ETHICAL COMPETENCY WHEN WORKING WITH INTIMATE PARTNER VIOLENCE AMONG CLINICIANS AFFECTED BY TRAUMA

A DISSERTATION

SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS

FOR THE DEGREE OF DOCTORATE OF PHILOSOPHY

IN THE GRADUATE SCHOOL OF THE

TEXAS WOMAN'S UNIVERSITY

DEPARTMENT OF PSYCHOLOGY AND PHILOSOPHY

COLLEGE OF ARTS AND SCIENCE

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DENTON, TEXAS

AUGUST 2018

DEDICATION

This dissertation is dedicated to individuals impacted by violence, and to the clinicians who devote their lives to helping and healing. This dissertation is also dedicated to those affected by vicarious trauma and to those who carry pain due to the process of doing the work that they love.

ACKNOWLEDGMENTS

I would like to thank my dissertation committee members who have given their time and energy to cultivating my professional and personal self. I am honored to be able to work with each esteemed psychologist on my committee. Thank you, Dr. Devdas for introducing me to my passion of trauma-informed clinical work and for genuinely investing in my personhood. Dr. Rosen, thank you for your support, warmth, and humor during difficult statistics meetings and encouraging me to believe in myself. Thank you, Dr. Scott, for your flexibility and hard work behind the scenes throughout my graduate training that has led me to be successful.

I would also like to thank Dr. Porras Pyland. Thank you for serving not only as my dissertation chair, but also as a mentor throughout my graduate training. I have valued your supervision and the time you dedicated to me from my first semester of graduate work, during my first semester of clinical practicum, as well as throughout this dissertation process. I deeply appreciate your presence, knowledge, and kindness. You have taught me to believe in myself and break through mental barriers and overcome my fears of not being enough. You have been a source of strength throughout my graduate training, and I have deeply valued our connection and your willingness to always devote time to knowing and supporting me as a person.

I would also like to thank my friends, family, and loved ones, who have supported me throughout my graduate and clinical work. I could not have gotten through the hard days without you. Thank you for loving me well and holding my hand to ground me

when I felt overwhelmed. I would especially like to thank my parents, David and Cathy Kazyaka, who have showered me with love and kindness and always encouraged me to pursue my dreams. Thank you for feeding me and keeping me sane. Thank you, also, to Chris and Dayle Perez, who are closer to a second set of parents than grandparents. I appreciate your love and devotion to me and my growth, and thank you for your unwavering support throughout my life.

Finally, I want to thank my clients over the years, especially those who were impacted by violence and experienced trauma. I am honored to sit with your stories and to be a part of your growth and healing. Being a part of that growth has changed and shaped me for the better.

ABSTRACT

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ETHICAL COMPETENCY WHEN WORKING WITH INTIMATE PARTNER VIOLENCE AMONG CLINICIANS AFFECTED BY TRAUMA

AUGUST 2018

Vicarious trauma (VT) is the internal and psychological change that occurs due to exposure to and empathic engagement with traumatic material. VT changes the ways in which clinicians view and interact with the world around them, and these changes are lasting and pervasive. While many of the predictors of VT are known, researchers have not yet explored the ways in which VT impacts clinical functioning. Beyond VT, many clinicians have experienced a personal history of trauma, and more specifically a personal history of intimate partner violence (IPV). Clinicians with a personal history of IPV may experience countertransference reactions, or over-identify with clients with a similar trauma history. Both VT and a personal history of IPV might impact ethical decision making. Ethical decision making involves using personal morality as well as professional guidelines to ensure the best quality care for clients. Ethical decision making can be impacted by clinicians' interpersonal reactivity, or their ability to engage in self-reflection and not become emotionally reactive. It has been proposed that VT and a personal history of IPV impact clinicians' emotional functioning, but it is unclear the extent to which ethical decision making is impacted by VT or a personal history of IPV.

In order to assess this link, the present study examined the ways in which clinicians differed in their interpersonal reactivity and ethical decision making when using vignettes to imagine working with either a survivor or perpetrator of IPV. The results of this study concluded that mental health workers demonstrated more ethical competence when working with a survivor of IPV than with a perpetrator of IPV, and this finding was consistent across the domains of boundaries in therapy, knowledge, comfort, and skill in ethical dilemmas, assessing for risk, and identification with the client. When examining VT separately, VT was a predictor of interpersonal reactivity, such that clinicians who were high in VT also endorsed high personal distress when working with a survivor of IPV. Additionally, VT was a significant predictor of empathic concern and personal distress when working with a perpetrator, such that as VT increased in therapists, the empathic concern for perpetrators decreased while their personal distress increased. Further, VT was found to be a significant predictor of ethical competence, such that mental health workers low in VT demonstrated better ethical competence than those high in VT both when working with a survivor of IPV and a perpetrator of IPV. A personal history of IPV was found to be a predictor of empathic concern when working with a survivor and when working with a perpetrator of IPV.

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CHAPTER I

INTRODUCTION

Vicarious Trauma

Vicarious trauma (VT) is the term for the cumulative negative psychological effect on psychologists and other mental health-care workers when working with traumatic material presented by clients (Pearlman & Saakvitne, 1995). VT describes the internal psychological changes that occur for individuals with repeated and long-term empathic engagement with trauma material (Pearlman & Saakvitne, 1995). VT is a natural consequence of helping professionals connecting with those in the midst of their own trauma reaction and cannot be blamed on clients or the individuals who have experienced trauma (Pearlman & Saakvitne, 1995). Further, the development of VT is a process that occurs throughout exposure to traumatic material and is not a sudden experience or event that occurs for individuals (Pearlman & Saakvitne, 1995). While there are risk factors that may make the development of VT more likely, any professional with repeated exposure to trauma material is at risk for the development of VT. Additionally, while this study focuses on VT within the context of mental health-care workers, any individuals who engage in trauma work may develop VT, including first responders, firefighters, police officers, lawyers, homeless shelter staff, medical professionals, suicide hotline workers, prison staff, trauma researchers, clergy members, and any other professionals who are exposed to, and connect empathically with the traumatic experiences of others (Pearlman & Saakvitne, 1995).

Professionals working intensely with clients healing from traumatic experiences, like mental health-care workers, are at high risk of developing VT, with as many as one-third of therapists in the trauma field self-reporting symptoms associated with VT (Adams & Riggs, 2008; Pearlman & Saakvitne, 1995). Mental health-care workers impacted by VT report negative psychological changes, including negative emotionality, or feelings of distress defined by anxiety, distrust in others, hypervigilance, depressed or saddened mood, feelings of worthlessness or hopelessness, anger, shock or numbness, tiredness, and feeling powerless (Cohen & Collens, 2013). These reactions can accumulate to therapists feeling generalized distress or feeling overwhelmed by their affective state (Cohen & Collens, 2013). Mental health-care workers might also experience somatic reactions such as, stomachaches, headaches, feeling tired, craving sweets, gastrointestinal distress, and various other somatic reactions. Additionally, VT can impact the ways in which therapists' view their surroundings, or may view the world and others as unsafe and untrustworthy, and experience a decrease in personal self-esteem. These changes may also cause mental health-care workers to disconnect interpersonally from their personal relationships or they may engage in trauma-based behavior (e.g., constantly scanning surroundings) to cope with the distress of these changes (Cohen & Collens, 2013; Pearlman & Saakvitne, 1995).

Some of the risk factors of VT include greater cumulative exposure to traumatic material, or engaging in primarily trauma work for the bulk of therapists' caseload, limited coping strategies, a self-sacrificing defense style, an insecure attachment style, and a previous history of any traumatic experience (Adams & Riggs, 2008; Bride, Jones,

& MacMaster, 2007; Ivicic & Motta, 2016; Marmaras, Lee, Siegel, & Reich, 2003; Pearlman & Saakvitne, 1995). Protective factors against the development of VT include positive engagement with a social support network, appropriate coping mechanisms, and a positive supervision experience (Cohen & Collens, 2013; Harrison & Westwood, 2009; Pearlman & MacIan, 1995).

Consequences of Vicarious Trauma

VT is often discussed within the context of secondary traumatic stress or compassion fatigue. However, secondary trauma is a separate construct and differs from VT in several ways. This study will focus on therapists' experiences of VT. Secondary traumatic stress describes the phenomenon of sudden adverse or negative reactions that helping professionals have in response to clients with trauma whom they are trying to help (Figley, 1995a). STS is defined as having symptomology similar to post-traumatic stress disorder (PTSD), without direct and personal exposure to a traumatic event (Figley, 1995a). STS has now been redefined as compassion fatigue, or exhausting therapists' abilities to be compassionate or engage empathically with clients (Figley, 1995a). STS was renamed compassion fatigue in order to buffer against stigmatization of the developing of traumatic-based responses within the helping field (Jenkins & Baird, 2002). Burnout refers to occupational stress or emotional exhaustion associated with the helping professions and is associated with psychological strain and tiredness coupled with inadequate support (Maslach, 1982).

VT differs from compassion fatigue in that VT is conceptualized as a more gradual permanent shift in mental health professionals' worldview (Jenkins & Baird,

2002; Pearlman & Saakvitne, 1995). VT involves cognitive and emotional shifts pertaining to trust, safety, control, self-esteem, and intimacy. Clinicians impacted by VT might also experience intrusive imagery or dreams associated with clients' traumatic memories (Cohen & Collens, 2013; Jenkins & Baird, 2002; Pearlman & Saakvitne, 1995). VT describes the internal and lasting shifts that occur due to extensive traumatic engagement, whereas compassion fatigue describes behavioral shifts that occur more rapidly in response to any amount of traumatic exposure and diminish when contact with trauma material has ceased (Jenkins & Baird, 2002). Because VT is the internal shifting that can occur after exposure to trauma material, external behavior can also shift in response to hearing traumatic stories, as well as the effects of VT. Therefore, while compassion fatigue and VT are related, compassion fatigue can be thought of as separate but correlated with VT, and in some cases a behavioral response to VT (Sabin-Farrell & Turpin, 2003).

Positive consequences of exposure to traumatic material include post-traumatic growth (PTG; Eidelson, D'Alessio, & Eidelson, 2003). PTG is the positive cognitive change that occurs as a result of exposure to and empathic engagement with trauma (Steed & Downing, 1998). PTG can be conceptualized as the inverse of VT, as mental health-care workers experiencing PTG report the sense of feeling lucky or blessed after being exposed to traumatic material (Eidelson et al., 2003).

Intimate Partner Violence

Intimate partner violence (IPV) is one of many forms of trauma that individuals can experience. The Centers for Disease Control and Prevention (CDC) (2016) defined

IPV as physical violence, sexual violence, stalking, or psychological aggression that is perpetrated by a current or former intimate partner. An intimate partner is an individual with whom the victim feels emotionally connected, is in regular contact with, has an ongoing physical or sexual relationship, is in a romantic relationship with, or in which both parties had close and personal knowledge of one another's' lives (CDC, 2016).

Physical violence within IPV includes any intentional use of physical force. These behaviors have the possibility of harming the victim, and can include hitting, slapping, throwing, strangling, or using one's body size to intimidate or affect the victim (CDC, 2016). Sexual violence involves instances in which the victim does not freely give, or is unable to give consent to sexual acts or sexual contact (CDC, 2016). Beyond physical force, sexual violence might also be coerced and victims may be pressured to engage in sexual contact by a perpetrator (CDC, 2016). Stalking can be defined as a pattern of repeated and unwanted attention and contact that can lead to an individual fearing for their own safety or the safety of others (CDC, 2016). Finally, psychological aggression is the emotional harming of an individual. This can include attempts to control the victim, expressions of verbal abuse (e.g., name calling), exploiting the victim's vulnerabilities, and causing the victim to experience self-doubt or feel inadequate in any way (CDC, 2016).

Prevalence rates of IPV vary across the world, but collective reports estimate that 45 million individuals worldwide have experienced IPV during their lifetime (Brieding et al., 2015). IPV can cause both short-term and long-term negative emotional, psychological, physical, and health concerns (Brieding et al., 2015, CDC, 2016; World

Health Organization, 2014). Additionally, individuals with a history of previous victimization are more likely to be revictimized in the future or to experience multiple traumatic experiences throughout their lifetime (CDC, 2016).

Ethical Decision Making

Ethical decision making is the process of identifying problematic situations and determining appropriate courses of action (American Psychological Association [APA], 2017). Ethical decision making involves having and maintaining professional and scientific knowledge and utilizing that knowledge to serve others (APA, 2017). The APA (2017) created the Ethical Principles of Psychologists and Code of Conduct, which contains five aspirational principles when working with clients: beneficence and nonmaleficence, fidelity and responsibility, integrity, justice, and respect for people's rights and dignity. Following the five principles, the ethical guidelines then lay out the code of conduct, which are mandated behaviors to ensure ethical practice (APA, 2017). These codes and principles guide ethical behavior for psychologists. Additionally, the APA ethical codes are the rules of conduct for psychologists, and although other mental health professionals have their own rules of conduct reflective of their field, this study will only be using the principles identified in the APA ethical guidelines.

The basis of the ethical guidelines provided by APA (2017) involves the principle of beneficence and nonmaleficence. Beneficence is the principle of working towards the benefit and well-being of clients, committing to not causing harm to them, and resolving any conflicts of clients' welfare in a timely and appropriate way that minimizes harm or risk (APA, 2017). One way that clinicians might minimize any potential risk to clients is

to engage in self-reflection to assess the impact their actions might have on clients (APA, 2017).

Fidelity and responsibility describe mental health-care workers' commitment to establishing therapeutic relationships that are built on trust and prioritize the needs of clients (APA, 2017). Clinicians should, therefore, aspire to devote sufficient time to exploring the best treatment interventions for clients. Integrity is the practice of being open, authentic, and honest when practicing psychology, and involves providing facts and correcting any misinformation in order to minimize harm towards clients (APA, 2017). Justice is the belief that all peoples are entitled to have access to and to benefit from psychology (APA, 2017). As an aspect of justice, mental health-care workers commit to recognizing their own levels of knowledge and experience and work within those limitations (APA, 2017). Finally, respect for people's rights and dignity encompass the principle that all people are worthy of dignity and respect and everyone has the right to privacy, confidentiality (in most cases) and the control over their own life. In order to respect all individuals, mental health-care workers commit to working towards minimizing any personal biases that might be held towards individuals or populations of people (APA, 2017).

Ethical Decision Making in Psychoytherapy

In order to engage in ethical decision making within a clinical setting, psychotherapists must first identify an ethical dilemma using personal or professional ethics to flag a problem, explore the dilemma fully, including who is impacted or affected by the dilemma, explore possible solutions and their ramifications, and make a decision

based on the course of action that best addresses the dilemma and minimizes harm to others (Clawson, 1994; Craft, 2013). Ideally, clinicians will have both high personal and professional ethics and integrate a sense of personal morality with their professional ethical guidelines. Personal ethics include clinicians' personal sense of morality or moral compass that guides them to acknowledge if something does not feel moral or right (Craft, 2013). However, personal ethics alone are not sufficient for ethical decision making (Handelsman, Gottlieb, & Knapp, 2005). Ethical decision making for mental health-care workers includes engaging in appropriate boundaries, engaging empathically with clients, and appropriately monitoring identification with clients (Benatar, 2000; Saakvitne, 2002; Wilson & Lindy, 1994). Boundaries establish a pattern of expectations within therapy, which help to create a sense of safety, security, and predictability within therapy and the therapeutic relationship (Wilson & Lindy, 1994).

Boundaries are particularly important when working with a trauma population, because for these clients, they may not have personally experienced safety and predictability within their lives, so boundaries within therapy help to model the establishment of boundaries as well as provide a corrective experience for those harmed by a lack of boundaries in their personal lives (Teyber & McClure, 2011; Wilson & Lindy, 1994). The establishment of boundaries varies among mental health care workers, but the experience of VT or personal experiences of past trauma can impact clinicians' abilities to engage in appropriate boundaries. For example, psychotherapists with poor boundaries may engage in behavior that falls outside of therapeutic norms, such as disclosing personal information to clients, allowing exceptions for clients, seeing them

multiple times a week or running over on the session time limit, or taking on too much responsibility for clients' lives (Benatar, 2000; Wilson & Lindy, 1994). In contrast, psychotherapists struggling with VT or a personal history of IPV could also engage in overly rigid boundaries, in which they adhere strictly to ethical guidelines and do not connect deeply with clients and are not flexible regardless of clients' difficulties or needs (Pearlman & Saakvitne, 1995).

Empathy is critical for the therapeutic relationship and for clients to heal (Keefe, 1976). Empathy establishes trust and connection between therapists and clients and is critical to positive outcomes for clients in therapy (Keefe, 1976). However, empathy can be impacted when psychotherapists are struggling with VT or a personal history of IPV (Pearlman & Saakvitne, 1995; Wilson & Lindy, 1994). Because psychotherapists' may feel overwhelmed by their own emotional reactions and sense of distress, they might disconnect from clients and struggle to empathically engage with client experiences (Cohen & Collens, 2013; Pearlman & Saakvitne, 1995; Wilson & Lindy, 1994).

Psychotherapists and other mental health workers may identify with clients or their experiences, in that psychotherapists may feel connected or have a felt sense of understanding the client (Saakvitne, 2002). Identification with clients may stem from personal experiences or personal reactions to the client and can be conceptualized as a form of countertransference, or the affective reactions clinicians experience in response to their clients, which are sometimes based in personal experiences (Little, 1957; Winnicott, 1949). If psychotherapists share a trauma history with their clients, or if both have had similar traumatic experiences, therapists are at greater risk for over-identifying

with their victimized client (Saakvitne, 2002). This is problematic as it could result in psychotherapists struggling to separate their personal experiences from those of the clients (Saakvitne, 2002). Psychotherapists struggling with VT may also struggle with over-identification, as these therapists might use over-identification as a defense against their own emotional distress by engaging in a familiar pattern (Marmaras et al., 2003).

Interpersonal Reactivity

Interpersonal reactivity, or the extent to which an individual or mental health-care worker feels impacted by working with clients is a form of emotional competence (Pope & Vasquez, 2016). Interpersonal reactivity is defined as the empathy we feel for others, or the internal feelings, thoughts, or general reactions of an individual when another person is expressing or communicating their experiences (Davis, 1983). Emotional competence is the reflection and awareness of self as fallible and the recognition of personal strengths and weaknesses (Pope & Brown, 1996). Emotional competence requires continuous self-assessment in order to ensure adequate ethical competence and appropriate ethical decision making (Pope & Vasquez, 2016). Any disruption in emotional competence, or any intense or negative interpersonal reactions, can lead to therapists making more mistakes, lacking energy, and discourteous behavior for either clients or the workplace, all of which impacts mental health workers' ability to appropriately determine a best course of action with ethical decisions (Pope & Vasquez, 2016).

For psychotherapists, having intense emotional reactions to client experiences can be a natural aspect of clinical work; however, these reactions can lead to feelings of

helplessness or compassion fatigue (Allden & Murakami, 2015; Pope, 2012). Additionally, mental health workers may feel emotionally reactive as a consequence of VT (Cohen & Collens, 2013). Clinicians with a personal history of IPV may also feel emotionally and interpersonally reactive when working with clients due to their personal experiences of trauma (Pope & Vasquez, 2016). Therapists who have intense emotional or interpersonal experiences or who are unaware of their own affective reactions are at higher risk for engaging in poor ethical decision making (Pope & Vasquez, 2016).

Purpose of the Study

Although literature has examined the impact of VT on individual functioning, the extent to which clinicians' occupational functioning is impacted remains unclear. The current study is designed to examine how mental health-care providers vary in ethical decision making when working with perpetrators versus victims of IPV. Past research has also explored the ways in which personal histories of IPV might impact clinical decision making with survivors of trauma. However, the extent to which mental health-care workers with a personal history of IPV will be impacted in their ability to make ethically appropriate decisions with perpetrators and survivors of IPV remains unclear. There is empirical and theoretical support for the ways in which VT develops and how VT subsequently impacts mental health-care workers, as well as support for the ways in which personal histories of trauma impact therapists' abilities to engage in appropriate clinical decision making with clients in general. However, this study hypothesizes that a link may exist between clinicians' struggling with VT, and their interpersonal reactivity and ethical decision making when working with survivors or perpetrators of IPV.

