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# Vicarious Trauma Among Sexual Assault Nurse Examiners

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**ABSTRACT**

Vicarious trauma (VT), the phenomenon of changes in cognition and worldview that result from empathic response and repeated exposure to narratives of trauma, is a risk for helping professionals. This descriptive, correlational study sought to examine levels of VT among sexual assault nurse examiners (SANEs) as compared with other women's health nurses. It also explored whether levels of VT are different for nurses who have experienced primary trauma alone, VT alone, or both personal trauma and VT. VT was assessed through an anonymous online survey using the nurses' total scores on the Trauma and Attachment Belief Scale. Trauma and Attachment Belief Scale scores were significantly higher for SANEs ($M = 178.5$, $SD = 42.6$) than for women's health nurses ($M = 168.1$, $SD = 41.4$; $p = 0.025$), indicating higher levels of trauma-related cognitive disruption in the SANE group. Scores were also significantly higher for both groups with personal trauma histories at the $p < 0.05$ level compared with the women's health nurses with no personal history. SANEs who had no personal history of trauma did not differ significantly from either group of nurses who did, suggesting that VT from working as an SANE is associated with levels of cognitive disruption similar to oneself having experienced trauma. Nurses should be aware of this phenomenon and its sequelae when choosing to pursue the specialty of sexual assault nursing. Hospitals and other organizations employing SANEs should also be aware of VT and provide a support system with resources in place to mitigate these effects. Future research should further explore effects of primary trauma versus VT, clinical manifestations and significance of varying levels of VT, and interventions and strategies for dealing with VT.

**KEY WORDS:**

SANE; sexual assault nurse examiner; Trauma and Attachment Belief Scale; vicarious trauma; women's health nurse

Helping professionals who are repeatedly exposed to and empathically engage with patients' or clients' narratives of trauma are at risk for experiencing cognitive changes and alterations in worldviews from the repeated exposure to trauma (Killian, 2008; McCann & Pearlman, 1990a, 1990b, 1990c; Pearlman & Saakvitne, 1995; Schauben & Frazier, 1995; Trippany, Kress, & Wilcoxon, 2004). This phenomenon, known as vicarious trauma (VT), can negatively impact professionals' personal and professional lives (McCann & Pearlman, 1990a, 1990b, 1990c; Pearlman & Saakvitne, 1995; Stamm, 2010). VT has been studied considerably among mental health providers (Chouliara, Hutchison, & Karatzias, 2009; Devilly, Wright, & Varker, 2009; Jenkins & Baird, 2002; Jordan, 2010; Newell & MacNeil, 2010; Saakvitne, Tennen, & Affleck, 1998; Way, VanDeusen, & Cottrell, 2007), but only a limited amount of research has been done among sexual assault nurse examiners (SANEs). This paucity is striking; as by the nature of their work with survivors of sexual assault, SANEs hear graphic trauma narratives from each patient for whom they care (Maier, 2011; Strunk & Strunk, 2012). The purposes of this study were to describe levels of VT among SANEs as compared with levels of VT among other women's health nurses and to explore how levels of VT are different for nurses who have themselves experienced primary trauma compared with nurses who have not been personally traumatized.

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Constructivist self-development theory was used as a framework for understanding the phenomenon of VT. Using both psychoanalytic theory and cognitive theories as a foundation, constructivist self-development theory is based on the belief that an individual's belief system, cognitive schemas, and personal reality shape how events are interpreted (McCann & Pearlman, 1990a, 1990b; Pearlman, 2003; Pearlman & Saakvitne, 1995). Therefore, every individual exposed to trauma either as a primary victim or through secondary exposure will be unique in his or her response to trauma.

Several instruments have been designed to explore concepts of secondary trauma; however, the Trauma Attachment Belief Scale (TABS) and its earlier version, the Trauma Stress Institute Belief Scale, are considered the standard by which to measure levels of VT (Elwood, Mott, Lohr, & Galovski, 2011; Pearlman, 2003; Trippany et al., 2004; Williams, Helm, & Clemens, 2012). These tools measure disruptions in cognitive schemas that are vulnerable to alteration through trauma exposure (McCann & Pearlman, 1990a; Pearlman & Saakvitne, 1995; Saakvitne et al., 1998). All experiences and life events are filtered through one's existing cognitive schemas; as such, alterations in these schemas through exposure to trauma alter an individual's future perceptions of life experiences and ways of relating in the world. Currently, there are no available tools that explicitly measure VT as a concept independent from primary trauma. However, the changes in cognition and beliefs examined by TABS "are strongly associated with the aftereffects of trauma, whether experienced directly or vicariously" (Pearlman, 2003, p. 40).

