td>
<td>5</td>
</tr>
<tr>
<td>Total percentage</td>
<td>100</td>
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*Note. Multiple answers were allowed, so totals can be greater than 100%.
Two of the 30 participants reported no association with trauma clients.*
helpful than coursework in preparation ($M = 3.44$, $SD = 1.78$, and $M = 3.85$, $SD = 1.37$, respectively). A significant inverse relationship was found between extent of coursework preparation and altered perceptions of self ($r = -.423$, $p < .05$). Additionally, a negative relationship was obtained between fieldwork experiences and negative psychological effects ($r = -.437$, $p < .05$). Finally, while 26 of the respondents indicated they engaged in some type of coping mechanism, their degree of engagement was only moderate ($M = 3.80$, $SD = 1.78$, on a scale of 1 to 7).

In Phase 2, interviews conducted with agency directors about the effects of VT on mental health providers yielded substantial in-depth data, which both supported and expanded on the findings from the first phase of the study. Through analysis of structured interviews, seven common themes were identified.

1. Trauma is a very common problem reported by clients in mental health agencies.
2. There are various types of trauma presented by clients.
3. Trauma victims are the most challenging clients.
4. Experience and training of clinicians are factors in treatment effectiveness.
5. Coping and support for mental health providers are necessary to treat trauma victims.
6. Time, resources, and funding of agencies are strained.
7. Clinicians’ perceptions of others and worldview are affected.

Directors reported that while clients’ trauma was not always the presenting problem, it was common. There was a consensus among directors that a wide variety of trauma types exist but that prominent issues often included domestic violence, childhood sexual abuse, crime incidents, and Hurricane Katrina experiences. Four of five agency directors noted that experience level was an important variable when supervising clinicians working with trauma victims. One of the directors stated, “It is very difficult as a director of those working with trauma and more so for clinicians with little experience.”

Trauma victims were often considered the most challenging clients, as they demand additional time and resources to process their experiences. One director expressed the idea by stating “Trauma victims become star clients” and further noting that “trauma clients take most time in supervision and typically come to therapy for longer periods of time, which uses resources.” In addition to time and resources, funding was an important issue for all directors. One stated, “After the hurricane there was an abundance of funding, but now with the economic crisis, it is a different story.” All agency directors reported a need for additional training for both clinicians and support staff who work with trauma victims. One director noted, “We are winging it; there is no training and it is really scary.”
Some directors reported that their overall worldview and perceptions of others were affected by working with trauma victims. Two of the five directors reported more hypervigilance, increased sensitivity to red flags, and a skewed worldview as a result of working with clinicians treating trauma victims. One director gave the following example: “Normal things like someone opening a door for you can become a red flag that someone is controlling.” Another director stated, “The world seems grimmer.”

All five directors believed coping and support were extremely important for those working with trauma victims. For example, one director aptly stated, “Clinicians become worn out and numb from working with victims of trauma.” When asked about support, another director stated, “I feel like I am everyone’s therapist and I don’t think I do enough for myself.” Peer support, cognitive self-talk, peer consulting, and support from friends were reported as the most frequently used coping strategies. Self-care, healthy boundaries, and balance in life were also emphasized by all of the directors.

DISCUSSION

The Phase 1 results suggest that repeated exposures to clients’ traumatic material may be related to significant adverse effects for mental health providers. Participants in this study experienced psychological symptoms such as increased anxiety, suspiciousness, and vulnerability. Seventy-three percent of participants reported increased psychological symptoms, with anxiety being the most common. Since respondents typically underreport symptoms, a higher percentage can be assumed. The findings suggest that mental health professionals in the areas of New Orleans affected by Hurricane Katrina have been treating clients while dealing with their own psychological issues. These results were consistent with research by McCann and Pearlman (1990), Rasmussen (2005), and Trippany et al. (2004).

Data collected regarding prevention and treatment of VT through caseload balancing, peer supervision, personal coping mechanisms, agency responsibility, and education and training were in line with previous studies (Adams & Riggs, 2008; Tehrani, 2007; Trippany et al., 2004). Findings suggest that practicum and internship prepare mental health professionals in the New Orleans area more than coursework training to work with trauma victims. While many professionals engage in some type of self-care to buffer the effects of VT, the extent of their engagement was not strong and could be bolstered given the extent of the hurricane’s impact on the citizenry. This is especially valid 4 or more years after the start of the recovery.

A relationship was found between working with trauma victims and an altered perception of self. There was an inverse relationship between the extent educational training and coursework prepared mental health professionals to work with trauma victims and the extent their perceptions of self
and the world have been altered due to working with trauma victims. Additionally, an inverse relationship was found between the extent practicum and internship prepared mental health professionals to work with trauma victims and the extent negative psychological effects were experienced due to working with trauma victims. The findings suggest that mental health educational programs should add more trauma-related coursework and training in order to better prepare students.

Most Phase 2 findings were consistent with findings in Phase 1. Factors such as experience level and trauma-specific training were found to impact mental health providers’ work with trauma victims. This finding was consistent with research by Adams and Riggs (2008) showing that novice therapists were more susceptible to VT. Participants from Phase 2 reported a disruption in worldview and perceptions of others, consistent with research by McCann and Pearlman (1990) as well as Rasmussen (2005). Coping and support were identified as essential coping mechanisms in trauma work. Finally, trauma clients were identified as the most challenging by the agency directors, a finding not identified in Phase 1 of the study.

Overall, Phase 1 and Phase 2 results suggest that mental health professionals may be adversely affected by their work with trauma victims. The incidence of psychological symptoms experienced by mental health professionals was the most alarming finding. Disruptions in perceptions about self, others, and the world are quite important as they may affect the clinician’s ability to provide effective services for clients. Finally, fieldwork prepared mental health professionals in the New Orleans area more than coursework for their work with trauma victims. This finding could be helpful for educators in the mental health profession.

LIMITATIONS AND CONCLUSION

Phase 1 of the study was an anonymous survey, which should minimize difficulty answering items that could be embarrassing or have a stigma attached to them. The survey was voluntary, so the respondents were a small, self-selected group and perhaps did not represent an accurate sampling of the population. It is possible that individuals who have experienced VT may be in denial, may want to provide socially desirable responses to survey items, or may not be practicing and therefore unavailable to take the survey. The inclusion of agency directors helped validate the survey by adding a new level of information and depth of knowledge on the impact VT has had on their agency and its functioning. Admittedly, the directors were dealing with sensitive information and insights, suggesting that they might have filtered their comments; however, their answers were not attributed to them, and they had the option of deleting any responses they deemed necessary prior to the data analysis.
Mental health professionals working in post–Hurricane Katrina New Orleans experienced negative psychological changes that might be related to their work with trauma victims. The effects of vicarious traumatization can include multiple affective symptoms, changes in cognitive schemas, disruptions in various life areas, and altered perceptions of self, others, and the world. Additional training is needed in program coursework and field experiences as well as for clinicians and administrative staff who have direct contact with trauma victims. The present results help bolster the empirical bases for understanding the personal and professional fallout from working regularly with trauma victims. Empirical data from both data sets could provide direction for further studies within the discipline in order to formulate prevention and treatment regimens for VT.

REFERENCES


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