Additionally, this study proposes a link between clinicians with a personal history of IPV, and their interpersonal reactivity and ethical decision making when working with survivors or perpetrators of IPV. While this link has been hypothesized in the past, it has not been directly studied, particularly when examining the differences between clinicians' responses to clients who are perpetrators of IPV versus survivors of IPV (Cohen & Collens, 2013).

Definition of Terms

For the current study, certain terms are operationally defined as follows:

- Vicarious Trauma/Vicarious Traumatization (VT) – The accumulation of lasting and distressing, or negative, internal changes, including emotional and cognitive changes that occur as a result of empathic engagement with traumatic material (Cohen & Collens, 2013; Pearlman & Saakvitne, 1995).
- Post-traumatic Growth (PTG) – The accumulation of lasting positive internal changes, including cognitive changes, that occur as a result of empathic engagement with traumatic material or with individuals who have experienced trauma (Cohen & Collens, 2013; Eidelson et al., 2003; Steed & Downing, 1998).
- Intimate Partner Violence (IPV) – Acts of physical violence, sexual violence, stalking, or psychological aggression that is perpetrated by a current or former intimate partner (CDC, 2016).
- Intimate Partner – An individual with whom the victim felt emotionally connected, had regular contact, had an ongoing physical or sexual relationship,

had identified as a couple or in a romantic relationship, or in which both parties had personal and intimate knowledge of one another's' lives (CDC, 2016).

- Perpetrators – Individuals who enact systematic acts of abuse or violence, including acts of physical violence, sexual violence, stalking, psychological aggression, or intimidation in order to control their intimate partners (CDC, 2016; Harway & O'Neil, 1999).
- Survivor – An individual who was the target or victim of intimate partner violence (Breiding et al., 2015; CDC, 2016).
- Countertransference – Reactions experienced by therapists in response to their clients or their clients' stories (Winnicott, 1949). These experiences are either objective, in that they reflect and are reactions in response to clients' interpersonal engagement, or subjective, or reflective of therapists' own history or personal distress (Little, 1957; Wilson & Lindy, 1994; Winnitcott, 1949).
- Prevalence – The amount of the population that have experienced a given phenomenon throughout their lifetime (Breiding et al., 2015).
- Ethical Decision Making – The process of identifying concerning situations and determining appropriate courses of action after first examining possible solutions and the outcomes of each solution (APA, 2017). Ethical decision making takes into account therapists' morality as well as professional guidelines set forth by professional organizations and state legislature (APA, 2017; Clawson, 1994). For this study, ethical decision making is defined as boundaries set by the clinician, including over versus under involvement with the client.

- Personal Ethics – Individuals' own sense of right and wrong, and is influenced by their lived experiences and intuition (Handelsman et al., 2005).
- Professional Ethics – Guidelines set forth by a governing professional body, such as APA, or by state legislature (APA, 2017; Handelsman et al., 2005). These guidelines must be adhered to by practicing clinicians in order to provide the best quality care for clients (APA, 2017).
- Clinical Decision Making – The ways in which therapists engage with clients, which involves identifying problems, generating solutions and assessing the outcome of each solution prior to making a decision (Spengler, Strohmer, Dixon, & Shivy, 1995). Clinical decision making is influenced by clinicians' personal experiences as therapists as well as their theoretical orientation, and involve the application of ethical considerations (Clawson, 1994; Craft, 2013). As a result, clinical decision making will be used in tandem with ethical decision making in this study.

CHAPTER II

LITERATURE REVIEW

Vicarious Traumatization

VT is the cumulative impact of working with victims or survivors of trauma (Pearlman & Saakvitne, 1995). VT is the inner transformation of clinicians that occurs due to empathic engagement with trauma material (Pearlman & Saakvitne, 1995). The repeated exposure of clinicians to the fear, pain, or sense of terror that accompanies trauma stories has a lasting impact on clinicians (Pearl & Saakvitne, 1995). This effect is considered a hazardous and to some extent, an inevitable effect of engaging with trauma material. VT is not reliant on a specific client trait or the process of clients healing from therapy, but rather it is an effect of the innate exposure to trauma material that results in VT (Pearl & Saakvitne, 1995). The long-term effects of working with trauma elicits traumatic response reactions (e.g., an emotional or somatic reaction to the trauma work and changes to schemas and behavior) (Benatar, 2000; Cohen & Collens, 2013).

Therapists who treat trauma can experience negative psychological effects and feel that their personal sense of self is disrupted as a result of helping people with trauma (Cohen & Collens, 2013; Pearlman & Saakvitne, 1995). The symptoms of VT seem to mimic the same symptoms of those suffering from post-traumatic, acute stress, or responses of first-hand trauma (Cohen & Collens, 2013; Finklestein, Stein, Greene, Bronstein, & Solomon, 2015; Schauben & Frazier, 1995). Professionals may experience a shift in their schemas, or the ways in which people frame and view their

world, such that they distrust people more readily, feel unsafe, feel powerless or out of control, become dependent upon others, have lowered self-esteem, or distance themselves from intimacy with others (Cohen & Collens, 2013; Hesse, 2002). These altered schemas impact professionals both personally and professionally (Hesse, 2002).

The symptoms of VT may be conceptualized as the spread of trauma reactions from the clients to therapists (Ivicic & Motta, 2016). Therapists undergo psychological changes which transform the ways in which therapists then interact with or perceive their environment or life outside of work (Cohen & Collens, 2013; Ivicic & Motta, 2016). After examining VT studies using a metaanalysis, Cohen and Collens (2013) found that VT reactions can be broken down into four themes: emotional and somatic reactions from trauma work, coping with the emotional impact of trauma work, the impact of trauma work-changes to schemas and behavior, and the process of schematic change and relating factors (Cohen & Collens, 2013).

Therapists affected by VT likely have a variety of emotional reactions to trauma work, including but not limited to, sadness, anger, fear, frustration, helplessness, powerlessness, despair, shock, numbness, nausea, tiredness (Cohen & Collens, 2013). The therapist affected by VT then struggles coping with difficult affect or the emotional impact of trauma work, leading to the therapist feeling overwhelmed or in intense distress (Cohen & Collens, 2013; Pearlman & Saakvitne, 1995). In regards to somatic reactions, therapists reported numbness, nausea, tiredness, and craving of sweets (Cohen & Collens, 2013).

VT impacts therapists' beliefs and schemas; VT shift the ways in which therapists make or find meaning in their life, resulting in a lasting change of the therapists' world views (Cohen & Collens, 2013). Further, therapists may begin to question themselves, their lives, or their identities (Cohen & Collens, 2013). Therapists affected by VT might also have a change in their perceptions of their own safety and develop more mistrust towards others (Cohen & Collens, 2013). Therapists affected by VT are more likely to view the world as unsafe (Cohen & Collens, 2013; Iliffe & Steed, 2000). Because their world is viewed as unsafe and not trustworthy, therapists may feel particularly vulnerable when engaging in the world around them (Cohen & Collens, 2013; Iliffe & Steed, 2000). This vulnerability can lead to therapists' withdrawing from their life and relationships, as withdrawal may feel easier than tolerating the distress of mistrusting others (Cohen & Collens, 2013; Iliffe & Steed, 2000). Additionally, this vulnerability can lead to therapists' experiencing a sense of hypervigilance, exhibited in behaviors such as constantly scanning their surroundings for danger when out in public (Cohen & Collens, 2013; Iliffe & Steed, 2000).

Therapists' mistrust of others relates to their feelings of being unsafe, and for therapists who work with sexual assault or IPV, this distrust of others may be predominantly directed towards men due to men perpetrating IPV at higher rates than women (CDC, 2016; Cohen & Collens, 2013; Iliffe & Steed, 2000; World Health Organization, 2014). As a result of experiencing VT, therapists may shift the ways in which they act or engage in life (Cohen & Collens, 2013). Mistrusting others results in the therapist becoming isolated, reducing intimacy in relationships, or becoming socially

disrupted (Cohen & Collens, 2013; Pearlman & Saakvitne, 1995). The therapist may further isolate his or her self by ruminating on client stories (Cohen & Collens, 2013). The therapist may also struggle with decreased sexual desire or may disregard pleasurable activities or self-care (Branson, Weigand, & Keller, 2014; Pearlman & Saakvitne, 1995).

Post-Traumatic Growth (PTG)

In addition to negative changes in beliefs and schemas, therapists might also experience positive cognitive shifts, sometimes referred to as PTG (Cohen & Collens, 2013; Eidelson et al., 2003; Steed & Downing, 1998). PTG is a positive psychological change that occurs after exposure to traumatic material, and can be conceptualized as related to, but the inverse of, VT (Tedeschi & Calhoun, 1995, 2004). Therapists might perceive life positively, such as having a greater appreciation for life or a more positive view of resiliency (Cohen & Collens, 2013). Therapists have reported a sense of feeling lucky or blessed after exposure to traumatic material (Cohens & Collens, 2013). Additionally, therapists might report feelings of increased compassion for their clients, and may report feeling humbled (Cohen & Collens, 2013).

Individuals who experience PTG are also exposed to traumatic material, but rather than the negative psychological consequences of VT or a trauma-like reaction, people who experience PTG are able to successfully manage and work through the emotional distress connected with their victimization. Further, individuals experience personal growth as a result of their trauma and may experience a positive psychological change after a traumatic experience (Tedeschi & Calhoun, 1995). This psychological change can

be viewed as the opposite of a vicarious trauma response, such that individuals may experience a positive shift in their view of the world and of themselves; for instance, clinicians might feel spiritually connected, find new meaning in their life, feel a sense of optimism or gain appreciation for his or her own good fortune (Tedeschi & Calhoun, 1995). In addition to VT, clinicians have also reported PTG responses as a result of vicarious exposure to trauma through clients (Cohen & Collens, 2013).

VT and PTG are experienced by professionals who work with trauma, but the two experiences are separate. The individual traits and views of the world seem to moderate professionals' experiences (Cohen & Collens, 2013). Clinicians with positive and optimistic outlooks on life are in a position to more likely develop PTG than therapists who are either experiencing current distress or have a risk factor for the development of VT (Cohens & Collens, 2013). This can be problematic for clinicians who have experienced long-term trauma or trauma during childhood, as their schemas, or views of the world, may be negatively skewed as a result of their trauma, which may incline these professional to be more likely to experience vicarious traumatization (Cohen & Collens, 2013).

Predictive Factors of Vicarious Trauma

The risk of VT is associated with the amount of time therapists spend working with trauma clients and the relationship is curvilinear. That is, long-term clinicians and very new clinicians are at highest risk for developing vicarious trauma (Adams & Riggs, 2008; Cohen & Collens, 2013; Ivicic & Motta, 2016; Mailloux, 2014; Schauben & Frazier, 1995; Way, VanDeusen, Martin, Applegate, & Jandle, 2004). VT results from

empathic engagement with traumatic material or with the long-term exposure of therapists to clients' trauma material (Schauben & Frazier, 1995). Because vicarious trauma is associated with the repeated exposure to trauma stories, it appears to be a hazard of clinical work with trauma, with prolonged exposure to working with a trauma population resulting in higher rates of vicarious trauma (Cohen & Collens, 2013; Figley, 1999; Schauben & Frazier, 1995). However, a lack of experience is also associated with vulnerability of developing vicarious trauma (Adams & Riggs; Ivicic & Motta, 2016; Mailloux, 2014).

Exposure to traumatic material. The subjective exposure to trauma material also increases risk of vicarious traumatization. Therapists with greater exposure to traumatic material through their clients are at higher risk for the development of VT (Pearlman & Saakvitne, 1995). Therefore, increased hours spent with trauma clients and cumulative exposure to traumatized clients is a risk factor for the development of vicarious traumatization (Ivicic & Motta, 2016). Therapists whose case load is primarily traumatized clients are more vulnerable to the development of VT (Ivicic & Motta, 2016). Additionally, the more time therapists spend a week working with traumatized clients, the more vulnerable they might be for the development of VT (Ivicic & Motta, 2016; Pearlman & Saakvitne, 1995). Clinicians who are exposed to vast amounts of traumatic material at one time, either through their case load or the hours spent hearing trauma stories in one week, likely feel overwhelmed or inundated with the traumatic material, which results in increased likelihood for changes in schemas or the

psychological impact of VT (Pearlman & Saakvitne, 1995; Way, VanDeusen, & Cottrell, 2007).

Poor coping strategies. Other factors that are linked to vicarious trauma include having limited or poor coping strategies, experiencing significant stress in personal lives, gender, and a personal trauma history (Ivicic & Motta, 2016; Sabin-Ferrell & Turpin, 2003). Clinicians who have inadequate coping strategies are unprepared to handle their personal reactions to traumatic material relayed by clients (Cohen & Collens, 2013). Poor coping strategies might include not being able to tolerate difficult affect, self-sacrificing for the benefit of others, not seeking adequate support from others, and poor insight or self-awareness (Adams & Riggs, 2008; Bride et al., 2007; Cohen & Collins, 2013). These clinicians are less prepared to weather the negative psychological reactions that lead to VT, thus putting the clinicians with poor coping strategies at risk for developing VT responses (Adams & Riggs, 2008).

When examining the distress of therapists who work with trauma, it appears that many of the negative reactions experienced by the therapists tend to be vicarious in nature; therapists experience distress in response to exposure to intense client material (Schauben & Frazier, 1995). This trend may be especially true for inexperienced clinicians or counselors who are in training (Ivicic & Motta, 2016). That may be because inexperienced clinicians are typically unaware of the concept or risk of vicarious trauma, when knowledge about the phenomenon can serve as a protective factor (Hesse, 2002). Additionally, inexperienced clinicians may not have effective coping strategies in place to protect against VT (Cohens & Collens, 2013). Finally, inexperienced clinicians might

engage in ineffective use of supervision, or have a lack of connection to the field, which also serves to increase risk for the development of VT (Ivicic & Motta, 2016).

Gender. Gender serves as a predictive variable for the development of VT. Women are at a higher risk of developing VT than men (Ivicic & Motta, 2016). Rates among women mental health workers are higher than those reported or measured for men who work in the mental health field (Ivicic & Motta, 2016). It is important to note that these measures are based on self-report scales, and men may not be as in touch with their experiences as women, thus resulting in a false negative on scales measuring VT (Ivicic & Motta, 2016). Further, women tend to work in the mental health field at higher rates than men, and gender as a risk factor may instead be more indicative of a greater number and variety of women mental health workers responding to study requests.

Personal history of trauma. For professionals who have experienced personal trauma, their defense style, or the unconscious processes that protect individuals from difficult affective experiences, could serve as a protective or risk factor for vicarious trauma (Adams & Riggs, 2008). People can have a variety of types of defense mechanisms, with the four primary defense styles being: maladaptive action style, or the inability to manage impulses through acting out, projecting onto others, withdrawing from others, or acting in a passive aggressive manner; image-distorting style, or splitting between self and other as good versus bad, or idealization of self or others; self-sacrificing style, or a need to maintain the view or perception of self as kind and giving through altruism or suppression of own affect in order to help others; and adaptive style, which is the healthiest coping style and consists of more mature defense styles like

appropriate suppression or sublimation (Bond, 2004). An adaptive defense style of comfortably engaging in intense feelings may help to shift a professional towards post-traumatic growth, whereas an avoidant or anxious attachment style may shift a professional towards vicarious trauma (Adams & Riggs, 2008).

Many individuals who have previously been victimized are more likely to engage in a self-sacrificing defense style, where they put the needs of others above their own needs. This style could result in an increased risk for developing a vicarious trauma response (Adams & Riggs, 2008). Clinicians with restrictive defense styles may find themselves experiencing less traumatic responses to their clinical work, but may be more interpersonally distant when engaging with clients. Alternatively, clinicians who are over-invested in their clients' stories may find themselves experiencing impulsive reactions or poor boundaries with their clients. Clinicians with adaptive defense styles are the least vulnerable to the development of VT (Adams & Riggs, 2008).

Attachment style. Attachment style could also serve to mediate the type of response professionals experience as a result of vicarious exposure to trauma (Marmaras et al., 2003). Attachment can be defined as the ways in which people engage interpersonally with others around them **(**Bowlby, 1977). There are four primary ways in which people attach to others (Bowlby, 1977). Bartholomew and Horowitz (1991) empirically assessed the four ways in which people attach and found that people might attach securely to others, in which individuals are comfortable with intimacy and autonomy with themselves and in relationships. People might also have a preoccupied attachment, when a person feels pulled to attain self-acceptance and peace through the

acceptance of others. These individuals are often in enmeshed intimate relationships with others in order to ease anxiety about their own worth. The third type of attachment is a dismissive style of attaching, or dismissive-avoidant, in which individuals dismiss the intimacy of others. People with this attachment style feel pulled to protect themselves from pain or disappointment by avoiding close relationships, having full autonomy, and detaching from others.

Finally, people might have a fearful, or fearful-avoidant, attachment style. People with this attachment style are socially avoidant and fearful of intimacy. People with a fearful attachment style anticipate rejection by others and may then avoid people in order to avoid feelings of rejection. Attachment may be related not only to the ways in which individuals engage interpersonally, but attachment could more generally moderate the effectiveness in which people cope with trauma (Marmaras et al., 2003). Women who have a fearful-avoidant attachment style are at a higher risk of experiencing VT (Marmaras et al., 2003). A fearful-avoidant attachment style in combination with a history of trauma further increases the risk of therapists experiencing VT, such that the therapist may attempt to avoid or cope with intrusive distress as a result of exposure to vicarious trauma (Marmaras et al., 2003).

Protective Factors Against VT

Social support. Adequate social support can serve as a protective factor against the development of VT (Harrison & Westwood, 2009). Social support can help mitigate the daily or cumulative stress of working with a traumatized population (Harrison & Westwood, 2009). A lack of social support could result in an increased vulnerability for

therapists in their daily lives (Harrison & Westwood, 2009). Further, social support has been found to be a mediator for the development of VT (Bride et al., 2007). Clinicians with a supportive social network are less likely to develop VT than those who lack social support (Bride et al., 2007). Appropriate and connected interpersonal relationships can help therapists to buffer their countertransference reactions and can help therapists to maintain appropriate therapeutic boundaries (Pearlman & Saakvitne, 1995). The tolerance of difficult affect and the maintenance of therapeutic boundaries can lead to more effective clinical and ethical decision making.

Coping with VT. Therapists may cope with the emotional impact of VT in a variety of ways (Cohen & Collens, 2013). Therapists may need the organizational support of their clinical site, as therapists may need to cope with VT by revising their work load and diversifying the types of roles they engage in (Cohens & Collens, 2013). Additionally, therapists may need the support of an inclusive work environment as well as peer and social support and supervision (Cohen & Collens, 2013; Iliffe & Steed, 2000). Peer and social support may help therapists to combat feelings of isolation and disconnection that result from the emotional distress of VT (Cohen & Collens, 2013; Iliffe & Steed, 2000). In addition to seeking support from others around them, therapists may cope by engaging in quality and meaningful self-care activities, such as exercising, healthy eating, resting, meditation, taking vacations, and spending time with friends having fun (Cohen & Collens, 2013; Iliffe & Steed, 2000). Personal psychotherapy may also help therapists mitigate the emotional distress of VT (Hunter & Schofield, 2006). The final way therapists have reported coping with VT include relying on their personal

belief system, such as feelings of spirituality, an optimistic outlook on life, or engaging in humor (Hunter & Schofield, 2006).

Positive supervision experience. Having a connection to the field of psychology or the profession has a positive psychological impact on clinicians (Holloway, 1995). One way to increase this connection is through clinical supervision. Clinical supervision is an integral aspect of training and development for inexperienced clinicians (Holloway, 1995). For therapists working with trauma, clinical supervision is particularly important, as this can be an avenue for inexperienced clinicians to learn about clinical work with trauma as well as a way for inexperienced therapists to learn about the impact of empathically engaging in trauma material and the concept of VT (Pearlman & Saakvitne, 1995). Additionally, clinicians who have engaged in clinical supervision and experienced a positive supervisory relationship with their supervisor (i.e., supervisees were able to be open and discuss their difficulties with their supervisors), were less likely to experience VT than those without positive supervisory experiences (Pearlman & MacIan, 1995).