Several studies measuring VT and other secondary trauma concepts used a comparison group of professionals not directly involved with sexual assault or domestic violence survivors (Cunningham, 2003; Devilly et al., 2009; Jenkins & Baird, 2002; Kadambi & Truscott, 2004; Sabin-Farrell & Turpin, 2003). The studies had mixed results and, in general, showed low levels of secondary trauma overall, causing some to question if the concept even exists in reality (Devilly et al., 2009; Elwood et al., 2011; Kadambi & Truscott, 2004; Sabin-Farrell & Turpin, 2003). Multiple researchers have examined the influence of a person's own history of trauma on the person's experience of secondary trauma. Results have been varied, although most studies do show positive correlations between personal trauma history and levels of secondary trauma (Cunningham, 2003; Dunkley & Whelan, 2006; Jenkins & Baird, 2002; Killian, 2008; Newell & MacNeil, 2010; Pearlman & Mac Ian, 1995; VanDeusen & Way, 2006). However, this association raises questions about the construct validity of VT as separate from primary trauma.

The following questions were examined to explore levels of VT among SANEs compared with other women's health nurses, and how levels of VT are different for nurses who have themselves experienced primary trauma compared with nurses who have not been personally traumatized.

1) What is the level of VT among SANEs and women's health nurses?
2) What is the incidence of experience of primary trauma among SANEs and women's health nurses?
3) Is there a difference in VT between SANEs and women's health nurses?
4) What is the difference in levels of VT between SANEs versus women's health nurses who both have and have not experienced primary trauma?

## Methods

### Design, Setting, and Recruitment

After approval from the institutional review board of a research-intensive university, the purpose and research questions were addressed through a quantitative, anonymous online survey. Participants were recruited through two professional nursing organizations. SANEs were recruited through the electronic distribution list of the International Association of Forensic Nurses (IAFN), an organization of approximately 3000 members. The comparison group of women's health nurses was recruited through the Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN), an organization with a total membership of more than 24,000 nurses. Both organizations gave permission to recruit. Participation was voluntary with the opportunity to be entered in a raffle for a $50 Visa gift card on completing the survey. This was done through a separate survey link to maintain participants' anonymity.

### Exclusion Criteria

The exclusion criteria included: (a) AWHONN members who had worked in neonatal intensive care or as SANEs (to exclude those at higher risk of having experienced VT through the nature of their work); (b) participants who were neither SANEs nor women's health nurses; (c) those who chose not to disclose whether they had a personal history of primary trauma; and (d) nurses who had recently (within the last 6 weeks) experienced personal sexual violence.

### Measurement

The survey assessed three dimensions: (a) demographic characteristics and professional background, (b) personal history of trauma, and (c) VT.

Personal history of trauma was assessed by asking if respondents have personally experienced rape, attempted rape, incest, or child sexual abuse or otherwise been made to engage in a sexual act to which they did not willingly consent.

VT was assessed using the TABS total score, which is the cumulative score of all TABS responses. The TABS uses 10 self-reported subscales to assess disruptions in cognitive schemas exploring beliefs about safety, intimacy, trust, control, and esteem in terms of both self and others. It consists

of 84 six-point Likert scale items ranging from strongly disagree to strongly agree (Pearlman, 2003). The instrument, originally created in 1988, has been researched and adapted for improved readability, reliability, and validity since then (Pearlman, 2003). The TABS has shown good reliability with 0.96 for internal consistency and 0.75 for test–retest reliability for TABS total score (Pearlman, 2003). Validity has been assessed by comparing TABS with similar and related tools and reviewing the composition of the instrument itself and by use and results of the tool over the years (Pearlman, 2003).