Previous Experiences of Personal Trauma

The literature related to clinician's previous experiences of personal trauma and the subsequent development of VT have widely varied. Some studies have reported a very clear link between a personal history of trauma and an increased vulnerability to the development of VT, whereas other studies have found that link to be negligible or nonexistent. Beyond VT, the link between previous trauma experiences and vulnerability to the negative consequences of working with trauma is unclear (Schauben & Frazier, 1995; Way et al., 2004),

Therapists who have previously experienced personal trauma may be at higher risk of developing VT or of experiencing the negative impact of working with trauma survivors than therapists without a personal history of trauma (Figley, 1999; Hesse, 2002). In general, clinicians who have experienced trauma seem to be more distressed when engaging in trauma work than clinicians without a trauma history, which can indicate a higher vulnerability for developing VT (Hesse, 2002; Schauben & Frazier, 1995).

However, other studies have not found this same vulnerability for therapists with a history of trauma (Cohen & Collins, 2013). A metaanalysis conducted by Cohen & Cohen (2013) failed to provide conclusive support for the relationship between a personal trauma history and VT. This then speaks to the need to examine the ways in which other factors may interact with a history of personal trauma (Adams & Riggs, 2008), as there is likely a mediating factor between a personal trauma history and VT. Additionally, it is unclear how the combination of both VT and trauma history impacts a clinician's clinical decision making when working with clients with a history of trauma.

It is important to examine how clinicians' experiences of a personal history of trauma might impact clinical or ethical decision making with a trauma population. Rates of trauma amongst therapists are at least equal to the general population, but some studies have indicated trauma experiences are higher among clinicians (Elliot & Guy, 1993). Approximately 25 % of women and 7.6 % of men have experienced IPV in their lifetime (Tjaden & Thoennes, 2000). IPV can have long term consequences for survivors of IPV (Black, 2011; Tjaden & Thoennes, 2000). These consequences might be psychological,

including feelings of anxiety, depression, or PTSD; or physical, including headaches, memory problems, high blood pressure, gastrointestinal difficulties, or chronic pain (Black, 2011).

When compared to non-mental health workers who have experienced victimization, mental health professionals appear to be better at coping with their psychological distress (Elliot & Guy, 1993). Specifically, therapists with personal victimization reported lower rates of anxiety, depression, dissociation, sleep disturbance, interpersonal impairment, and substance use than individuals who have been victimized but do not work in mental health (Elliot & Guy, 1993; Follette, Polusny, & Milbeck, 1994). Further, mental health professionals as a whole report better psychological functioning than individuals of other professions, despite reporting higher rates of abuse or victimization than professionals in other fields (Elliot & Guy, 1993).

It appears that although therapists may have been victimized, these individuals may have learned more positive coping mechanisms to mitigate psychological distress than individuals who have been victimized but do not work in the mental health field (Elliot & Guy, 1993). As therapists gain experience and attend to their own growth, both as a person, and as a professional, therapists with trauma histories report fewer psychological symptoms of distress and appear to be at lower risk for VT. This perhaps speaks to both the individual differences of those therapists, and the process of training and growing both personally and professionally for those clinicians (Benatar, 2000).

Further, experienced therapists reported that their own experiences of trauma caused them to become better therapists (Benatar, 2000). Therefore, it can be assumed

that therapists would experience similar outcomes to the general population in response to IPV, but perhaps have developed positive or helpful coping mechanisms to minimize those consequences. While Black (2011) discussed some of the long term consequences of IPV, it is unclear how those consequences impact clinicians in their work, clinical decision making, or ethical decision making.

Clinicians who have experienced trauma may struggle with long-term interpersonal consequences of trauma, such as a difficulty developing trust in relationships or with setting and maintaining boundaries within relationships (Marmaras et al., 2003; Schauben & Frazier, 1995). This pattern of distrust can show up in therapy, such that counselors with past trauma histories may find it difficult to establish trust and rapport in the relationship when compared to counselors without a trauma history, which could result in either more long-term therapy or premature termination when the clinician has experienced trauma (Schauben & Frazier, 1995). Further, traumatized clinicians may not effectively utilize boundaries in their own life due to their past experiences and disrupted attachment, and may then struggle with modeling boundaries for clients (Marmaras et al., 2003).

Clinical and Ethical Decision Making

Relationship Between Clinical and Ethical Decision Making

Both clinical and ethical decision making involves therapists reacting to stimuli provided by clients. In clinical decision making, therapists engage in intuition and reasoning and react accordingly (Clawson, 1994). Clinical decision making involves making judgments surrounding the client problem, deciding on the modality or type of

treatment to use with clients, assessing the outcomes of therapy and the need to adjust treatment, as well as countless other decisions made within the context of the therapeutic relationship (Spengler et al., 1995). Therapists engage in critical thinking and problem-solving strategies in order to make the appropriate decisions while caring for clients (Wainwright, Shepard, Harman, & Stephens, 2011). Therapists will base clinical decisions on the specific context of the situation, and their own prior experiences of decision making (Clawson, 1994). Therefore, clinical decision making evolves and grows over time, with experienced clinicians as more skilled in clinical decision making than novice therapists (Wainwright et al., 2011).

Additionally, there is a curvilinear relationship with ethical decision making in which novice therapists and highly experienced therapists are at higher risk of making poor ethical decisions (Knapp & VandeCreek, 2012). This may be caused by clinicians' tendency to overestimate the accuracy of their clinical judgments and are overconfident in their decisions without appropriate cause for their confidence (Miller, Spengler, & Spengler, 2015). Clinical decision making models generally follow the guidelines of identifying a problem, conceptualizing the problem within a theoretical framework, exploring possible avenues of treatment, assessing the potential outcomes of each solution, and selecting a treatment based on those conclusions (Clawson, 1994). These steps also align with ethical decision making models (Clawson, 1994).

Ethical decision making compliments clinical decision making in that it takes into account therapists' moral reflection (Craft, 2013). Moral reflection and the intensity of a morally-driven reaction guides clinicians to make decisions that align both with their

clinical experience and their ethical guidelines (Clawson, 1994; Craft, 2013). Ethical decision making involves clinicians adhering to an ethical code, which posits that mental health workers will hold themselves to standards to ensure they are providing the best quality care possible (American Psychological Association, 2008).

The Ethical Principles of Psychologists and Code of Conduct, developed by the APA (2008), are ethical guidelines meant to protect clients and provide the best quality care for clients that go beyond legal statues created by state legislature. The APA guidelines include rules for appropriate behavior and distinguish between ethical and unethical decisions. The guidelines are meant to allow some clinical judgment, so while they guide behavior, clinicians ultimately make decisions after considering contextual factors (APA, 2017). When engaging in clinical decision making, clinicians must consider their ethical guidelines, thereby making the two intrinsically tied.

Personal Ethics versus Professional Ethics

Ethical decision making takes into account both personal and professional ethics. Personal ethical decision making is driven by therapists' personal set of morals and their own compassion towards others (Handelsman et al., 2005). In order to engage in ethical decision making, clinicians must tune-in to their own moral compass to identify ethical dilemmas and explore various solutions and outcomes (Craft, 2013). However, personal morality alone is not sufficient for appropriate ethical decision making (Handelsman et al., 2005). Clinicians with only high personal ethics may become overinvolved with their clients, assert themselves intrusively into clients' lives (e.g., through inappropriate advocacy), fail to maintain therapeutic boundaries, and choose personal morality over

legal or professional ethical guidelines (Knapp, Handelsman, Gottlieb, & VandeCreek, 2013).

Professional ethics alone is also insufficient for adequate and appropriate ethical decision making (Knapp et al., 2013). While those informed of professional ethical guidelines are better able to protect clients from harm, the APA (2008) ethical code was created with flexibility for clinical decision making (Knapp et al., 2013). Therapists who only adhere to professional ethics and pay no attention to personal ethics run the risk of overly distancing themselves from their clients, which can cause interpersonal rupture between therapists and their clients (Knapp et al., 2013). Additionally, these therapists can seem cold and rigid, and can ultimately harm clients by attending to some rules or regulations over others, or placing ethical guidelines above the therapeutic relationship (Knapp et al., 2013).

Ethical Acculturation Model

Handelsman et al. (2005) posited that therapists need to incorporate high personal and professional ethics in order to appropriately engage in ethical decision making. In order to track the ideal incorporation of personal and professional ethics, Handelsman et al., (2005) identified and created an ethical model using Berry's (1980) racial/ethnic acculturation model (see Table 1). Difficulties with ethical decision making can be predicted by the extent to which the therapists adopt or incorporate personal and professional ethics (Knapp et al., 2013). Within an ethical acculturation model, therapists can be identified as either high or low on both personal and professional ethics dimensions (Knapp et al., 2013). Clinicians high in both personal and professional ethics

would be identified as using integration ethical strategies; clinicians with low professional ethics but high personal ethics would be identified as using separation strategies; clinicians with low personal ethics but high professional ethics would be identified as utilizing assimilation strategies, and clinicians with both low personal and professional ethics would be using marginalization ethical strategies (Knapp et al., 2013). According to this model, the ideal ethical strategy would be integration.

Table 1

Acculturation Model of Ethics (Handelsman et al., 2005; Knapp et al., 2013)

		Professional Ethics	
		High	Low
Personal Ethics			
High		**Integration** Professionally informed Guided by personal compassion Highly effective psychologist	**Separation** Personal compassion is not restricted by professional ethics May get overinvolved with clients (poor boundaries)
Low		**Assimilation** Learned and adopted professional ethics, but lacks compassion or personal ethics May be rigid or legalistic	**Marginalization** Low personal and professional ethics Risks being exploitative

Knapp et al., (2013) identified that aside from integration, each of the ethical strategies have unique weaknesses and pitfalls. Therapists utilizing separation strategies would be very compassionate with clients but may not be adequately tempered by professional ethics, thus becoming overly involved with clients while failing to maintain appropriate therapeutic boundaries. Therapists utilizing assimilation strategies would adopt professional ethical standards, but would lack compassion for their clients, and may come across as cold, rigid, or overly legalistic. Finally, therapists utilizing marginalization strategies would not be compassionate with clients or have adopted professional ethics, and run the risk of exploiting clients.

Therapists experiencing VT or who have a personal history of IPV may be engaging in ethical strategies different than how they might otherwise engage if not in distress. Additionally, these therapists may differ in how they ethically engage with perpetrators or survivors of IPV. These therapists might engage in separation strategies with survivor clients and assimilation strategies with perpetrators. However, this link has not yet been studied in the literature, thereby highlighting the importance of the current study.

Interpersonal Reactivity in Ethical Decision Making

There is a relationship between clinicians' emotional state and their ethical decision making, this is referred to as emotional competence (Pope & Brown, 1996). Ethical competence is the personal reflection and awareness of the self as a human capable of making mistakes and recognizing personal strengths and weaknesses (Pope & Brown, 1996). Emotional competence requires continual self-reflection and personal

assessment in order to ensure clinicians are not overstepping their ethical commitments or making decisions based on their emotional state (Pope & Vasquez, 2016). One type of emotional competence includes interpersonal reactivity, or the ability to which clinicians can actively engage, empathize, and connect with their clients (Davis, 1983).

Connelly, Helton-Fauth, and Mumford (2004) found that therapists' affective or mood states accounted for more variation in the types of ethical decisions clinicians made than other possible states, including therapists' interpersonal reactions to clients. Emotions clearly impact clinicians and the ways in which they interact with clients. Therapists having intense emotional reactions are a normative aspect of clinical experience; however, these reactions can elicit feelings of helplessness in mental health workers or a state of compassion fatigue, which could lead to VT (Allden & Murakami, 2015; Pope, 2012). Negative emotionality can hinder clinicians' ability to make decisions that align with both their personal and professional ethics (Connelly et al., 2004). Negative emotions can also lead clinicians to underreact to ethical dilemmas (Connelly et al., 2004).

The link between interpersonal reactivity and ethical decision making is particularly important when considering therapists impacted by VT or who may have a history of trauma. Because VT impacts clinicians' emotional experience, by increasing emotional distress or by reducing therapists' ability to tolerate difficult affect, clinicians who struggle with VT may also have a reduced ability to engage in appropriate ethical decision making (Cohen & Collens, 2013; Connelly et al., 2004). Further, clinicians with a history of personal trauma may also struggle with emotional distress when working

with survivors or perpetrators of IPV, and may have reduced ability to engage in appropriate ethical decision making with these populations (Benatar, 2000). Mental health workers with a personal history of IPV may be more emotionally reactive when working with clients (Benatar, 2000; Pope & Feldman-Summers, 1992). It has been shown that when individuals experience high emotional intensity or personal distress their empathic abilities are impacted (Okun, Shepard, & Eisenberg, 2000). Therefore, when clinicians experience intense emotionality due to countertransference or VT, their ability to have empathy and interpersonally connect with their clients will likely be negatively impacted (Okun et al., 2000; Pearlman & Saakvitne, 1995). Therapists who have intense emotional experiences, or who are unaware of their own affective reactions (which describe therapists struggling with VT or a personal history of IPV) are at higher risk for engaging in poor ethical decision making (Pope & Feldman-Summers, 1992; Pope & Vasquez, 2016).

The Impact of History of Trauma and Vicarious Trauma on Clinical Work

Emotional or somatic reactions of VT could affect the therapist's clinical work, as he or she may also feel detached with clients and struggle to feel empathy for the client, or he or she may become emotionally reactive and experience distress during session (Cohen & Collens, 2013; Pearlman & Saakvitne, 1995; Wilson & Lindy, 1994). The difficulty tolerating or coping with emotional distress may affect the therapist's social or occupational functioning (Cohen & Collens, 2013; Pearlman & Saakvitne, 1995). Further, clinicians may struggle to "turn off" feelings of distress, and may feel the emotional or somatic reactions long after a session ends (Cohen & Collens, 2013). The

difficulty in turning away from difficult affect may lead therapists to feel irritable, experience insomnia, or may lead therapists to act out in atypical ways due to feeling overwhelmed (Cohen & Collens, 2013). Clinicians who struggle with VT struggle broadly with clients, but it is unclear how therapists with VT will be impacted when working with survivors or perpetrators of IPV. These therapists could be even more heightened, or emotionally reactive, and may further struggle with ethical and clinical decision making with these clients.

Therapists with a personal history of trauma may also experience emotional distress when working with clients, depending on how recent their traumatic experience was and if they were able to adequately heal from their trauma (Schauben & Frazier, 1995). Therapists who work with clients with a similar trauma background as their own may be particularly impacted, as they may struggle with over-identifying with those clients (Saakvitne, 2002). Therefore, therapists with a history of IPV may struggle to engage in appropriate and reflective clinical or ethical decision making when working with survivors of IPV. Additionally, it is unclear how therapists with a history of trauma are occupationally impacted when working with perpetrators of trauma, so therapists with a history of IPV may also struggle with appropriate ethical or clinical decision making when working with perpetrators of IPV.

Therapist empathy with trauma clients. When therapists with a history of traumatization encounter clients who have been traumatized, the therapists likely have an emotional reaction towards those clients and their clients' trauma histories. This emotional reaction is likely intensified because of these therapists' personal trauma

experiences (Benatar, 2000). Because therapists with a history of trauma may be able to relate or connect with the stories of their clients, their empathy towards trauma clients may be either hindered or magnified (Wilson & Lindy, 1994).

VT overwhelms clinicians' emotional state, and clinicians with VT experience distressing emotions that are difficult to tolerate (Cohen & Collens, 2013). Therapists experiencing VT then do not have the emotional capacity to fully engage empathically with clients' stories and struggles (Pearlman & Saakvitne, 1995). Additionally, because therapists with VT may distance themselves from their affective experience, they may not engage as authentically or as fully as they might have prior to experiencing VT (Cohen & Collens, 2013; Pearlman & Saakvitne, 1995).

Countertransference with clients. Countertransference is the affective reactions, either conscious or unconscious, that therapists experience in response to their clients or their clients' stories (Little, 1957; Winnicott, 1949). Countertransference is present in all therapies and is specific between therapists and individual clients; therapists might have a variety of countertransference responses to each of their clients (Pearlman & Saakvitne, 1995). Therapists might react to clients based on client presentations or the ways in which clients engage in therapy. Therapists might also react to clients based on their own personal experiences or histories, and clients may inadvertently trigger a traumatic response in response to their own history (Little, 1957; Winnicott, 1949).

Therapists who experience countertransference when working with trauma clients are at risk of experiencing distress or intrusive memories or reactions rooted in their own personal trauma histories (Wilson & Lindy, 1994). This can be very emotionally

distressing to therapists, and may result in therapists' advertently or inadvertently withdrawing emotionally from their clients (Wilson & Lindy, 1994). Genuine empathy for clients who are working through trauma is crucial, yet therapists experiencing intense countertransference reactions may not have the same empathic capacity they might otherwise have (Wilson & Lindy, 1994). This may be based in traumatized clinicians' feelings of anxiety or vulnerability (Benatar, 2000). Therapists with past victimization may disconnect or emotionally detach from a trauma client, resulting in a loss of empathy, in order to cope with their own emotional distress, such as feelings of hopelessness, vulnerability, fear, or anger (Marmaras et al., 2003). Countertransference in which therapists are reminded of their own trauma history seems to inevitability result in a rupture of empathy, at least in the immediate context for which the initial reaction occurs (Wilson & Lindy, 1994). Further, if therapists experience VT, their ability to trust and feel in control may be hindered, which could result in a loss or a hindrance to empathy for those therapists (Smith, Kleijn, & Hutschemaekers, 2007).

However, if a countertransference reaction is one of compassion and understanding, without triggering intrusive traumatic thoughts or memories for therapists, the countertransference reaction can serve to enhance empathy and emotional connectivity between therapists and their clients (Wilson & Lindy, 1994). Instead, clients processing trauma may feel connected with therapists, which would establish safety and trust within the therapeutic relationship, thus encouraging clients to further process their traumatic experiences (Wilson & Lindy, 1994). When examining the ways in which therapists perceived their empathic response, experienced therapists reported they felt

that they were more likely to empathize with clients who presented with trauma-related difficulties (Benatar, 2000). Additionally, experienced therapists reported they believed they were less likely to stigmatize clients who had a trauma history because of their personal experiences with trauma (Benatar, 2000). It is unclear how clinicians in training, or early career therapists might view their emotional reactions towards holding empathy for trauma clients. They might perhaps feel similar to experienced clinicians, or more overwhelmed by their countertransference reactions depending upon their experience with countertransference and the extent to which they have processed and healed from their own traumatic experiences.

VT and countertransference are related and impact one another (Pearlman & Saakvitne, 1995). VT affects therapists' sense of self and their ways of interacting with others; therefore, VT impacts countertransference responses. When therapists feel more intense VT responses, they have stronger countertransference responses, which then could heighten VT responses, thus creating a vicious cycle for therapists (Pearlman & Saakvitne, 1995).

Over-identification with trauma clients. When examining the aspects that were most difficult when working with a trauma population, most counselors self-reported that they were reminded of their own trauma history or experiences of abuse, as when therapists share a similar traumatic experience with their clients, this can impact therapists' identification with those clients (Saakvitne, 2002; Schauben & Frazier, 1995). Therapists who share personal trauma experiences with their clients may feel more connected to their clients but doing so places them at higher risk for emotional reactivity,

psychological distress, and potentially vicarious trauma (Saakvitne, 2002). Further, these therapists are at risk for over-identifying with their victimized client (Saakvitne, 2002). This over-identification could result from therapists' inability to separate their personal experiences from their clients' experiences (Saakvitne, 2002). Trauma therapists may also over-identify with their trauma clients in order to help therapists gain a sense of control over personal overwhelming feelings within the therapy session (Marmaras et al., 2003). Because re-experiencing or exposure to vicarious trauma can be overwhelming, therapists with trauma histories may cope with their distress by engaging in a familiar pattern of identifying with clients' trauma stories (Marmaras et al., 2003).

However, if therapists are able to separate their trauma experiences from their clients, either by working with clients who have experienced a different type of trauma than their own, or by separating their identity from the client, then therapists are less likely to develop VT or experience psychological distress (Benatar, 2000). Separation is linked with less psychological distress and a decreased risk for vicarious traumatization (Benatar, 2000). Therefore, while therapists might feel increased comfort and control when they identify with clients, therapists must ultimately manage emotional distress by separating from their clients and their stories in order to have healthy affective engagement in their clinical work (Benatar, 2000).

Therapists might also over-identify with the client, leading to experiences of countertransference (Pearlman & Saakvitne, 1995). Therapists with VT struggle to disconnect from traumatic material and potentially the clients themselves (Cohen & Collens, 2013; Pearlman & Saakvitne, 1995). Clinicians who struggle with VT also

experience schematic changes, and may struggle with viewing the world as more dangerous than they previously had; this schematic change could also lead to therapists viewing their world as more closely tied and connected with traumatic stories told by clients (Cohen & Collens, 2013; Pearlman & Saakvitne, 1995).

Countertransference reactions, specifically over-identification, are particularly important to discuss and process with supervisors (Miller, 1998). Those able to openly express their reactions to a supervisor or colleague may help to mitigate their countertransference reactions as well as separate their own experiences from the client (Miller, 1998). If therapists are not able to effectively manage their distress or emotional reactions, they could cause harm to a victimized client, or in some cases re-victimize them due to exposing them to this distress (Hesse, 2002).

Boundaries within therapy. Boundaries are an important aspect of clinical and ethical decision making within the therapeutic relationship, but even more so when processing trauma, as boundaries help to establish a pattern or expectation within therapy, thus establishing security and safety within the therapeutic relationship (Wilson & Lindy, 1994). However, this is not always easy for clinicians, especially those who have personal histories of trauma (Wilson & Lindy, 1994). Two boundary violations are prominent risks for therapists with trauma histories: clinicians who personally struggle with boundaries and subsequently struggle to establish boundaries in the therapeutic relationship; and therapists' inappropriate self-disclosure of their own personal trauma to clients (Wilson & Lindy, 1994).

In regards to self-disclosure, Benatar (2000) found that experienced therapists who have experienced trauma were divided in their beliefs regarding whether they should disclose their survivor status to their clients. In general, the literature on self-disclosure rejects therapists' self-disclosure of past personal trauma, as it is not appropriate or therapeutic, and could instead burden clients (Benatar, 2000). Therefore, the therapists who might choose to engage in self-disclosure of their own trauma may be violating therapeutic boundaries.

Therapists affected by VT may struggle to maintain therapeutic boundaries and with establishing trust and rapport in the therapeutic relationship (Cohen & Collens, 2013; Pearlman & Saakvitne, 1995). Therapists might also engage in erratic decision-making with clients, such that they may over-engage with clients by rescuing their clients, or under-engage with clients by not ethically attending to the clients and their needs (Pearlman & Saakvitne, 1995).

Limited self-awareness. While therapists with a history of trauma may be at risk for VT or may struggle to express empathy, many therapists with a history of trauma view themselves as more qualified to work with trauma clients because of their past experiences (Benatar, 2000). This self-assessment as knowledgeable and prepared does not necessarily reflect actual training in working with trauma, and even clinicians with no training or experience rated themselves as qualified and knowledgeable (Connor, Nouer, Mackey, Banet, & Tipton, 2012). Further, therapists with trauma histories may not be able to effectively assess their clinical skills or work, and may not be able to effectively

see their own limitations or recognize that their personal difficulties could impact their ability to effectively intervene with clients (Marmaras et al., 2003).

Similar to other therapists, if therapists with trauma histories are experiencing distress or perceiving a therapeutic situation as difficult, they are likely to overestimate their competency and may not seek the appropriate supervision and consultation or may have an initial reaction of withdrawal rather than connection with the client (Smith et al., 2007). Working with trauma is inherently difficult and stressful, but the difficulties may be further compounded by therapists' past experiences of trauma (Smith et al., 2007).

Therapists' Personal Biases

Therapists intrinsically hold attitudes and beliefs that might negatively impact their perceptions and interactions with their clients (APA, 2008; Sue, 2001). Personal biases are influenced both by greater cultural and societal contexts as well as individual identities and experiences (Brown, 2006; Sue, 2001). Personal biases may be held against individuals of a variety of identity contexts, including race, ethnicity, sex, gender, sexual orientation, age, religion, or any other identity variable (APA, 2008; Brown, 2006; Sue, 2001).

Inevitably, individuals also hold biases surrounding IPV (Meyer, 2011). Most people hold negative attitudes towards perpetrators of crime, particularly violent or aggressive crimes and believe they should receive harsh punishments (Dowler, 2003). Individuals have mixed attitudes towards survivors of IPV. Some may express empathy, while others may question why the survivor did not leave the relationship sooner, or even acknowledge their experience as abuse. Victim-blaming attitudes are particularly relevant

for former survivors of IPV (Meyer, 2011). Therapists with a history of IPV are more likely to accept justifications of physical violence perpetrated by an intimate partner (Mitchell, Parekh, Russ, Forget, & Wright, 2013). Finally, therapists assume that within opposite-sex relationships, the man is the perpetrator while the woman is the survivor (Blasko, Winek, & Bieschke, 2007). While this is reflective of the typical pattern of perpetration, as most perpetrators of IPV are men, this is also a bias held by therapists (Blasko et al., 2007; CDC, 2016; World Health Organization, 2014). Therapists experiencing personal reactions, including countertransference reactions may not be able to adequately engage in appropriate ethical or clinical decision making (Clawson, 1994; Pearlman & Saakvitne, 1995). Therapists with a history of IPV or who have VT may hold particular biases towards perpetrators and survivors of IPV that could impact their ethical decision making with those clients.

Using Vignettes in Research

Because it is difficult to empirically measure ethical decision making, this study is going to utilize vignettes to create a client whom the participants will imagine they are working with. Vignettes can be defined as a story or example that gives concrete instances of individuals and their behaviors within a specific context or situation, and asks participants to respond or react to the story provided (Barter & Renold, 1999; 2000). Vignettes can be a valuable approach in psychological research to assess participants' perceptions, attitudes, or beliefs (Barter & Renold, 1999; 2000) and have been used in the past to uncover possible unconscious biases (Lapatin et al., 2012). Vignettes should be designed to address the appropriate research question, facilitate participant identification

with the subject of the vignette, and should be standardized in terms of the characters' identity variables to prevent unconscious biases of the participants (Lapatin et al., 2012). Provided vignettes meet this criteria, they are a viable research methodology (Lapatin et al., 2012).

Summary

In summary, vicarious traumatization is an intensive problem for many clinicians who work with trauma populations. VT impacts both new and seasoned clinicians and impacts the ways in which clinicians feel and how they view the world. Therapists with VT experience emotional distress and have the experience of feeling overwhelmed. VT can cause shifts to clinicians' schemas and the ways in which clinicians interact with their world. However, VT is not yet fully understood and it is unclear how therapists with VT engage clinically and ethically with both survivors and perpetrators of IPV. Additionally, therapists with a history of intimate partner violence may be vulnerable to developing VT, and may struggle with ethical decision making when working with survivors of IPV. It is unclear how therapists with a history of IPV might engage clinically or make decisions when working with perpetrators of IPV. Ethical decision making is based on both personal and professional ethics. Intense emotionality or emotional reactivity as well as personal biases can impact clinicians' ability to appropriately engage in ethical decision making.

By exploring the ways in which ethical decision making differs for therapists with VT when faced when an ethical dilemma for perpetrators or survivors of IPV, clinicians can better understand the impact of VT on occupational functioning and can work to

protect clients. By exploring the ways in which therapists with histories of IPV differ in their ability to engage in ethical decision making when faced with an ethical dilemma for both perpetrators and survivors of IPV, clinicians can better understand the lasting impact of IPV on clinicians' occupational functioning and work to provide the best quality client care. This research may further assist in the development of strategies for ethical decision making for clinicians experiencing VT or with a personal history of IPV. Additionally, if ethical decision making is negatively impacted by either VT or personal histories of IPV, perhaps psychology can work to better accommodate the emotional impact of working with trauma populations for clinicians.

For the present study, the author will examine the relationships between:

1. VT, interpersonal reactivity and ethical decision making when faced with an ethical dilemma involving a perpetrator of IPV.
2. The relationship between VT, interpersonal reactivity and ethical decision making when faced with an ethical dilemma involving a survivor of IPV.
3. The relationship between a history of IPV, interpersonal reactivity and ethical decision making when faced with an ethical dilemma involving a perpetrator of IPV.
4. The relationship between a history of IPV, interpersonal reactivity and ethical decision making when faced with an ethical dilemma involving a survivor of IPV.

Hypotheses

Based on previous findings on vicarious trauma, intimate partner violence, and ethical decision making, the following hypotheses are proposed.

Differences will be determined based on statistical significance.

1. The type of client that participants read about will impact their interpersonal reactivity and the ways in which they engage in ethical decision making.
    a. Participants will have higher interpersonal reactivity when presented with the client in vignette 1 (survivor) compared to the client in vignette 2 (perpetrator).
    b. Participants will have more flexible boundaries and over-identify with the client in vignette 1 (survivor) compared to the client in vignette 2 (perpetrator).
2. VT will predict and impact therapists' interpersonal reactivity and ethical competence.
    a. VT will predict interpersonal reactivity when working with a survivor of IPV, such that as VT increases, interpersonal reactivity will increase.
    b. VT will predict interpersonal reactivity when working with a perpetrator of IPV, such that as VT increases, interpersonal reactivity will increase.
    c. VT will predict ethical competence when working with a survivor of IPV, such that as VT increases, ethical competence will decrease.
    d. VT will predict ethical competence when working with a perpetrator of IPV, such that as VT increases, ethical competence will decrease.
3. A personal history of IPV will predict participants' interpersonal reactivity and ethical competence.

a. A history of IPV will predict interpersonal reactivity when working with a survivor of IPV, such that as the endorsement of IPV experiences increases, interpersonal reactivity will increase.
b. A history of IPV will predict interpersonal reactivity when working with a perpetrator of IPV, such that as the endorsement of IPV experiences increases, interpersonal reactivity will increase.
c. A history of IPV will predict ethical competence when working with a survivor of IPV, such that as the endorsement of IPV experiences increases, ethical competence will decrease.
d. A history of IPV will predict ethical competence when working with a perpetrator of IPV, such that as the endorsement of IPV experiences increases, ethical competence will decrease.

4. Experiences of VT and a personal history of IPV will interact to affect clinicians' interpersonal reactivity and ethical competence.
    a. Clinicians with a personal history of trauma and who experience VT will have higher interpersonal reactivity scores when working with a survivor of IPV.
    b. Clinicians with a personal history of trauma and who experience VT will have higher interpersonal reactivity scores when working with a perpetrator of IPV.

c. Clinicians with a personal history of trauma and who experience VT will have lower ethical competence scores when working with a survivor of IPV.
d. Clinicians with a personal history of trauma and who experience VT will have lower ethical competence scores when working with a perpetrator of IPV.

5. Interpersonal reactivity will act as a mediating variable between VT and ethical competence as well as between a history of IPV and ethical competence.
    a. Interpersonal reactivity will mediate the relationship between VT and ethical competence when working with a survivor of IPV.
    b. Interpersonal reactivity will mediate the relationship between VT and ethical competence when working with a perpetrator of IPV.
    c. Interpersonal reactivity will mediate the relationship between a history of IPV and ethical competence when working with a survivor of IPV.
    d. Interpersonal reactivity will mediate the relationship between a history of IPV and ethical competence when working with a perpetrator of IPV.

CHAPTER III

METHODS

Participants

This study recruited mental health professionals through email, and they were invited to participate through the flyer for the study (see Appendix A), which led participants to the recruitment letter (see Appendix B). Participants included mental health workers who work with clients and with survivors or perpetrators of IPV in a clinical capacity. Participants consented to informed consent to participate (see Appendix C). The initial sample included 155 participants who began the study. Data from 46 participants was excluded because they did not complete all or most of the survey, leaving a final sample of 109 participants.

Measures

Participants were asked to complete a demographic questionnaire and a VT scale prior to being presented with case study vignettes. The demographic questionnaire was created by the researcher based on basic demographic variables and to assess a personal history of IPV. After completion of the demographic questionnaire, IPV screener, and a VT assessment, participants were presented with two vignettes. After exposure to each vignette, participants were asked to complete an interpersonal reactivity scale and an ethical decision-making tool while considering the vignette they had just read. Each of these measures are described in further detail below.

Demographic Questionnaire

Participants were asked to complete a demographic questionnaire (see Appendix D) to assess personal cultural identity, such as age, gender, ethnicity, relationship status, and highest level of academic training. The questionnaire also gathered information regarding the clinician's history of working with a trauma (IPV) population, and their level of training in regards to IPV.

History of IPV Screener

Participants were asked to complete a personal history of IPV questionnaire (see Appendix E) after the demographic questionnaire in order to assess a personal history of IPV. As part of the screener, participants were asked about the types of abuse they have experienced, the length of the abusive relationship(s), and the length of time since their last abusive relationship. This screener is based on the American Medical Association Screening Questions developed by the American Medical Association (1992). This questionnaire was tailored to assess for a history of IPV in the participant's past, as well as to assess the number of relationships in which the participant was victimized and the length of time since the last abusive relationship ended. The scale had moderate reliability, $\alpha = .65$.

Trauma and Attachment Belief Scale (TABS)

The Trauma Attachment and Belief Scale (TABS) is a research measure that evaluates the symptomology of traumatic experiences (see Appendix F). The TABS was developed by Pearlman (2003), and was previously the Traumatic Stress Institute (TSI)

Belief Scale. The TABS is used to assess for traumatic reactions in individuals who have had a traumatic experience and focuses on the internal and cognitive shifts that occur due to exposure to traumatic material. The TABS is an 84-item self-report questionnaire that is comprised of five subscales: Safety, Trust, Esteem, Intimacy, and Control. All of these subscales are implicated in mental health workers' experiences of VT (Cohen & Collens, 2013). The TABS provides scores for each of the subscales as well as a total score. The TABS utilizes a 6-point scale ranging from 1 (disagree strongly) to 6 (agree strongly), in order to assess the extent to which participants endorse each symptom. The TABS has demonstrated strong reliability for the full measure, with alphas of .96 for internal consistency and .75 for test-retest reliability (Pearlman, 2003). Subscales ranged in internal consistency from .67 to .87, and in test-retest reliability from .60 to .79 (Pearlman, 2003). In this study, there was strong overall reliability for the total score, with $\alpha = .89$.

The TABS was designed to measure beliefs that have shifted due to exposure to trauma and was designed with the intention to also assess for VT in psychotherapists (Sabin-Farrell & Turpin, 2003; Pearlman, 2003). During their meta-analysis, Sabin-Farrell and Turpin (2003) identified the TSI-belief scale (now TABS) as one of the more accurate measures of VT in psychological research, as it most closely follows the theoretical construct of VT. While the TABS examines more general traumatic belief reactions, this tool can help to better identify any underlying or internal shifts that mental health workers experience as a result of working with a trauma population. This research project utilized four subscales of the TABS: self-safety, self-trust, other-trust, and self-

control. Self-safety is a 13-item subscales of the TABS which measures participants' level of safety and security, and examines the extent to which individuals feel vulnerable to harm perpetrated by themselves or someone else (e.g., "I believe I am safe") (Pearlman, 2003). Self-trust is a 7-item subscale of the TABS which measures participants' self-assurance and confidence in their own perceptions, judgements, and self-efficacy (e.g., "I often doubt myself") (Pearlman, 2003). Other-trust is an 8-item subscale which measures the extent to which they feel they can rely or depend on others (e.g., "Trusting people is not smart") (Pearlman, 2003). Finally, self-control is a 9-item subscale designed to measure the extent to which individuals feel they must control or manage their feelings and behaviors (e.g., "I must be in control of myself") (Pearlman, 2003). These subscales were selected because they assessed for the psychological and behavioral changes that might accompany the schematic shifts associated with VT (Pearlman & Saakvitne, 1995).

Vignettes

After completing the demographic questionnaire, the history of IPV screener, and the TABS, participants were presented with a case example in the form of a vignette (see Appendix G). The vignettes were created by the researcher, who has worked with both survivors and perpetrators of intimate partner violence in a clinical capacity. Both of the vignettes introduce a hypothetical client and identify that client as either a survivor or perpetrator of intimate partner violence. The first vignette identified the client as a survivor of intimate partner violence seeking mental health counseling services, while the

second vignette identified the client as a perpetrator of intimate partner violence seeking mental health counseling services.

Ethical Decision Making

Ethical decision making was assessed using a scale created for the purpose of this research study (see Appendix H). The ethical decision making scale was presented to participants following exposure to each of the vignettes. The scale was created using the Boundaries in Practice (BIP) scale, the Client Identification Scale, and utilizes the constructs established by the ethical acculturation model. The BIP scale measures knowledge, comfort, ethical decision making, and experience for clinicians when presented with various ethical dilemmas (Kendall et al., 2011). The BIP presents participants with various vignettes and asks participants to place themselves in that situation and answer the questions accordingly (Kendall et al., 2011). Because this study focuses on ethical decision making when a client is either a perpetrator or a survivor of IPV, the vignettes in the BIP were modified to better reflect the purposes of this study. Additionally, not all of the situations in the BIP fit with the focus of this study, so only four items were directly taken from the BIP. However, the style of questioning of the BIP was continued throughout the ethical decision making scale. Despite the shifts in the BIP, there was moderate reliability for the scale when applied to working with survivors of IPV, $\alpha = .67$, as well as with perpetrators of IPV, $\alpha = .74$.

The Client Identification Scale was created by Bamber and Iyer (2007). The Client Identification Scale is four items and is used to assess how closely a clinician identifies with their client. This scale has been used in other research and has been found

to be an effective means of exploring client identification (Herda & Lavelle, 2015). This scale was only modified to reflect the hypothetical client in the vignettes rather than the original instructions to imagine a client for whom the participant is actively providing treatment. There was limited reliability with this scale, as $\alpha = .58$ when it was applied to working with a survivor of IPV and $\alpha = .58$ when it was applied to working with a perpetrator of IPV.

Overall, reliability of the ethical competence measure was $\alpha = .65$ when the measure was utilized when asking participants to consider working with a survivor of IPV. Further, the overall reliability of the measure was $\alpha = .71$ when it was utilized when asking participants to consider working with a perpetrator of IPV. Overall, the ethical competence was a viable measure in regards to its reliability.

Interpersonal Reactivity Index

The Interpersonal Reactivity Index (IRI) is a 28-item self-report measure that measures participants' ability to the feelings of others, and empathically connect and engage with others (see Appendix I). The IRI examines empathy from a multidimensional perspective and examines four constructs of empathy, including interpersonal functioning, or social competence, self-esteem, emotionality, and sensitivity towards the feelings of others; therefore, the IRI examines the emotional, behavioral, and cognitive dimensions of empathy (Davis, 1983). The IRI asks participants to assess their behavior on a 5-point scale depending on how well each item describes the participant.

The IRI has four subscales that measure empathy, and include Perspective Taking, Fantasy, Empathic Concern, and Personal Distress. For the purposes of this

study, only the Empathic Concern and Personal Distress subscales were assessed. These scales appear to tap the emotional reactivity associated with a VT response (Davis, 1983; Pearlman & Saakvitne, 1995). All four subscales of the IRI have demonstrated moderate internal reliability, ranging from .71 to .77, and were shown to have test-retest reliabilities ranging from .62 to .71 (Davis, 1980). In this study, the reliability was α = .73 when the IRI when the scale examined working with a survivor of IPV, and α = .70 when the IRI was utilized when examining working with a perpetrator of IPV. Additionally, the IRI has demonstrated strong construct validity (Davis, 1983). The IRI has been used to assess empathy, emotional, and interpersonal competence in a variety of populations including those in the helping professions (Constantine, 2000; Okun et al., 2000).

Procedure

Individuals who work in the mental health field received an email with an attached recruitment letter explaining that the purpose of the study was to examine the clinical differences and ethics when working with perpetrators of IPV compared to survivors of IPV. All participants were informed that participation was voluntary and that they could withdraw from the study at any time without penalty. Mental health workers interested in participating in the study were asked to click on the link provided in the recruitment letter, and this took them to the informed consent of the study. The informed consent, as well as the measures of the study, were located within PsychData, a secure online data storage for psychological research. Participants were then asked to read the informed consent and indicate that they read the document and wished to continue.