## Results/Findings

### Sample

Four hundred eighty-two people consented to participate in the study. The final sample included 144 (42%) SANEs and 196 (58%) women's health nurses ($N$ = 340). One hundred nineteen participants were eliminated because either their demographic responses indicated they met the exclusion criteria or they exited the survey before starting the TABS. Of the 363 who started the TABS, 18 who accessed the survey through means other than IAFN or AWHONN were excluded from this analysis. Two additional participants were removed from the SANE group who indicated that they had not yet worked as SANEs. Finally, three participants were excluded from the analysis because of having answered <80% of the TABS, whereas those with less frequent missing data were addressed through mean substitutions. The final total sample met the recruitment goal of 200 total participants, 100 in the SANE group and 100 in the women's health group, identified through a power analysis using $\alpha$ level of 0.05, power of 0.8, and medium effect size ($r$ = 0.3).

The mean age of respondents was 47 ($SD$ = 11.4) years, with a median of 48 years, spanning 22–74 years. Ninety-nine percent ($n$ = 336) of the sample was female. Ninety-two percent ($n$ = 313) of the sample were identified as White. Seventeen percent had associate degrees ($n$ = 57), 38% had bachelor degrees ($n$ = 129), 13% had completed some graduate school ($n$ = 45), 26% had master degrees ($n$ = 89), and 5% had doctoral degrees ($n$ = 17). Close to three quarters of the sample (70%) had experience in areas of nursing outside women's health or sexual assault nursing.

Of the responding SANEs, 37% ($n$ = 52) work primarily with adults, 8% ($n$ = 11) work primarily with pediatric patients, and 55% ($n$ = 77) care for both adult and pediatric patients. These nurses had worked as SANEs for 3 months to 27 years ($M$ = 8.5 years, $SD$ = 5.3 years). The women's health nurses had experience in labor and delivery ($n$ = 57, 26%), postpartum ($n$ = 16, 7%), and outpatient OB-GYN ($n$ = 16, 7%); as women's health nurse practitioners ($n$ = 2, 1%) and nurse midwives ($n$ = 3, 1%); and in multiple areas of women's health ($n$ = 127, 58%). These nurses had worked in women's health for 6 months to 49 years ($M$ = 17 years, $SD$ = 11.7 years).

### VT and Personal Trauma

Nurses' scores on the TABS reflect the level of VT the nurse is experiencing. Higher TABS scores indicate greater levels of disruption in cognition and worldview. Scores can range from 95 points or less in the bottom first percentile of respondents to 304 points or greater in the 99th percentile of respondents. The results were normally distributed with a mean raw score of 172.5 ($SD$ = 42, range = 93–313). The median score was 169.5, and the mode was 142. The TABS suggests converting raw scores into standard normalized $t$ scores, having a mean of 50 and a standard deviation of 10. The lowest possible $t$ score is <20, and the highest possible $t$ score is >80. The nurses' mean $t$ score was 48 (minimum = 22, maximum = 76).

When asked "have you ever personally experienced rape, attempted rape, incest, child sexual abuse, or otherwise been made to engage in a sexual act to which you did not willingly consent?" as a measure of personal history of trauma, 46% ($n$ = 157) responded "yes," and 54% ($n$ = 183) responded "no." Among SANEs specifically, 48% ($n$ = 70) had a personal history, and 52% ($n$ = 75) did not. Among women's health nurses alone, 45% ($n$ = 88) had a personal history, and 55% ($n$ = 108) did not.

### Group Comparisons

An independent $t$ test compared levels of VT among SANEs as compared with women's health nurses. The mean TABS score was significantly higher for SANEs ($M$ = 178.5, 49$T$, $SD$ = 42.6) than for women's health nurses ($M$ = 168.1, 46$T$, $SD$ = 41.4; $t(338) = 2.248$, $p = 0.025$).

A one-way ANOVA compared the effects of a personal history of trauma on levels of VT in SANEs and women's health nurses. Personal history of trauma had a significant effect on VT levels at the $p < 0.05$ level ($F(3, 337) = 4.939$, $p = 0.002$). Post hoc comparisons using Scheffe and Bonferroni tests show that mean TABS score for women's health nurses with no personal history of trauma ($M$ = 160.3, $SD$ = 35.6) was significantly different from the mean TABS score of women's health nurses with a personal history of trauma ($M$ = 177.8, $SD$ = 46) and SANEs with a personal history of trauma ($M$ = 181.8, $SD$ = 45.2). However, it was not significantly different from the mean TABS score of SANEs with no personal history of trauma ($M$ = 176.5, $SD$ = 40.9).