Participants were informed that by clicking the "accept" link at the bottom of the informed consent, they were indicating they understood the purpose of the study and agreed to the terms of the informed consent.

After providing informed consent, participants were directed to the demographics questionnaire and were asked to complete all questions provided. Once the demographic information was collected, participants were directed to the history of IPV screener, where they answered questions pertaining to their personal history. Once completed, participants were directed to the TABS, where they provided information regarding their current level of VT. Participants were then presented with one of two of the study vignettes. After exposure to one of the vignettes, participants were asked to imagine themselves as the mental health worker in the scenario and answered the ethical decision making measure as well as the interpersonal reactivity index. Participants were then presented with the other vignette, and again were asked to imagine themselves as the mental health worker in the scenario and filled out the interpersonal reactivity index as well as the ethical decision making measure while imagining themselves in that situation. Participants were then given a list of mental health resources (see Appendix J), and then thanked for their time, debriefed, and provided with information on how to obtain the results of the study (see Appendix K).

Additionally, participants had the opportunity to voluntarily enter their name into a drawing to win one of four $50 gift cards to Amazon.com. Winners for the raffle were selected using a random number generator, and winners were notified by the emails

provided in their entry in the raffle. This study was approved by the Institutional Review Board at Texas Woman's University, see Appendix L for the approval letter for the study.

Statistical Analysis

All standard assumptions were checked and testing categories were combined, if necessary.

Descriptive Statistics

Prior to conducting the proposed analyses, descriptive statistics (mean, median, standard deviations, and ranges for continuous data) and frequencies were calculated on all demographic variables, level of education, training experience, and clinical experience in order to assess the frequency of responses amongst participants.

The following hypotheses were proposed:

Hypothesis 1

A paired samples *t*-test assessed the differences between participants' interpersonal reactivity when working with perpetrators of IPV and their interpersonal reactivity when working with survivors of IPV. Similarly, a paired samples *t*-test assessed the differences between participants' ethical decision making when working with perpetrators of IPV and when working with survivors of IPV.

Specific predictions include: Participants' interpersonal reactivity and ethical decision making will be different when they respond to the perpetrator vignette versus the survivor vignette.

a. Clinicians will report lower interpersonal reactivity when working with a perpetrator of IPV compared to a survivor of IPV.

b. Clinicians will report less ethical competence when working with a perpetrator of IPV compared to a survivor of IPV.

Hypothesis 2

In order to assess the impact of VT on interpersonal reactivity and ethical decision making, linear regressions were utilized in order to examine VT as a predictor variable. A linear regression was run using VT as a predictor of interpersonal reactivity when working with a survivor of IPV, and a second regression analysis was used to examine VT as a predictor of interpersonal reactivity when working with a perpetrator of IPV. A similar process was used for ethical competence. Two linear regressions were run with VT as a predicting variable for ethical competence with both a survivor and a perpetrator of IPV.

Specific predictions include: VT will predict interpersonal reactivity and ethical decision making when working with both survivors and perpetrators of IPV.

a. VT will be a positive predictor of interpersonal reactivity when working with a survivor of IPV, such that as VT increases, interpersonal reactivity will also increase.
b. VT will be a positive predictor of interpersonal reactivity when working with a perpetrator of IPV, such that as VT increases, interpersonal reactivity will also increase.
c. VT will be a negative predictor of ethical competence, such that clinicians high in VT will report less ethical competence when working with a survivor of IPV.

d. VT will be a negative predictor of ethical competence, such that clinicians high in VT will report less ethical competence when working with a perpetrator of IPV.

Hypothesis 3

In order to assess the impact of a history of IPV on interpersonal reactivity and ethical decision making, linear regressions were utilized in order to examine a personal history of IPV as a predictor variable. A linear regression was run using a history of IPV as a predictor of interpersonal reactivity when working with a survivor of IPV, and a second regression analysis was used to examine a history of IPV as a predictor of interpersonal reactivity when working with a perpetrator of IPV. A similar process was used for ethical competence. Two linear regressions were ran with a history of IPV as a predicting variable for ethical competence with both a survivor and a perpetrator of IPV.

Specific predictions include: a personal history of IPV will predict interpersonal reactivity and ethical decision making when working with both survivors and perpetrators of IPV.

a. A history of IPV will be a positive predictor of interpersonal reactivity when working with a survivor of IPV, such that as the more extensive a trauma history an individual has, the higher their interpersonal reactivity.
b. A history of IPV will be a positive predictor of interpersonal reactivity when working with a perpetrator of IPV, such that as the more extensive a trauma history an individual has, the higher their interpersonal reactivity.

c. A personal history of IPV will be a negative predictor of ethical competence, such that clinicians with a more extensive trauma history will report more less ethical competence when working with a survivor of IPV.
d. A personal history of IPV will be a negative predictor of ethical competence, such that clinicians with a more extensive trauma history will report more less ethical competence when working with a perpetrator of IPV.

Hypothesis 4

In order to assess how VT and a personal history of IPV affect one another, a factorial ANOVA was run in order to see a potential interaction effect between VT and a personal history of IPV on interpersonal reactivity scores. In order to do this, VT and IPV, which were continuous variables, were split into high or low based on the median score for each variable.

Specific predictions include: There will be a main effect of VT and a main effect of a personal history of IPV on interpersonal reactivity. There will also be an interaction effect of VT and a personal history of IPV on interpersonal reactivity scores.

a. There will be a main effect of VT and a history of IPV, as well as an interaction effect between VT and a history of IPV on interpersonal reactivity when working with a survivor of IPV. It is expected that interpersonal reactivity will be heightened for individuals who are struggling with VT and who have an extensive trauma history.
b. There will be a main effect of VT and a history of IPV, as well as an interaction effect between VT and a history of IPV on interpersonal reactivity

when working with a perpetrator of IPV. It is expected that interpersonal reactivity will be heightened for individuals who are struggling with VT and who have an extensive trauma history.

In order to assess how VT and a personal history of IPV affect one another, a factorial ANOVA will be run in order to see a potential interaction effect between VT and a personal history of IPV on ethical decision making scores.

Specific predictions include: There will be a main effect of VT and a main effect of a personal history of IPV on ethical competence. There will also be an interaction effect of VT and a personal history of IPV on ethical competence scores.

c. There will be a main effect of VT and a history of IPV, as well as an interaction effect between VT and a history of IPV on ethical competence when working with a survivor of IPV. It is expected that ethical competence will be decreased for individuals who are struggling with VT and who have an extensive trauma history.
d. There will be a main effect of VT and a history of IPV, as well as an interaction effect between VT and a history of IPV on ethical competence when working with a survivor of IPV. It is expected that ethical competence will be decreased for individuals who are struggling with VT and who have an extensive trauma history.

Hypothesis 5

This study utilized Baron and Kenny's (1986) method of finding a mediating variable in order to assess interpersonal reactivity as a mediating variable between ethical

competence and VT. In order to do this, three regression analyses were run between VT and interpersonal reactivity, VT and ethical decision making, and interpersonal reactivity and ethical decision making.

Specific predictions include: interpersonal reactivity will be a mediating variable between VT and ethical decision making.

e. Interpersonal reactivity will mediate the relationship between VT and ethical competence when working with a survivor of IPV.
f. Interpersonal reactivity will mediate the relationship between VT and ethical competence when working with a perpetrator of IPV.

In order to assess interpersonal reactivity as a mediating variable between ethical decision making and mental health workers with a personal history of IPV, a parallel process was used. This study utilized Baron and Kenny's (1986) method of finding a mediating variable. In order to do this, three regression analyses were run between a personal history of IPV and interpersonal reactivity, a personal history of IPV and ethical decision making, and interpersonal reactivity and ethical decision making.

Specific predictions include: interpersonal reactivity will be a mediating variable between a personal history of IPV and ethical decision making.

g. Interpersonal reactivity will mediate the relationship between a history of IPV and ethical competence when working with a survivor of IPV.
h. Interpersonal reactivity will mediate the relationship between a history of IPV and ethical competence when working with a perpetrator of IPV.

CHAPTER IV

RESULTS

Descriptive Statistics

This study recruited mental health professionals through email. The initial sample included 155 participants who began the study. Data from 46 participants was excluded because they did not complete all or most of the survey, leaving a final sample of 109 participants. The mean age of participants was 33.27 years (SD = 8.90). Participants ranged in age from 23 to 71. Of the participants, 60.6% (66 individuals) indicated that they are currently working with IPV in their clinical work. Participants were asked to self-identify their gender, and 86 participants self-identified as female (86%), 17 self-identified as male (15.6%), two self-identified as transgender (1.8%), and four identified as "other" (cis-female, gender fluid, gender nonconforming, and non-binary).

When examining the ethnicity of participants, 10 (9.2%) identified their ethnicity to be Asian/Asian-American/South Asian, one participant (.9%) identified as Black/African/African-American, seven participants (6.4%) identified as Hispanic/Latinx, no participants identified as Native American, 88 participants (80.7%) identified as White/European American, no participants identified as Pacific Islander, and three participants identified their ethnicity as "other" (Bi-racial: Asian and Latina, Bi-racial, and Middle Eastern).

In regards to education, all participants indicated higher education attainment in the field of psychology. Most participants were either receiving doctoral-level training or

had completed their doctoral degree. Of the participants who indicated "other," one participant reported they had completed their Master's degree in a psychology related field, but were also enrolled in a doctoral program; one participant reported they had attained their doctoral degree and were currently employed as a post-doctoral position; one participant reported they had earned a Master's in education, and were a second-year student in a Master's of Social Work program, and one participant reported they had earned a doctoral degree in Counselor Education and Supervision (see Table 2).

Table 2

Highest Education Attained

Education level	*n*	%
Bachelor's degree	2	1.8
Enrolled in Master's training program	8	7.3
Master's degree	21	19.3
Enrolled in a doctoral training program	35	32.1
Doctoral degree	39	35.8
Other	4	3.7

When examining clinical work, the majority of participants reported working with survivors and current victims of IPV, while the study was split on whether the participants had worked with perpetrators of IPV (see Table 3). On average, participants worked with their clinical population for 6.12 years (SD = 7.64), ranging from 0 years to

48 years, 4.08 months (SD = 2.77), ranging from zero months to 10 months, and .22 weeks, (SD = .55), ranging from zero weeks to two weeks.

Table 3

Clinical Experience of Participants

Clinical Population	Yes (%)	No (%)
Survivors of intimate partner violence	100 (91.7%)	9 (8.3%)
Current victims of intimate partner violence	78 (71.6%)	31 (28.4%)
Perpetrators of intimate partner violence	54 (49.5%)	55 (50.5%)

When asked about the percentage of their caseload that involved working with IPV, participants reported varied experiences of working with IPV. Most participants reported working with IPV in 50% or less of their caseload (see Table 4).

Table 4

Percent of Caseload that is Working with IPV

Percent of caseload	*n*	%
0-25%	71	65.1%
25-50%	22	20.2%
50-75%	3	2.8%
75-100%	13	11.9%

When asked about their place of work, nine participants (8.3%) reported they worked in an independent practice, 24 participants (22%) reported they worked in a community agency or domestic violence agency, 12 participants (11%) reported they worked in an inpatient or hospital setting, 53 participants (48.6%) reported they worked in a counseling center, and 11 participants (10.1%) reported "other." Work sites reported as "other" included places such as a county jail, a student advocacy resource center, a high school, private practice, a research hospital, and a university-affiliated treatment center (see Table 5).

Table 5

Agency or Workplace of Participants

Type of Workplace	*n*	%
Independent practice	9	8.3%
Community Agency/Domestic Violence Agency	24	22%
Inpatient/Hospital	13	11.9%
Counseling Center	53	48.6%
Other	11	10.1%
Three years at a domestic violence agency; one year at a university counseling center	1	.9%
County Jail	1	.9%
Student Advocacy Resource Center (past: jail)	1	.9%
High school counselor	1	.9%

Type of Workplace	*n*	%
Private practice	1	.9%
Not currently employed	1	.9%
Research hospital	1	.9%
Research study	1	.9%
University clinic	1	.9%
University – affiliated treatment center	1	.9%

Hypothesis 1

Hypothesis 1a: Difference in Interpersonal Reactivity when Working with a Survivor versus a Perpetrator of IPV

A paired samples *t*-test was used to examine the differences between participants' interpersonal reactivity when working with perpetrators of IPV and their interpersonal reactivity when working with survivors of IPV. There was no significant difference in interpersonal reactivity between clinicians when presented with a vignette about working with a survivor of IPV ($M = 42.22$, $SD = 5.47$) and when presented with a vignette about working with a perpetrator of IPV ($M = 41.95$, $SD = 5.37$), $t(100) = .96$, $p = .34$. Additionally, when examining the subscales of interpersonal reactivity, clinicians did not differ in their experience of empathic concern when presented with a vignette about working with a survivor of IPV ($M = 28.70$, $SD = 3.86$) and when presented with a vignette about working with a perpetrator of IPV ($M = 28.37$, $SD = 4.07$), $t(104) = 1.56$, $p = .122$, nor did clinicians differ in their subjective experience of personal distress when

presented with a vignette about working with a survivor of IPV (M = 13.59, SD = 3.47) and when presented with a vignette about working with a perpetrator of IPV (M = 13.54, SD = 3.81), $t(103) = .214$, $p = .831$.

Hypothesis 1b: Difference in Ethical Competence when Working with a Survivor versus a Perpetrator of IPV

A paired samples t-test was used to examine the differences between participants' ethical competency when working with perpetrators of IPV and when working with survivors of IPV. Ethical competency was used as a total scale comprised of comfort, knowledge, and decision making in an ethical dilemma (Boundaries in Practice Scale), as well as the level of identification the mental health worker felt with the client. When presented with a vignette about working with a survivor of IPV (M = 76.09, SD = 6.20), clinicians reported more ethical competency than when presented with a vignette about working with a perpetrator of IPV (M = 73.71, SD = 6.86), $t(93) = 5.38$, $p < .001$ (see Table 6).

When examining the varying components that comprise ethical competency, (1) boundaries in practice, (2) knowledge about ethical decisions, (3) comfort in ethical decisions, (4) ethical decisions, and (5) over-identification with the client, all of the subscales of ethical competence were significant when comparing the vignettes of working with a survivor or a perpetrator of IPV. Clinicians reported more competency in ethical decision making around boundaries in ethical dilemmas when presented with a vignette about working with a survivor of IPV (M = 36.72, SD = 3.33) than when presented with a vignette about working with a perpetrator of IPV (M = 35.59, SD =

3.78), $t(100) = 4.43$, $p < .001$ (see Table 6). When presented with ethical dilemmas, clinicians reported significantly more knowledge about the ethical dilemmas when the client was a survivor of IPV ($M = 12.45$, $SD = 1.74$) than when the client was a perpetrator of IPV ($M = 11.82$, $SD = 1.92$), $t(104) = 5.62$, $p < .001$. When presented with ethical dilemmas, clinicians reported significantly more comfort about the ethical dilemmas when the client was a survivor of IPV ($M = 11.60$, $SD = 2.09$) than when the client was a perpetrator of IPV ($M = 11.02$, $SD = 2.40$), $t(105) = 2.99$, $p = .003$.

When presented with ethical dilemmas, clinicians made more ethical decisions in ethical dilemmas with the client who was a survivor of IPV ($M = 12.56$, $SD = .91$) than the client who was a perpetrator of IPV ($M = 12.69$, $SD = .91$), $t(103) = -2.68$, $p = .009$. Additionally, clinicians reported stronger identification with the client who was a survivor of IPV ($M = 39.28$, $SD = 4.59$) than the client who was a perpetrator of IPV ($M = 38.14$, $SD = 4.65$), $t(98) = 3.74$, $p < .001$. When asked how ethical it would be to schedule a client, who presented with intense distress and hopelessness, for the next day after disclosing their distress, clinicians viewed it as more ethical to schedule the client who was a survivor of IPV ($M = 2.50$, $SD = .71$) than the client who was a perpetrator of IPV ($M = 2.34$, $SD = .07$), $t(106) = 4.11$, $p < .001$ (see Table 7).

Table 6

Differences Between Clinicians When Working with a Survivor Compared to a Perpetrator of IPV

	Survivor		Perpetrator				
Scale	M	SD	M	SD	*r*	*t*	*df*
Interpersonal Reactivity	42.22	5.47	41.95	5.37	.867**	.96	100
Ethical Competency	76.09	6.20	73.71	6.86	.79**	5.38**	93

* $p < .05$ ** $p < .001$

Table 7

Frequency of Responses When Asked About Scheduling a Hopeless Client

	Survivor *n* (%)	Perpetrator *n* (%)
Never Ethical	3 (2.8%)	4 (3.7%)
Ethical Under Some Conditions	58 (53.2%)	71 (65.1%)
Ethical Under Most Conditions	37 (33.9%)	24 (22%)
Always Ethical	10 (9.2%)	8 (7.3%)

Hypothesis 2

In order to examine the impact of VT on interpersonal reactivity and ethical competency, four linear regression analyses were run to examine whether VT predicts: (1) interpersonal reactivity when working with survivors, (2) interpersonal reactivity when working with perpetrators, (3) ethical competency when working with survivors, and (4) ethical competency when working with perpetrators.

Hypothesis 2a: VT as a Predictor of Interpersonal Reactivity with a Survivor of IPV

A regression analysis was used to determine if VT could be used to predict interpersonal reactivity when working with a survivor of IPV. VT was found to be a statistically significant predictor of interpersonal reactivity when working with a client who was a survivor of IPV, $F(1, 81) = 4.70$, $p = .033$, $R^2 = .056$, Adjusted $R^2 = .044$, $\beta = .236$. VT explained approximately 5.6% of the variance in clinicians' interpersonal reactivity when presented with working with a survivor of IPV. As VT increased, interpersonal reactivity increased. When examining the subscales of interpersonal reactivity, VT was not found to be a significant predictor of empathic concern when working with a survivor of IPV, $F(1, 81) = .004$, $p = .953$, $R^2 = .000$, Adjusted $R^2 = -.012$, $\beta = -.007$. However, VT was found to be a significant predictor of personal distress when working with a survivor of IPV, $F(1, 82) = 12.84$, $p = .001$, $R^2 = .137$, Adjusted $R^2 = .126$, $\beta = .077$. VT explained approximately 13.7% of the variance in clinicians' personal distress when presented with working with a survivor of IPV. As VT increased, personal distress increased.

Hypothesis 2b: VT as a Predictor of Interpersonal Reactivity with a Perpetrator of IPV

A regression analysis was used to determine if VT could be used to predict interpersonal reactivity when working with a perpetrator of IPV. VT was not found to be a statistically significant predictor of interpersonal reactivity when working with a client who was a perpetrator of IPV, $F(1, 79) = 1.52$, $p = .221$, $R^2 = .019$, Adjusted $R^2 = .007$, $\beta = .138$. However, when examining the subscales of interpersonal reactivity, VT was

found to be a significant predictor. VT was a significant predictor of empathic concern when working with a perpetrator of IPV, $F(1, 82) = 4.14$, $p = .045$, $R^2 = .049$, Adjusted $R^2 = .037$, $\beta = -.22$. VT explained approximately 4.9% of the variance in clinicians' empathic concern when presented with working with a perpetrator of IPV. As VT increased, empathic concern decreased. Further, VT was found to be a significant predictor of personal distress when working with a perpetrator of IPV, $F(1, 80) = 17.91$, $p < .001$, $R^2 = .185$, Adjusted $R^2 = .174$, $\beta = .430$ (see Table 8). VT explained approximately 18.5% of the variance in clinicians' personal distress when presented with working with a perpetrator of IPV. As VT increased, personal distress increased.

Table 8

Relationship Between Vicarious Trauma and Interpersonal Reactivity

Predictor	*B*	*SE B*	β	*t*	*p*
Working with Survivor of IPV	.075	.035	.236	2.17*	.033
Empathic Concern	-.001	.023	-.007	-.06	.953
Personal Distress	.077	.021	.37	3.58*	.001
Working with Perpetrator of IPV	.046	.037	.138	1.23	.221
Empathic Concern	-.050	.025	-.22	-2.03*	.045
Personal Distress	.105	.025	.43	4.23**	< .001

*$p < .05$ ** $p < .001$

Hypothesis 2c: VT as a Predictor of Ethical Competence with a Survivor of IPV

Parallel analyses were run to examine ethical competency. Ethical competency was used as a total scale comprised of comfort, knowledge, and decision making in an

ethical dilemma (Boundaries in Practice Scale), as well as the level of identification the mental health worker felt with the client. A regression analysis was used to determine if VT could be used to predict ethical competency when working with a survivor of IPV. VT was found to be a statistically significant predictor of ethical competency when working with a client who was a survivor of IPV, $F(1, 77) = 24.98$, $p < .001$, $R^2 = .245$, Adjusted $R^2 = .235$, $\beta = -.495$. VT explained approximately 24.5% of the variance in clinicians' ethical competence when presented with working with a survivor of IPV. As VT increased, ethical competency decreased.

Hypothesis 2d: VT as a Predictor of Ethical Competence with a Perpetrator of IPV

A regression analysis was used to determine if VT could be used to predict ethical competence when presented with working with a perpetrator of IPV. VT was found to be a statistically significant predictor of ethical competence when working with a client who was a perpetrator of IPV, $F(1, 77) = 10.91$, $p = .001$, $R^2 = .124$, Adjusted $R^2 = .113$, $\beta = -.352$ (see Table 9). VT explained approximately 12.4% of the variance in clinicians' ethical competency when presented with working with a perpetrator of IPV. As VT increased, ethical competence decreased.

Table 9

Relationship Between Vicarious Trauma and Ethical Competence

Predictor	*B*	*SE B*	β	*t*	*p*
Working with Survivor of IPV	-.183	.037	-.495	-4.998**	< .001
Working with Perpetrator of IPV	-.137	.041	-.352	-3.30*	.001

*$p < .05$ **$p < .001$

Hypothesis 3

In order to examine participants with a personal history of IPV on their interpersonal reactivity and ethical competence, four linear regression analyses were run to examine whether a history of IPV predicted: (1) interpersonal reactivity when working with survivors, (2) interpersonal reactivity when working with perpetrators, (3) ethical competency when working with survivors, and (4) ethical competency when working with perpetrators.

Hypothesis 3a: Interpersonal Reactivity with a Survivor of IPV

A regression analysis was used to determine if a history of IPV, which was measured as a continuous variable based on the number of traumatic experiences, could be used to predict interpersonal reactivity when presented with working with a survivor of IPV. A history of IPV was found to be a statistically significant predictor of interpersonal reactivity when working with a client who was a survivor of IPV, $F(1, 57) = 45.322$, $p = .025$, $R^2 = .086$, Adjusted $R^2 = .069$, $\beta = .292$. A history of IPV explained approximately 8.5% of the variance in clinicians' interpersonal reactivity when presented with working with a survivor of IPV. The more experiences of IPV participants endorsed, the higher their reported experiences of interpersonal reactivity when the client was a survivor.

When examining the subscales of interpersonal reactivity, a history of IPV was found to be a significant predictor of empathic concern, $F(1, 59) = 18.92$, $p < .001$, $R^2 = .246$, Adjusted $R^2 = .233$, $\beta = -.496$. A history of IPV explained approximately 24.6% of the variance in mental health workers' empathic concern when working with a survivor

of IPV. As a history of IPV increased, empathic concern decreased. However, a history of IPV was not found to be a significant predictor of personal distress when working with a survivor of IPV, $F(1, 61) = .254$, $p = .616$, $R^2 = .004$, Adjusted $R^2 = -.012$, $\beta = .065$.

Hypothesis 3b: Interpersonal Reactivity with a Perpetrator of IPV

A regression analysis was used to determine if a history of IPV could be used to predict interpersonal reactivity when presented with working with a perpetrator of IPV. A history of IPV was not found to be a statistically significant predictor of interpersonal reactivity when working with a client who was a perpetrator of IPV, $F(1, 57) = 2.84$, $p = .098$, $R^2 = .047$, Adjusted $R^2 = .031$, $\beta = -.218$. However, when examining the subscales of interpersonal reactivity, a history of IPV was a significant predictor of empathic concern when working with a perpetrator of IPV, $F(1, 60) = 8.85$, $p = .004$, $R^2 = .130$, Adjusted $R^2 = .116$, $\beta = -.361$. A history of IPV explained approximately 13% of the variance in clinicians' empathic concern when presented with working with a perpetrator of IPV. As mental health workers experienced more IPV, empathic concern decreased. A history of IPV was not found to be a significant predictor of personal distress when working with a perpetrator of IPV, $F(1, 59) = .326$, $p = .57$, $R^2 = .006$, Adjusted $R^2 = -.012$, $\beta = .075$ (see Table 10).

Table 10

Relationship Between a History of IPV And Interpersonal Reactivity

Predictor	*B*	*SE B*	β	*t*	*p*
Working with Survivor of IPV	-.314	.136	-.292	-2.31*	.025
Empathic Concern	-.374	.086	-.496	-4.45**	< .001
Personal Distress	.049	.097	.065	.504	.616
Working with Perpetrator of IPV	-.248	.147	-.218	-1.68	.098
Empathic Concern	-.324	.109	-.316	-2.97*	.004
Personal Distress	.059	.104	.075	.571	.57

*$p < .05$ ** $p < .001$

Hypothesis 3c: Ethical Competence with a Survivor of IPV

Parallel analyses were run to examine ethical competence. Ethical competency was used as a total scale comprised of comfort, knowledge, and decision making in an ethical dilemma (Boundaries in Practice Scale), as well as the level of identification the mental health worker felt with the client. A regression analysis was used to determine if a history of IPV could be used to predict ethical competency when presented with working a survivor of IPV. A history of IPV was not found to be a statistically significant predictor of ethical competency when working with a client who was a survivor of IPV, $F(1, 57) = .412$, $p = .523$, $R^2 = .007$, Adjusted $R^2 = -.010$, $\beta = -.085$.

Hypothesis 3d: Ethical Competence with a Perpetrator of IPV

A regression analysis was used to determine if a history of IPV could be used to predict ethical competency when presented with working with a perpetrator of IPV. A

history of IPV was not found to be a statistically significant predictor of ethical competency when working with a client who was a perpetrator of IPV, $F(1, 57) = 1.26$, $p = .266$, $R^2 = .022$, Adjusted $R^2 = .004$, $\beta = -.147$.

Hypothesis 4

In order to examine how VT and a personal history of IPV affect one another, a factorial ANOVA was run in order to see a potential interaction effect between VT and a personal history of IPV on interpersonal reactivity scores. In order to do this, VT and IPV, which were continuous variables, were split into high or low based on the median score for each variable.

Hypothesis 4a: Interpersonal Reactivity when Working with a Survivor of IPV

When examining interpersonal reactivity, there was not a significant main effect of VT on interpersonal reactivity when presented with working with a survivor of IPV, $F(1, 101) = 1.28$, $p = .26$. Additionally, there was not a significant main effect of IPV on interpersonal reactivity when presented with working with a survivor of IPV, $F(1, 101) = .002$, $p = .961$. Finally, there was not a significant interaction effect between VT and IPV when participants were presented with working with a survivor of IPV, $F(1, 101) = .167$, $p = .683$.

When examining a subscale of interpersonal reactivity, personal distress, there was a significant main effect of VT (high VT: $M = 14.47$, $SD = 3.49$; low VT: $M = 12.21$, $SD = 2.85$) on personal distress when presented with working with a survivor of IPV, $F(1, 104) = 17.89$, $p < .001$. However, there was not a significant main effect of IPV on personal distress when presented with working with a survivor of IPV, $F(1, 104) = 2.54$,

p = .114. Finally, there was a significant interaction effect between VT and IPV when participants were presented with working with a survivor of IPV, $F(1, 104) = 4.07$, p = .046. Clinicians high in VT and high in IPV experienced higher personal distress (M = 16.16; SD = 3.02) than those high in VT but had fewer experiences of IPV (M = 13.79; SD = 3.46).

Hypothesis 4b: Interpersonal Reactivity when Working with a Perpetrator of IPV

When examining interpersonal reactivity, there was not a significant main effect of VT on interpersonal reactivity when presented with working with a perpetrator of IPV, $F(1, 100) = .002$, p = .963. Additionally, there was not a significant main effect of IPV on interpersonal reactivity when presented with working with a perpetrator of IPV, $F(1, 100)$ = .58, p = .448. Finally, there was not a significant interaction effect between VT and IPV when participants were presented with working with a perpetrator of IPV, $F(1, 100)$ = .151, p = .699 (see Table 11).

When examining personal distress, a subscale of interpersonal reactivity, there was a significant main effect of VT (high VT: M = 14.42, SD = 3.82; low VT: M = 12.20, SD = 3.38) on personal distress when presented with working with a perpetrator of IPV, $F(1, 101) = 12.97$, $p < .001$. Additionally, there was a significant main effect of IPV (high IPV: M = 14.56, SD = 3.87; low IPV: M = 13.06, SD = 3.69) on personal distress when presented with working with a perpetrator of IPV, $F(1, 101) = 5.11$, p = .026. Finally, there was not a significant interaction effect between VT and IPV when participants were presented with working with a survivor of IPV, $F(1, 101) = 1.50$, p = .224 (see Table 11).

Table 11

Interaction between VT and IPV on Personal Distress When Working with a Survivor and Perpetrator of IPV

	df	*MS*	*F*	*p*
Working with a Survivor of IPV				
VT	1	180.40	17.89	>.001**
IPV	1	25.60	2.54	.114
VT*IPV	1	40.99	4.07	.046*
Working with a Perpetrator of IPV				
VT	1	164.97	12.97	>.001**
IPV	1	64.99	5.11	.026*
VT*IPV	1	19.03	1.50	.224

* $p < .05$ ** $p < .001$

Hypothesis 4c: Ethical Competence when Working with a Survivor of IPV

In order to examine how VT and a personal history of IPV affect one another, a factorial ANOVA was run in order to see a potential interaction effect between VT and a personal history of IPV on ethical competence scores. Ethical competency was used as a total scale comprised of comfort, knowledge, and decision making in an ethical dilemma (Boundaries in Practice Scale), as well as the level of identification the mental health worker felt with the client.

When examining ethical competency, there was a significant main effect of VT (high VT: $M = 74.46$, $SD = 6.66$; low VT: $M = 77.76$, $SD = 5.13$) on ethical competency

when presented with working with a survivor of IPV, $F(1, 96) = 9.67$, $p = .002$. Individuals with lower VT engaged in more competent ethical decision-making. However, there was not a significant main effect of IPV on ethical competency when presented with working with a survivor of IPV, $F(1, 96) = 2.72$, $p = .102$. Finally, there was not a significant interaction effect between VT and IPV when participants were presented with working with a survivor of IPV, $F(1, 96) = 2.65$, $p = .107$.

When examining over-identification, one of the subscales of ethical competence, there was a significant main effect of VT (high VT: $M = 38.45$, $SD = 4.79$; low VT: $M = 40.38$, $SD = 4.06$) on identification when presented with working with a survivor of IPV, $F(1, 98) = 5.42$, $p = .022$ (see Table 12). People low in VT identified more strongly with the survivor of IPV. However, there was not a significant main effect of IPV on identification when presented with working with a survivor of IPV, $F(1, 98) = 1.28$, $p = .260$. Finally, there was not a significant interaction effect between VT and IPV when participants were presented with working with a survivor of IPV, $F(1, 98) = .44$, $p = .509$.

Table 12

Interaction Between VT and IPV on Over Identification

	df	*MS*	*F*	*p*
Working with a Survivor of IPV				
VT	1	110.78	5.42	.022*
IPV	1	26.211	1.28	.260
VT*IPV	1	9.00	.44	.509

* $p < .05$ ** $p < .001$

Hypothesis 4d: Ethical Competence when Working with a Perpetrator of IPV

When examining ethical competency, there was a significant main effect of VT (high VT: $M = 72.62$, $SD = 7.02$; low VT: $M = 75.12$, $SD = 6.00$) on ethical competency when presented with working with a perpetrator of IPV, $F(1, 96) = 5.52$, $p = .021$ (see Table 13). Clinicians low in VT engaged in more competent ethical decision making compared to those high in VT. However, there was not a significant main effect of IPV ethical competency when presented with working with a perpetrator of IPV, $F(1, 96) = 1.32$, $p = .254$. Finally, there was not a significant interaction effect between VT and IPV when participants were presented with working with a perpetrator of IPV, $F(1, 96) = 1.62$, $p = .206$.

Table 13

Interaction Between VT and IPV on Ethical Competency

	df	*MS*	*F*	*p*
Working with a Survivor of IPV				
VT	1	345.28	9.67	.002*
IPV	1	97.17	2.72	.102
VT*IPV	1	95.68	2.65	.107
Working with a Perpetrator of IPV				
VT	1	238.84	5.52	.021*
IPV	1	56.942	1.32	.254
VT*IPV	1	70.24	1.62	.206

* $p < .05$ ** $p < .001$

Hypothesis 5

In order to examine interpersonal reactivity as a mediating variable between ethical decision making and mental health workers with VT, this study utilized Baron and Kenny's (1986) method of finding a mediating variable. In order to do this, three regression analyses were run between VT and interpersonal reactivity, VT and ethical decision making, and interpersonal reactivity and ethical competence. Ethical competency was used as a total scale comprised of comfort, knowledge, and decision making in an ethical dilemma (Boundaries in Practice Scale), as well as the level of identification the mental health worker felt with the client.

Hypotheses 5a and 5b: Interpersonal Reactivity as a Mediating Variable between VT and Ethical Competence

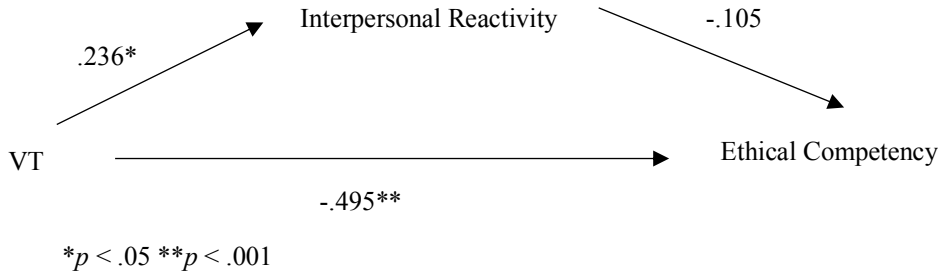
Working with a survivor of IPV. When working with survivors of IPV, VT was found to be a statistically significant predictor of interpersonal reactivity, $F(1, 81) = 4.70$, $p = .033$, $R^2 = .056$, Adjusted $R^2 = .044$, $\beta = .236$. VT explained approximately 5.6% of the variance in clinicians' interpersonal reactivity when presented with working with a survivor of IPV.

Additionally, when working with survivors of IPV, VT was found to be a statistically significant predictor of ethical competency, $F(1, 77) = 24.98$, $p < .001$, $R^2 = .245$, Adjusted $R^2 = .235$, $\beta = -.495$, which is the first step in the Baron and Kenny (1986) method of finding mediating variables (see Figure 1). VT explained approximately 24.5% of the variance in clinicians' ethical competence when presented with working with a survivor of IPV.

However, when examining interpersonal reactivity as a mediating variable, while the overall model of prediction was significant $F(2, 45) = 14.10$, $p = .000$, $R^2 = .273$, Adjusted $R^2 = .254$, interpersonal reactivity as a mediating variable was not significant, $t(2) = -1.03$, $p = .305$, $\beta = -.105$ (see Figure 1).

Figure 1

Interpersonal Reactivity as a Mediating Variable When Working with a Survivor of IPV



Working with a perpetrator of IPV. When working with perpetrators of IPV, VT was not found to be a statistically significant predictor of interpersonal reactivity, $F(1, 79) = 1.52$, $p = .221$, $R^2 = .019$, Adjusted $R^2 = .007$, $\beta = .138$. VT was found to be a statistically significant predictor of ethical competence when working with a client who was a perpetrator of IPV, $F(1, 77) = 10.91$, $p = .001$, $R^2 = .124$, Adjusted $R^2 = .113$., $\beta = -.352$. VT explained approximately 12.4% of the variance in clinicians' ethical competency when presented with working with a perpetrator of IPV. Because VT was not a significant predictor of interpersonal reactivity when working with perpetrators, the mediating regression analysis was not completed.

Hypothesis 5c and 5d: Interpersonal Reactivity as a Mediating Variable between a History of IPV and Ethical Competence

In order to examine interpersonal reactivity as a mediating variable between ethical competence and mental health workers with a personal history of IPV, a parallel process was used. This study utilized Baron and Kenny's (1986) method of finding a mediating variable. In order to do this, three regression analyses were run between a personal history of IPV and interpersonal reactivity, a personal history of IPV and ethical decision making, and interpersonal reactivity and ethical decision making. This process was run two times to examine the impact on working with a survivor and perpetrator of IPV.

Working with a survivor of IPV. When working with a survivor of IPV, a history of IPV was found to be a statistically significant predictor of interpersonal reactivity, $F(1, 57) = 45.322$, $p = .025$, $R^2 = .086$, Adjusted $R^2 = .069$, $\beta = -.292$. A history of IPV explained approximately 8.5% of the variance in clinicians' interpersonal reactivity when presented with working with a survivor of IPV. However, a history of IPV was not found to be a statistically significant predictor of ethical competency when working with a client who was a survivor of IPV, $F(1, 57) = .412$, $p = .523$, $R^2 = .007$, Adjusted $R^2 = -.010$, $\beta = -.085$. Because a history of IPV was not a significant predictor of ethical competence, the mediating regression analysis was not run.

Working with a perpetrator of IPV. When working with a perpetrator of IPV, a history of IPV was not found to be a statistically significant predictor of interpersonal reactivity when working with a client who was a perpetrator of IPV, $F(1, 57) = 2.84$, $p =$

.098, R^2 = .047, Adjusted R^2 = .031, β = -.218. Further, when working with a perpetrator of IPV, a history of IPV was not found to be a statistically significant predictor of ethical competency when working with a client who was a perpetrator of IPV, $F(1, 57) = 1.26$, p = .266, R^2 = .022, Adjusted R^2 = .004, β = -.147. Because a history of IPV was not a significant predictor of interpersonal reactivity or ethical competence, the mediating regression analysis was not run.

CHAPTER V

DISCUSSION

Summary of Major Findings

Differences in Clinicians when Working with a Survivor and Perpetrator of IPV

This study compared mental health workers' interpersonal reactivity, through empathic concern and personal distress, when working with a survivor of IPV and their interpersonal reactivity when working with a perpetrator of IPV. This was due to previous suggestions that therapists hold biases and negative attitudes towards IPV and perpetrators of IPV (Dowler, 2003; Meyers, 2011). In this study, there were no significant differences in interpersonal reactivity when clinicians considered working with a survivor of IPV compared to when they considered working with a perpetrator of IPV. Further, there were no significant differences found between mental health workers' empathic concern or personal distress when they considered working with a survivor of IPV and when they considered working with a perpetrator of IPV. Hypothesis (1a), that mental health workers would experience heightened interpersonal reactivity when working with perpetrators of IPV than when they work survivors of IPV, was rejected. This suggests that mental health workers are able to engage, connect, and empathize with both survivors and perpetrators of IPV at similar levels (Davis, 1983). This contradicts past literature predictions and could indicate that participants may have been answering in a socially desirable way or answering in a way that reflected their ideal perception of themselves as competent with varying clinical populations (Larson & Bradshaw, 2017).

Analysis from this study also examined mental health workers' ethical competence when working with a survivor compared to a perpetrator of IPV. Ethical competence was determined by exposing clinicians to ethical dilemmas and asking them to rate their knowledge and comfort with various scenarios, and examining their decision-making in these scenarios. Additionally, identification, defined as clinicians viewing the client as a potential extension of self (e.g., "When someone praises this client, it feels like a personal compliment"), with the client was examined as an aspect of ethical competence. When examining the varying components that comprise ethical competency, (1) boundaries in practice, (2) knowledge about ethical decisions, (3) comfort in ethical decisions, (4) ethical decisions, and (5) over-identification with the client, all of the subscales of ethical competence were significant when comparing the vignettes of working with a survivor or a perpetrator of IPV.