The mean score for women's health nurses with personal history of trauma and SANEs without personal history is very similar with a raw score difference of only 1.3 points and a shared standardized score of 49$T$. As the difference between women's health nurses without a personal history and SANEs without a personal history was approaching significance, the researcher further tested that relationship. An independent-sample $t$ test comparing the two groups without personal history of trauma shows a significant difference at a $p < 0.01$ level, $t(181) = 2.839$, $p = 0.005$.

## Discussion

This study answered questions about VT in SANEs and women's health nurses and examined how personal history of trauma affects levels of VT. Levels of VT for the whole sample fell in the 42nd percentile of TABS respondents (Pearlman, 2003). Having worked as an SANE was associated with significantly higher levels of VT than working as a women's health nurse, with SANEs' TABS scores in the 46th percentile and women's health nurses' TABS scores in the 35th percentile. This suggests that SANEs are at higher risk for cognitive changes related to VT than women's health nurses who do not work with trauma as a normal part of their jobs. Although the difference is statistically significant, it is worth noting that both groups fall within the "average interpretive range" based on the TABS' normative group ($N$ = 1743; Pearlman, 2003). Although past studies analyzing qualitative data have shown consistent support for concepts of secondary trauma with trauma providers viewing their work as potentially harmful to their worldview, these average levels of TABS scores are consistent with past research that found overall low and moderate levels on quantitative secondary trauma measures (Bober & Regehr, 2006; Cunningham, 2003; Dunkley & Whelan, 2006; Elwood et al., 2011; Johnson & Hunter, 1997; Kadambi & Truscott, 2004).

Close to half of the sample reported a history of personal trauma. SANEs were slightly more likely to have experienced this primary trauma than women's health nurses, with 48% of SANEs and 45% women's health nurses responding yes to the question "have you ever personally experienced rape, attempted rape, incest, child sexual abuse, or otherwise been made to engage in a sexual act to which you did not willingly consent?" This is consistent with nationally reported rates of sexual violence. The U.S. based 2010 National Intimate Partner and Sexual Violence Survey reports that 18.3% of women have experienced attempted or completed rape (defined as vaginal, oral, or anal penetration with a penis, finger, or other object) in their lifetimes and that 44.6% had experienced other sexual violence (Black et al., 2011).

The one-way ANOVA showed a significant difference in TABS scores depending on personal history. Post hoc comparisons revealed significant differences between women's health nurses without personal history of trauma and both SANEs and women's health nurses who did have personal histories of trauma. Those who had personal histories showed higher levels of trauma. The differences between women's health nurses and SANEs with personal histories were not significant. However, it is worth noting that the group exposed to both personal trauma and VT had the highest mean score. Inconsistencies in previous research and the nature of the tool itself make it difficult to draw further conclusions regarding if personal history makes one more vulnerable to the effects of VT, if disruptions caused by primary trauma and VT are cumulative, or if this is merely a trend without significance (Cunningham, 2003; Dunkley & Whelan, 2006; Elwood et al., 2011; Jenkins & Baird, 2002; Killian, 2008; Newell & MacNeil, 2010; Pearlman & Mac Ian, 1995; VanDeusen & Way, 2006).

SANEs who had not experienced trauma were not significantly different from any other group in the original analysis. However, additional testing to further explore the relationship between the two groups without personal histories did show a significant difference, with SANEs again scoring higher than women's health nurses. Perhaps most notably, the SANEs who had never experienced trauma themselves did not score differently from either group of nurses who had. These results suggest that VT from SANE work causes levels of cognitive disruption similar to the disruption caused by personally experiencing a sexual violation.

Working as a SANE is associated with significant changes in cognition related to VT. VT has been associated with significant negative outcomes including depression, anxiety, substance abuse, and burnout (McCann & Pearlman, 1990a; Pearlman & Saakvitne, 1995; Stamm, 2010). Educating and orienting nurses to new roles requires significant time and investment. As such, losing nurses to burnout is a large drain on a system's resources. Given the significant amount of education needed to succeed in the specialized field of forensic nursing, this is especially problematic when it occurs among SANEs. VT can lead to lessened empathy and greater distancing from patients and can also decrease connection with peers and colleagues (Tabor, 2011). This results in a decrease in quality of patient care and weaker forensic teams. The effects may also reach into the nurse's personal and family lives.