Overall, mental health workers demonstrated more ethical competence when working with a survivor of IPV compared to when working with a perpetrator of IPV. This supports the Hypothesis (1b) proposed by this study. Mental health workers demonstrated more competency with maintaining boundaries when working with a survivor of IPV than when working with a perpetrator of IPV, and indicated more rigidity in boundaries when working with a perpetrator of IPV than when working with a survivor of IPV. This is noteworthy, as boundaries establish safety and security within the therapeutic relationship, which could indicate that mental health workers might struggle when setting patterns or expectations in therapy with perpetrators of IPV (Wilson & Lindy, 1994).

Further, mental health workers reported feeling more knowledgeable about ethical dilemmas when the client was a survivor of IPV than when the client was a perpetrator of IPV. Because ethical decision making requires clinicians to be knowledgeable about and adhere to an ethical code in order to provide quality care (APA, 2017; Clawson, 1994; Claw, 2013), this finding could indicate that mental health workers are less prepared to engage in ethical decision making with perpetrators of IPV than they are with survivors of IPV. Additionally, mental health workers reported feeling more comfortable in handling ethical dilemmas when the client was a survivor of IPV than when the client was a perpetrator of IPV. Clinicians' lack of comfort when handling ethical dilemmas with perpetrators of IPV could reflect their personal feelings or lower personal ethics when working with perpetrators, such that mental health workers might be more prone to assimilation strategies, or utilizing professional ethical standards at the expense of compassion for their clients, when engaging in ethical decision making with perpetrators (Handelsman et al., 2005; Knapp et al., 2013).

When presented with ethical dilemmas, mental health workers made more ethical decisions when the client was a survivor of IPV than when the client was a perpetrator of IPV. For example, when clinicians were presented with an ethical dilemma related to risk associated with suicidality, and were asked if they would schedule a client with intense distress and hopelessness for the next day after disclosing their distress, clinicians viewed the decision to schedule the client who was a survivor of IPV as more ethical than they did the perpetrator of IPV. This finding might reflect mental health workers' attitudes connected to risk when working with perpetrators, a possible bias against perpetrators of

IPV, or perhaps clinicians' tendency to view perpetrators as manipulative (Dowler, 2003; Meyer, 2011). This could reflect low professional ethics in mental health workers when working with perpetrators of IPV, which might suggest that clinicians are utilizing marginalization strategies, in that they are both lacking in compassion, or personal ethics, and are also not adhering to professional ethics by not utilizing ethical practices when clients endorse suicidal ideation, when engaging in ethical decision making with perpetrators of IPV (Handelsman et al., 2005; Knapp et al., 2013).

Finally, mental health workers reported stronger identification with the client who was a survivor of IPV than the client who was a perpetrator of IPV. This finding reflects previous literature findings of therapists having strong identification with survivors of trauma (Saakvitne, 2002; Schauben & Frazier, 1995). It is unclear if mental health workers in this study were over-identifying with the survivor of IPV. Alternatively, clinicians might struggle to identify with a perpetrator of IPV, which could reflect a counter-transference reaction (Wilson & Lindy, 1994), in that the clinicians viewed their self as distinct and different from a perpetrator of IPV.

Impact of VT on Interpersonal Reactivity and Ethical Competence

VT was examined as a predictor of interpersonal reactivity with both a survivor and perpetrator of IPV. When working with the survivor of IPV, VT was a significant predictor of interpersonal reactivity for mental health workers, such that as VT increased, interpersonal reactivity increased. This finding supported the proposed Hypothesis (2a) of this study. When examining the two subscales, VT did not impact clinicians' empathic concern with a survivor of IPV, which is contradictory to previous findings that when

mental health workers experience VT, they do not have the emotional capacity to fully engage or empathically connect with their clients (Cohen & Collens, 2013; Pearlman & Saakvitne, 1995). However, VT was found to be a significant predictor of personal distress when working with a survivor of IPV. This finding is consistent with VT literature, which has demonstrated and proposed that VT can interfere with clinicians' emotional state (Cohen & Collens, 2013; Pearlman & Saakvitne, 1995). Further, VT can impact countertransference reactions, and interpersonal reactivity in therapists, which is reflected in the results of this study (Pearlman & Saakvitne, 1995). While personal distress and empathic concern were proposed as components of empathy in the literature, this finding is consistent with Cristea et al.'s (2014) finding that personal distress and empathic concern are different mechanisms in helping behavior, and therefore should be examined separately.

However, VT was not found to be a significant predictor of interpersonal reactivity for mental health workers who were presented with a vignette of a perpetrator of IPV. When examining the subscales of interpersonal reactivity, VT was found to be a significant predictor of both empathic concern and personal distress when working with a perpetrator of IPV, such that as VT increased in therapists, the empathic concern for perpetrators decreased while their personal distress increased. This finding is consistent with previous research which indicates that VT impairs affective regulation and the interpersonal connections mental health workers hold with their clients (Cohen & Collens, 2013; Pearlman & Saakvitne, 1995). Further, this finding could suggest that VT could impair mental health workers' ability to manage their personal biases against

perpetrators of IPV (Blasko et al., 2007; Clawson, 1994; Meyer, 2011; Pearlman & Saakvitne, 1995).

When examining ethical competence, VT was found to be a significant predictor of ethical competence when working with both a survivor and a perpetrator of IPV. For both working with a survivor and perpetrator, as VT increased, or clinicians reported higher levels of VT, ethical competence declined. This finding supports the hypotheses (1c and 1d) of this study, which proposed that VT would negatively impact ethical competence. This finding supports past research, which has found that VT broadly impacts therapists (Cohens & Collens, 2013), but is noteworthy in that it specifically examines mental health workers when working with a survivor and perpetrator of IPV. Further, this research finding also suggests that VT impacts not only clinicians' well-being but could also impair their ability to engage in ethical decision-making, which reflects Pearlman & Saakvitne's (1995) suggestion that VT impairs therapists' capacity to appropriately attend to their clients and the needs of their clients.

Impact of a Personal History of IPV on Interpersonal Reactivity and Ethical Competence

A history of IPV was examined as a predictor of interpersonal reactivity for mental health workers when working with a survivor and perpetrator of IPV. When working with a survivor of IPV, a history of IPV was found to be a significant predictor of interpersonal reactivity, which reflects the Hypothesis 3a proposed by this study. The more experiences or intense histories of IPV mental health workers had, the lower their reported experiences of interpersonal reactivity. When examining the subscales of

interpersonal reactivity, a history of IPV was a significant predictor of empathic concern when working with a survivor of IPV, such that the more experiences, or the more intense the history, of IPV, the lower the empathic concern. Previous literature on empathy in clinicians impacted by a history of IPV is mixed, and has indicated that therapists with a history of trauma might be either hindered or magnified in clinical work (Benatar, 2000; Wilson & Lindy, 1994). However, literature on empathy has indicated that empathic concern might better reflect altruism, and being high in empathic concern might be a favorable characteristic for a mental health worker (Cristea et al., 2014). Therefore, this finding could reflect that highly traumatized therapists might struggle to feel sympathy and concern for survivors of IPV (Pulos, Elison, & Lennon, 2004). A possible explanation for this finding might be that traumatized clinicians' past experiences of IPV could lead them to feel unworried for their clients who have experienced IPV. Another possible explanation might be that traumatized mental health workers might be more desensitized to violence or experiences of IPV and, therefore, feel less concern or pity.

Further, a history of IPV was not found to be a significant predictor of personal distress when working with a survivor of IPV. The finding that a personal history of IPV is not a predictor of personal distress is contradictory to the proposed Hypothesis 3b of this study as well as previous findings in research, which suggest that a history of IPV can lead therapists to experience personal distress or struggle with emotional reactivity (Marmaras et al., 2003; Saakvitne, 2002). While this finding is contradictory, it could reflect clinicians' ability to separate their own traumatic experiences from their clients,

which could reflect their ability to effectively connect and engage with a survivor of IPV (Benatar, 2000). Further, this finding demonstrates that therapists with a history of trauma are not reporting personal distress when working with survivors of IPV, which could reflect that the therapists are able to engage in distress tolerance and could be well-adjusted and not emotionally reactive.

When examining interpersonal reactivity in mental health workers when working with a perpetrator of IPV, a similar pattern emerged. Although there was a slight trend in the data, a history of IPV did not predict overall interpersonal reactivity, which is contradictory to the proposed Hypothesis 3b. However, when examining the subscales of interpersonal reactivity, a history of IPV was found to be a significant predictor of empathic concern when working with a perpetrator of IPV, such that as experiences, or intensity, of IPV increased, empathic concern decreased. This finding could reflect previous literature that a history of IPV might hinder empathy, or it could also reflect previous literature's findings that therapists with a history of trauma might struggle with countertransference reactions, which could impact empathic concern (Wilson & Lindy, 1994). Additionally, this finding might also reflect attitudes or biases therapists hold against perpetrators of IPV (Dowler, 2003; Meyer, 2011; Mitchell et al., 2013). A history of IPV was not found to be a significant predictor of personal distress when working with a perpetrator of IPV.

This is contradictory of previous research, which has suggested that individuals with a history of IPV might be distressed or emotionally reactive when working with a perpetrator of IPV (Clawson, 1994; Pearlman & Saakvitne, 1995). However, when

considering empathic concern and personal distress as separate components of reactivity and empathy (Cristea et al., 2014), this finding demonstrates that therapists with a history of trauma do not have high sympathy for perpetrators of IPV, but also do not necessarily feel anxious or tense while working with perpetrators of IPV.

A history of IPV was also examined as a predictor of ethical competence. A history of IPV was not found to be a significant predictor of ethical competence neither for working with a survivor or perpetrator of IPV. This finding does not support the Hypotheses 3c and 3d of this study. This finding does not reflect previous literature, as therapists with a history of trauma have been shown to struggle with boundaries and may be at risk of over-identifying with their clients, which could impact ethical competence (Marmaras et al., 2003; Saakvitne, 2002; Schauben & Frazier, 1995; Smith et al., 2007; Wilson & Lindy, 1994). However, the scale utilized self-reporting, and therapists with a history of trauma might struggle to engage in accurate self-reflection, and may struggle to recognize their own limitations which could impact their ability to effectively intervene with clients (Benatar, 2000; Connor et al., 2012; Marmaras et al., 2003).

Interaction between VT and a Personal History of IPV

Impact on interpersonal reactivity. When examining interpersonal reactivity with a client who is a survivor of IPV, there was no significant main effect of VT, a history of IPV, nor an interaction between VT and IPV. However, when examining the subscales of interpersonal reactivity, there was a significant main effect of VT on personal distress, and a significant interaction effect of VT and a history of IPV on personal distress, such that clinicians high in VT and who had also experienced more

intense IPV experienced greater personal distress than clinicians who were high in VT but had fewer experiences of IPV. This supports the proposed Hypothesis 4a, that clinicians high in VT and who have experienced IPV would experience greater distress. This finding is noteworthy and connects previous literatures' findings that a history of IPV and experiences of VT could impact emotional distress when working with clients (Clawson, 1994; Cohen & Collens, 2013; Pearlman & Saakvitne, 1995).

When examining overall interpersonal reactivity when working with a perpetrator of IPV, there was no significant main effect, nor an interaction effect with VT and a history of IPV. However, when examining the subscale of personal distress, there was a significant main effect of VT and a significant main effect of a history of IPV, but there was not a significant interaction effect. This finding does not fully support the Hypothesis 4b proposed by this study that VT and a history of IPV would impact mental health workers experiences of emotional reactivity when working with a perpetrator of IPV. However, it does reflect that mental health workers high in VT experienced more affective distress when working with a perpetrator of IPV than those low in VT. This finding both reflects previous research and adds to previous literature.

Previous findings reflect that VT can negatively impact personal distress and emotional reactivity (Cohen & Collens, 2013; Pearlman & Saakvitne, 1995). However, no previous study has examined the intersection of this finding when specifically working with a perpetrator of IPV. Additionally, this finding shows that mental health workers with a greater history of IPV experienced more distress when working with a perpetrator of IPV than those with fewer or no experiences of IPV. Similarly, this finding is both

reflective of past literature that a history of trauma can impact emotional reactivity (Clawson, 1994; Pearlman & Saakvitne, 1995), but is unique in that it examines the intersection of this finding when working specifically with a perpetrator of IPV.

Impact on ethical competence. When examining the interaction of VT and a history of IPV on ethical competence when working with a survivor of IPV, there was a significant main effect of VT. That is, individuals lower in VT demonstrated more ethical competence than those higher in VT. However, there was not a significant main effect of a history of IPV, nor was there a significant interaction effect between VT and a history of IPV. This does not support the Hypothesis 4c proposed by this study, which anticipated that VT and a personal history of IPV would interact and impact ethical competence and decision-making.

The main effect of VT is reflective of previous literature's findings that VT can impact emotionality and competent decision-making (Cohen & Collens, 2013; Pearlman & Saakvitne, 1995; Wilson & Lindy, 1994), but is unique in that it demonstrates the link between VT and ethical competence. This finding does not reflect previous findings that a history of IPV could impact clinical decision-making (Schauben & Frazier, 1995), however it might suggest that clinicians are resilient and able to engage in competent clinical and ethical decision-making in the research vignettes regardless of their histories of trauma. This finding should be interpreted with caution, as clinicians were not working with clients, but rather were completing these questions as they related to a hypothetical research vignette, and mental health workers might know how to ideally respond in

ethical dilemmas, but could struggle with the application of ethical behavior in their clinical work with real clients.

Similarly, when examining over-identification, one of the subscales of ethical competence, there was a main effect of VT when working with a survivor of IPV. Specifically, people low in VT demonstrated more identification with the survivor of IPV than those high in VT. Previous research has demonstrated that therapists who are high in VT seem to struggle with disconnecting from traumatic material (Cohen & Collens, 2013; Pearlman & Saakvitne, 1995). So while this finding does not reflect over-identification, it could suggest that therapists high in VT are engaging in a strategy of disconnection due to their schematic changes and view of the world as dangerous due to VT (Benatar, 2000; Cohen & Collens, 2013; Pearlman & Saakvitne, 1995). However, there was not a main effect of a personal history of IPV, nor an interaction effect between VT and a history of IPV. This finding is not consistent with previous findings that therapists with a history of trauma might struggle to over-identify with clients who hold a similar trauma background (Saakvitne, 2002).

A similar pattern emerged when examining ethical competence when working with a perpetrator of IPV. There emerged a significant main effect of VT on ethical competence, such that clinicians low in VT demonstrated more ethical competence than those high in VT, but there was not a significant main effect of a history of IPV, nor was there a significant interaction effect between VT and a history of IPV when working with a perpetrator of IPV. This finding does not support the Hypothesis 4d proposed by this study. This finding does align with VT literature that asserts that VT can impact clinical

decision-making (Cohen & Collens, 2013; Pearlman & Saakvitne, 1995; Wilson & Lindy, 1994), but it is unique in that it examines ethical decision-making with a perpetrator of IPV. Similar to working with a survivor of IPV, the insignificant results of a personal history of IPV impacting ethical competence is contradictory to previous literature's findings (Schauben & Frazier, 1995), but could reflect that mental health workers are able to be resilient and engage in competent ethical and clinical work despite their trauma histories. This finding should be interpreted with caution, as clinicians were not working with clients, but rather were asked about their ethical competence about hypothetical research vignettes; and mental health workers might know how to ideally respond in ethical dilemmas, but could struggle with the application of ethical behavior in their clinical work with real clients.

Interpersonal Reactivity as a Mediating Variable

Interpersonal reactivity was first examined as a mediating variable between VT and ethical competence. When working with a survivor of IPV, VT was a significant predictor of interpersonal reactivity, and of ethical competence. However, interpersonal reactivity was not a significant mediating variable between VT and ethical competence when working with a survivor of IPV. Additionally, when working with perpetrators of IPV, VT was not found to be a significant predictor of interpersonal reactivity and therefore interpersonal reactivity was not a mediating variable between VT and ethical competence when working with a perpetrator of IPV.

These findings do not support the proposed Hypotheses 5a or 5b, which anticipated that interpersonal reactivity would mediate the relationship between VT and

ethical competence. Additionally, while this link was unique to this study, these findings do not align with previous findings that intense emotionality or emotional reactivity can impact clinicians' ability to engage in competent ethical decision-making (Cohen & Collens, 2013; Connelly et al., 2004; Pearlman & Saakvitne, 1995). It is unclear as to why interpersonal reactivity did not mediate the relationship between VT and ethical competence, but this could be driven by this study broadly defining interpersonal reactivity and ethical competence, and if these constructs were examined more narrowly, such as only examining one component of ethical competence, this relationship could become evident.

Additionally, interpersonal reactivity was proposed as a mediating variable between a personal history of IPV and ethical competence. When working with a survivor of IPV, a history of IPV was not found to be a significant predictor of interpersonal reactivity, nor a significant predictor of ethical competence. Therefore, interpersonal reactivity is not a mediating variable between a history of IPV and ethical competence when working with a survivor of IPV. Similarly, when working with a perpetrator of IPV, a history of IPV was not found to be a significant predictor of interpersonal reactivity nor of ethical competence, and interpersonal reactivity could, therefore, not be a mediating variable between a history of IPV and ethical competence when working with a perpetrator of IPV.

These findings do not support the proposed Hypotheses 5c and 5d, which anticipated that interpersonal reactivity would mediate the relationship between a history of IPV and ethical competence. While this link was unique to this study, these findings

do not align with previous findings that a history of IPV can impact emotional distress and reduce ability to engage in appropriate decision-making (Benatar, 2000; Okun et al., 2000; Pearlman & Saakvitne, 1995; Pope & Vasquez, 2016). It is unclear as to why interpersonal reactivity did not mediate the relationship between a personal history of IPV and ethical competence, but this could be driven by this study broadly defining interpersonal reactivity and ethical competence, and if these constructs were examined more narrowly, such as only examining one component of ethical competence, this relationship could become evident.

Strengths, Limitations, and Future Directions

Strengths

Strengths of this study were the inclusion of perpetrators of IPV as a clinical population, especially as it relates to the study of VT and a personal history of IPV. Additionally, this study sought to seek out specifically the experiences of mental health workers in order to assess the impact of VT on clinicians and on clients. This study furthered the body of literature of VT by exploring not only the impact of VT on the clinician, but also the impact of VT on ethical competence, which impacts clients and clinical decision-making. This study also examined interpersonal reactivity as a construct that could be impacted by VT and a history of IPV. Additionally, this study examined empathic concern and personal distress as separate constructs of interpersonal reactivity, which furthers literature that empathic concern and personal distress are related but distinct components of empathy and reactivity. Finally, this study utilized vignettes to

better explore the application of clinical work in mental health workers, which was a strength of the study.

Limitations

Limitations for this study include the demographics of the sample. Most participants identified as cis-women, and the sample was overwhelmingly White. Across race and ethnicity, women tend to have higher scores of empathy and score higher on measures of interpersonal reactivity than men (Berg et al., 2015). Additionally, Black or African-American individuals scored higher on self-reports of empathy and interpersonal reactivity (Berg et al., 2015). Therefore, these results are not generalizable to all mental health workers and reflect the cultural lenses of the participants sampled, as men might have had lower empathy scores, and people of color might have experienced greater empathy or interpersonal reactivity than the White participants.

Additionally, this study developed and adapted scales to fit the topic of working with IPV, and therefore used the scales outside of their original adaptation. For example, this study used an abbreviated version of the TABS and IRI, and the ethical competence scale was adapted from the Boundaries in Practice Scale. While the scales were adapted using sound theory, there was limited reliability on some of the scales used in this study, which could have influenced the results of this study. This study utilized vignettes, which although they provided information that self-report surveys alone could not have provided, they do not fully capture therapists' decision-making in real-life situations or with real clients. Therefore, it could be unclear if mental health workers would be able to effectively utilize their knowledge in their true clinical work.

Directions for Research

Future directions for research might include examining clinical work with survivors and perpetrators of IPV but utilizing a control client, or variable, in order to further assess differences in clinical and ethical decision making when working with a traumatic clinical population. Additionally, countertransference and personal biases could be examined as predictor variables for empathic concern when working with survivors or perpetrators of IPV. It might be particularly useful to explore clinicians' attitudes and biases when working with perpetrators of IPV, and the implications of such biases (Iliffe & Steed, 2000).