The significant difference in TABS scores of women's health nurses as compared with those of SANEs strengthens the argument that VT does exist. The fact that both groups are within the average range of scores leaves questions about how great a concern the phenomenon is practically in the lives of these nurses. Through the use of women's health nurses as a comparison group and the assessment of personal history of trauma, this study also adds to the body of literature by helping to explore primary trauma versus VT.

## Limitations

The use of a convenience sample limits the generalizability of the study. In addition, the proportion of organizational membership response was low. However, the large sample size and the use of a power analysis add strength to the research (Burns & Grove, 2005). It is certainly possible that there are differences between nurses who belong to their professional organizations and those who do not, and that perhaps those who do, have a stronger professional support network. It is possible that those willing to take the time to respond may have done so because they perceive

that they have been affected by VT or that those who feel strongly affected would have avoided taking the survey. This sample was largely homogenous with 99% female and 92% White respondents. In addition, the language assessing personal history of trauma is original and has not been validated, although there is a precedent for this in previous research (Kadambi & Truscott, 2004; Killian, 2008; Maier, 2011; Pearlman & Mac Ian, 1995; Schauben & Frazier, 1995). The question only asks about personal history of sexual violence and does not explore if respondents have personal histories of other types of trauma. It is possible that VT levels would be different depending on the type of trauma experienced. Future research could explore these issues further.

### Implications for Clinical Forensic Nursing Practice

Nurses choosing to go into this specialty should have an understanding of the phenomenon of VT as a possible sequela of pursuing this work as it may have both personal and professional implications. Defining VT and identifying prevention strategies are competencies of the didactic SANE education guidelines from the IAFN (2013). This education should go further and include information on possible risk factors for and sequelae of VT. This awareness before entering the field would allow nurses to make an informed decision and to be vigilant in assessing for these effects in themselves and their colleagues as they progress in their careers. Gaining an understanding of personal trauma history as a possible risk factor for developing VT has implications for prevention strategies and providing resources to nurses with a prior history of primary trauma.

It is clear that support for the nurses who work in this area is important. SANE teams and leaders can acknowledge that VT is a part of this specialized work and encourage nurses to practice good self-care and seek support when needed. Professional organizations and leaders in the field should encourage continued education on the subject and must work to foster a culture within the SANE community where discussing effects of VT openly is accepted and supported. Hospitals and other organizations employing SANEs should also be aware of VT and have a support system and resources in place to mitigate these effects. SANEs should be encouraged to reach out to any burnout or self-care-related resources available through employers and in their communities. Higher levels of cognitive disruption have been found in trauma workers who have less time for leisure activities; however, it must be acknowledged that commonly recommended strategies for dealing with VT including leisure, self-care, and supervision have not been associated with lower symptoms of traumatic stress (Bober & Regehr, 2006). The field must continue to seek more effective strategies to prevent and respond to VT and work to implement both protective and responsive policies.

### Implications for Future Research

Future research and analysis should explore the subscales of the TABS to gain better understanding of which schemas are most affected by SANE work. Useful information would also be gained from longitudinal research showing change in levels of VT over time. Additional research to further explore the effects of VT versus primary trauma would also be valuable as well as exploration of different types of primary trauma. Qualitative or mixed-method research to further examine experienced ramifications of different levels of VT could help guide a more concrete understanding of threshold for concern, clinical significance, and interventions. Future research should also explore other factors that worsen or alleviate the effects of VT as well as interventions to help mitigate these effects.

## Conclusion

VT is a risk of the work of SANEs that has a link to higher levels of cognitive disruptions in beliefs about safety, trust, intimacy, control, and esteem. Having a personal history of trauma may increase this risk. Working as an SANE appears to be associated with cognitive disruptions as significant as those experienced when one is personally traumatized. Nurses should be aware of this when they choose to pursue SANE work and should be focused on awareness of these changes in themselves and colleagues in the field as well as on self-care. Organizations that employ and utilize SANEs should also be aware of this phenomenon and be prepared to provide support and resources as appropriate.

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