Another direction for future research might include examining these findings through multicultural lenses. The results of this study might shift depending on the identity of the participants, as this study overwhelmingly examined White cis-women. Additionally, future directions could include examining personal distress and ethical competence with clients of varying social locations. In this study, participants were not presented with demographic information for the client in the vignette. In the future, it could be meaningful to examine the ways in which clinicians' perceive clients differently on dimensions of gender, race/ethnicity, social class, and sexual orientation, as well as other identity variables.

Finally, this study examined interpersonal reactivity with a perpetrator and survivor of IPV. In the vignettes, it was indicated that both clients presented reported feeling distress. In particular, the perpetrator client reported feeling distress, and it would be interesting to examine personal distress, specifically empathic concern, with clinicians

if the perpetrator client did not report negative feelings or remorse for their actions. This would be meaningful, as most perpetrator clients begin therapy in a state of minimizing or denying their actions, or blaming others for their actions (Henning & Holdford, 2006; Henning, Jones, & Holdford, 2005; Scott & Straus, 2007). Therefore, a vignette reflecting a perpetrator who did not readily express distress or remorse would more accurately reflect clinical work with the population of perpetrators of IPV. Further, it would be helpful to examine the ways in which personal distress and ethical competence vary when working with perpetrators who express distress or remorse compared to those who do not.

Directions for Clinical Work

This study demonstrates that VT can impact and influence empathic concern, personal distress, and ethical competence in clinical work with survivors and perpetrators of IPV. Therefore, it will be crucial for clinicians and agencies to provide adequate coping for therapists impacted by VT, such as seeking or providing adequate supervision, and self-care activities (Cohen & Collens, 2013; Iliffe & Steed, 2000; Hunter & Schofield, 2006). Additionally, it would be beneficial for mental health workers to engage in self-reflection, especially when working with perpetrators of IPV in order to promote ethical care for this clinical population and to manage countertransference reactions (Pope & Vasquez, 2016).

Conclusion

This study explored vicarious traumatization, which is an invasive problem for many therapists who work with trauma populations, and elicits schematic changes, emotional distress, and feeling overwhelmed. This study also explored the impact of VT

on interpersonal reactivity, or empathic concern and personal distress, as well as ethical competence, including knowledge, comfort, and skills in ethical dilemmas as well as identification with clients, when working with a survivor and a perpetrator of IPV. Further, because mental health workers with a personal history of IPV can also impact emotionality and decision-making, a history of IPV was explored in a similar manner as VT. The results of this study concluded that mental health workers demonstrated more ethical competence when working with a survivor of IPV than with a perpetrator of IPV, and this finding was consistent across the domains of boundaries in therapy, knowledge, comfort, and skill in ethical dilemmas, assessing for risk, and identification with the client. When examining VT separately, VT was a predictor of interpersonal reactivity, such that clinicians who were high in VT also endorsed high personal distress when working with a survivor of IPV.

Additionally, VT was a significant predictor of empathic concern and personal distress when working with a perpetrator, such that as VT increased in therapists, the empathic concern for perpetrators decreased while their personal distress increased. Further, VT was found to be a significant predictor of ethical competence, such that mental health workers low in VT demonstrated better ethical competence than those high in VT both when working with a survivor of IPV and a perpetrator of IPV. A personal history of IPV was found to be a predictor of empathic concern when working with a survivor and when working with a perpetrator of IPV. These results could be used to help inform clinical and ethical decision making, especially for therapists working in a trauma population, or specifically with IPV.

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APPENDIX A

Flyer for Study

My name is Kristin Kazyaka, and I am a doctoral student working with Dr. Claudia Porras Pyland at Texas Woman's University. I am recruiting for a dissertation study about clinicians' personal and professional experiences with intimate partner violence and the ways in which those experiences impact their clinical work with perpetrators and survivors of intimate partner violence.

Participation in this study is voluntary, and you may withdraw from the study at any time without penalty. By completing the study, you can choose to enter to win a raffle for one of four $50 Amazon gift cards. Please know that there is a potential risk of loss of confidentiality in all email, downloading, electronic meetings, and internet transactions.

If you are interested, please view on the attached recruitment letter for the study, or follow the link below to access the study directly.

If you feel comfortable, please forward this email with the link to the recruitment letter to others who could be qualified to complete this study.

If you have any questions, please do not hesitate to contact me (kkazyaka@twu.edu) or Dr. Claudia Porras Pyland (cporras@twu.edu).

Thank you for your time!
Warmly,

Kristin Kazyaka, M.A.
Doctoral Candidate
Texas Woman's University

APPENDIX B

Recruitment Letter

You are being invited to participate in a research study for Kristin Kazyaka's dissertation at Texas Woman's University. The purpose of the current study is to examine the ways in which mental health workers work with perpetrators of intimate partner violence compared to survivors of intimate partner violence. The research is intended to supply the researcher with more information about the effects of working with an intimate partner violence population on clinicians and their occupational functioning. Additionally, participants will also be asked about their own experiences with intimate partner violence. Completion of the surveys in the study takes approximately 30 - 45 minutes. You are only permitted to participate once in the current study, as exposure to the study may impact how you respond to the questions if asked a second time.

In order to be eligible to participate in this study, you must:

(a) Be at least 18 years old

(b) Work as a mental health practitioner

(c) Have worked with intimate partner violence in a clinical capacity

Participation in this study is voluntary and participants may withdraw from the study at any time without penalty. This study has been approved by the Texas Woman's University Institutional Review Board. Please click on the following link to view the informed consent document and to participate in the study:

[link]

There is a potential risk of loss of confidentiality in all email, downloading, and Internet transactions. Thank you in advance for your time. Your information and participation will contribute to the researcher's dissertation and to the body of research on the topic of

intimate partner violence. Additionally, by choosing to participate, you have the option to enter a raffle to win one of four $50 Amazon gift cards.

Sincerely,

Kristin Kazyaka
(kkazyaka@twu.edu)

APPENDIX C

Informed Consent

TEXAS WOMAN'S UNIVERSITY
CONSENT TO PARTICIPATE IN RESEARCH

Title: Ethical Competency When Working with Intimate Partner Violence Among Clinicians Affected by Trauma

Investigator and Advisors:
Kristin Kazyaka, M.A.……..……..kkazyaka@twu.edu
Claudia Porras Pyland, Ph.D. (Advisor)…...……...cporras@twu.edu

Explanation and Purpose of the Research

You are being asked to participate in a study by Kristin Kazyaka, completed under the supervision of Claudia Porras Pyland, Ph.D. at Texas Woman's University. This study consists of online questionnaires, two short vignettes and following questions. The purpose of this study is to examine the ways in which mental health workers differ in their clinical work and ethics when working with perpetrators of intimate partner violence compared to survivors of intimate partner violence.

Description of Procedures

As a participate of the study you will be asked to spend approximately 30 minutes to 45 minutes of your time on a series of questions and vignettes. You are being asked to read and review this consent form and click on the button if you agree to participate. If you do not wish to participate, you can click on the button that states you do not agree to participate. If you do agree to participate, you will be directed to a short demographic survey. You will then be directed to the study, which includes questions about personal history of intimate partner violence, your experiences with working with these clients, and clinical vignettes with following questions. Once you have completed the survey you will be directed to a new page where you will be debriefed about the research intentions, and will be given the opportunity to enter to win a gift certificate. In order to be a participant in the study, you must be at least 18 years of age or older and work as a mental health professional. In this study, the questions may be sensitive, as you will be asked questions about individuals in which you have seen or cared for, as well as questions about your own experiences with intimate partner violence.

Potential Risks

There is a possibility of emotional distress as a result of completing this study, as it assesses past traumatic experiences. A list of psychological resources will be provided for you, and you can choose to withdraw from the study at any time.

The following resources are available to you to help you locate assistance:
American Psychological Association Psychologist Locator

http://locator.apa.org/

National Register of Health Service Psychologists

http://www.findapsychologist.org/

Mental Health of America Referrals

http://www.nmha.org/go/searchMHA

Psychology Today Find a Therapist

http://therapists.psychologytoday.com/rms/

National Board for Certified Counselors

http://www.nbcc.org/CounselorFind

Emergency Medical Services

911

National Suicide Prevention Lifeline

1 – 800 – 273 – 8255

SAMHSA Treatment Referral Helpline

1 – 877 – 726 – 4727

There is a possible risk involving the loss of confidentiality. Confidentiality will be protected to the extent that is allowed by the law, and is collected using a secure platform (PsychData). However, there is a potential risk of loss of confidentiality in all email, downloading, and Internet transactions. Researchers will not know the names of the individuals participating in the study, and only the researcher and her advisor will have access to the data. All sign up information and data will be deleted at the completion of the study. The results of each study may be presented in either conferences and/or scientific publications, without identifying information. Participants will have the option of sharing their email address with researchers if they are interested in obtaining a copy of the results at the completion of the study or if they are interested in entering the raffle. These email addresses will be entered into a separate Psychdata.com file in order to secure that participant answers are stored separately from any identifiable information.

There is also a potential risk of fatigue. You may take breaks as needed or leave the study at any time.

Another possible risk includes the loss of time. The study will take 30-45 minutes to complete, and you can leave the study at any time.

Finally, there is a risk of coercion in this study. Please know that you can choose to not participate in this study, and are free to withdraw from the study at any time. Additionally, any relationships with the primary investigator or her research advisor will not be affected by your decision to participate or not participate in the study.

The researchers will work to prevent any possible concerns or problems that could arise during this study. You should let the researchers know at once if there is a problem and they will assist you accordingly. However, TWU does not provide medical services or

financial assistance for injuries that might happen because you are taking part in this research.

Participation and Benefits

Your participation is completely voluntary in this study, and you may stop at any time without consequences. Your participation in this research will contribute to a larger body of research on conceptualizing intimate partner violence and impact of trauma work on clinicians. Additionally, by completing this research study, you have the opportunity to enter to a raffle to win one of four $50 Amazon gift cards.

Questions Regarding the Study

If you have any questions about the research study, you should ask the researchers. If you have any questions about your rights as a participant, you may contact the Texas Woman's University Office of Research and Sponsored Programs at 940-898-3378 or via email at IRB@twu.edu

- I agree to participate
- I do not agree to participate

APPENDIX D

Demographic Questionnaire

Please answer the questions in a way that applies best to you.

1. Are you currently working with intimate partner violence?
    - Yes
    - No
2. Age: _____
3. Gender:
    - Female
    - Male
    - Transgender
    - Other
4. Please indicate your ethnicity
    - Asian/Asian American/South Asian
    - Black/African/African American
    - Hispanic/Latin American
    - Native American
    - White/Caucasian/European American
    - Pacific Islander
    - Other (please specify)
5. What is your highest level of academic training?
    - Bachelor's degree in a Psychology related field
    - Bachelor's degree in a non-Psychology related field
    - Enrolled in a Master's training program in Psychology related field

- Master's degree in a Psychology related field
- Master's degree in a non-Psychology related field
- Enrolled in a Doctoral training program in Psychology related field
- Doctoral degree in a Psychology related field
- Doctoral degree in a non-Psychology related field
- Other (Please Specify) : _____

6. What clinical population have you worked with? (Mark all that apply)
   - Survivors of intimate partner violence
   - Current victims of intimate partner violence
   - Perpetrators of intimate partner violence
7. How long have you worked with the above populations?

   _____years _____months _____weeks
8. What percentage of your caseload involves working with survivors/victims of intimate partner violence or *perpetrators of intimate partner violence?
   - 0-25%
   - 25-50%
   - 50-75%
   - 75-100%
9. What answer best constitutes the type of agency or location where you work with clients of intimate partner violence?
   - Independent practice
   - Community agency/Domestic violence agency

- Inpatient/Hospital
- Counseling Center
- Other (Please Specify): _____

APPENDIX E

Personal History of IPV Screener

Please answer the questions in a way that applies best to you.

1. Are you, or have you ever, been in a relationship in which you have been physically hurt or threatened by your partner?
2. Has a partner ever destroyed things that you cared about?
3. Has a partner ever threatened you or your children?
4. Has a partner ever forced you to engage in sexual contact when you didn't want to?
5. Has a partner ever pressured you to engage in sex that made you feel uncomfortable?
6. Have you ever felt afraid of a partner?
7. Has a partner ever prevented you from leaving the home, seeing friends, going to work, or continuing your education?
8. Has a partner ever called you names or belittled you?
9. Has a partner ever tried to control you or have power over you?
10. If you answered yes to **any** of the questions (1-9), how many times have you had a relationship in which these questions would apply? _____
11. If you answered yes to **any** of the questions (1-9), when was the last time you experienced this?
    - 0-1 year
    - 1-3 years
    - 3-5 years
    - 5-10 years

- over 10 years

APPENDIX F

Trauma and Attachment Belief Scale

(Copyrighted)

APPENDIX G

Vignettes for Study

Vignette 1

Please read the following scenario and use it to answer the following questions. Imagine yourself as the mental health worker.

A victim of intimate partner violence has been referred to you for mental health counseling services. During your first session, the client reports a history of experiencing verbal, emotional, and physical abuse and reports that a past partner was actively violent. The client expresses distress over this history, and you and the client agree to utilize therapy to focus on that history of violence. The client described being shoved and hit by a current partner

Vignette 2

Please read the following scenario and use it to answer the following questions. Imagine yourself as the mental health worker.

A perpetrator of intimate partner violence has been referred to you for mental health counseling services. During your first session, the client reports a history of engaging in verbal, emotional, and physical abuse and reports being actively violent with a past partner. The client expresses distress over this history, and you and the client agree to utilize therapy to focus on that history of violence. The client described shoving and hitting a current partner.

APPENDIX H

Ethical Decision Making Measure

As you are working with the client from the previous scenario, consider each situation and identify the response that fits best for you.

1a. You have been under a lot of personal stress and this client asks you what is wrong

- How would you rate your level of knowledge for dealing with this situation?
    - No knowledge
    - Limited knowledge
    - Sound knowledge
    - Excellent knowledge
- How comfortable would you feel in dealing with this situation?
    - No discomfort
    - Low discomfort
    - Medium discomfort
    - High discomfort

1b. You find yourself telling this client about your problems.

- How ethical is this decision?
    - Never ethical
    - Ethical under some conditions
    - Ethical under most conditions
    - Always ethical

2a. You have been working with this client for a few months, and offer advice based on your own personal experiences.

- How ethical is this decision?

- Never ethical
- Ethical under some conditions
- Ethical under most conditions
- Always ethical

3a. You start to feel responsible for the well-being of this client

- How would you rate your level of knowledge for dealing with this situation?
  - No knowledge
  - Limited knowledge
  - Sound knowledge
  - Excellent knowledge
- How comfortable would you feel in dealing with this situation?
  - No discomfort
  - Low discomfort
  - Medium discomfort
  - High discomfort

3b. You find yourself doing extra things for this client that they could do themselves

- How ethical is this decision?
  - Never ethical
  - Ethical under some conditions
  - Ethical under most conditions
  - Always ethical

4a. This client discloses that they are feeling intense distress and reports a sense of hopelessness

- How would you rate your level of knowledge for dealing with this situation?
    - No knowledge
    - Limited knowledge
    - Sound knowledge
    - Excellent knowledge
- How comfortable would you feel in dealing with this situation?
    - No discomfort
    - Low discomfort
    - Medium discomfort
    - High discomfort

4b. You decide to let this client leave without any additional questions or assessment

- How ethical is this decision?
    - Never ethical
    - Ethical under some conditions
    - Ethical under most conditions
    - Always ethical

4c. After disclosing this to you, this client asks to see you for additional sessions this week.

- How would you rate your level of knowledge for dealing with this situation?
    - No knowledge
    - Limited knowledge
    - Sound knowledge
    - Excellent knowledge
- How comfortable would you feel in dealing with this situation?
    - No discomfort
    - Low discomfort
    - Medium discomfort
    - High discomfort

4d. You decide to schedule this client in during your administrative time the following day

- How ethical is this decision?
    - Never ethical
    - Ethical under some conditions
    - Ethical under most conditions
    - Always ethical

Please indicate the extent to which you agree or disagree with the following statements as they relate to this client [1 = Strongly disagree; 7 = Strongly agree]

1. When someone praises this client, it feels like a personal compliment 1 2 3 4 5 6 7
2. If I were to talk about this client, I would say "we" rather than "they" 1 2 3 4 5 6 7
3. This client's successes are my successes 1 2 3 4 5 6 7
4. If someone were to criticize this client, it would feel like a personal insult 1 2 3 4 5 6 7
5. I feel like I personally understand this client 1 2 3 4 5 6 7
6. I feel deep empathy for this client 1 2 3 4 5 6 7
7. I feel comfortable with working with this client 1 2 3 4 5 6 7

APPENDIX I

Interpersonal Reactivity Index

INTERPERSONAL REACTIVITY INDEX

The following statements inquire about your thoughts and feelings in a variety of situations. For each item, indicate how well it describes you by choosing the appropriate letter on the scale at the top of the page: A, B, C, D, or E. When you have decided on your answer, fill in the letter next to the item number. READ EACH ITEM CAREFULLY BEFORE RESPONDING. Answer as honestly as you can. Thank you.

ANSWER SCALE:

A	B	C	D	E
DOES NOT DESCRIBE ME WELL			DESCRIBES ME VERY WELL	

1. I daydream and fantasize, with some regularity, about things that might happen to me. (FS)
2. I often have tender, concerned feelings for people less fortunate than me. (EC)
3. I sometimes find it difficult to see things from the "other guy's" point of view. (PT) (-)
4. Sometimes I don't feel very sorry for other people when they are having problems. (EC) (-)
5. I really get involved with the feelings of the characters in a novel. (FS)
6. In emergency situations, I feel apprehensive and ill-at-ease. (PD)
7. I am usually objective when I watch a movie or play, and I don't often get completely caught up in it. (FS) (-)
8. I try to look at everybody's side of a disagreement before I make a decision. (PT)
9. When I see someone being taken advantage of, I feel kind of protective towards them. (EC)
10. I sometimes feel helpless when I am in the middle of a very emotional situation. (PD)
11. I sometimes try to understand my friends better by imagining how things look from their perspective. (PT)
12. Becoming extremely involved in a good book or movie is somewhat rare for me. (FS) (-)
13. When I see someone get hurt, I tend to remain calm. (PD) (-)
14. Other people's misfortunes do not usually disturb me a great deal. (EC) (-)
15. If I'm sure I'm right about something, I don't waste much time listening to other people's arguments. (PT) (-)
16. After seeing a play or movie, I have felt as though I were one of the characters. (FS)
17. Being in a tense emotional situation scares me. (PD)
18. When I see someone being treated unfairly, I sometimes don't feel very much pity for them. (EC) (-)
19. I am usually pretty effective in dealing with emergencies. (PD) (-)
20. I am often quite touched by things that I see happen. (EC)
21. I believe that there are two sides to every question and try to look at them both. (PT)
22. I would describe myself as a pretty soft-hearted person. (EC)

23. When I watch a good movie, I can very easily put myself in the place of a leading character. (FS)
24. I tend to lose control during emergencies. (PD)
25. When I'm upset at someone, I usually try to "put myself in his shoes" for a while. (PT)
26. When I am reading an interesting story or novel, I imagine how I would feel if the events in the story were happening to me. (FS)
27. When I see someone who badly needs help in an emergency, I go to pieces. (PD)
28. Before criticizing somebody, I try to imagine how I would feel if I were in their place. (PT)

APPENDIX J

List of Mental Health Resources

Referral Resources

The following resources are available to you to help you locate assistance:

American Psychological Association Psychologist Locator
http://locator.apa.org/

National Register of Health Service Psychologists
http://www.findapsychologist.org/

Mental Health of America Referrals
http://www.nmha.org/go/searchMHA

Psychology Today Find a Therapist
http://therapists.psychologytoday.com/rms/

National Board for Certified Counselors
http://www.nbcc.org/CounselorFind

Emergency Medical Services
911

National Suicide Prevention Lifeline
1 – 800 – 273 – 8255

SAMHSA Treatment Referral Helpline
1 – 877 – 726 – 4727

APPENDIX K

Thank You/Compensation Page

Thank you for your time in completing this research study!

If you would like to sign-up to receive a summary of the findings of this research once it has been completed, please follow the link below where you will be asked to provide your email address.

[Insert link here]

As a thank you for completing this study, you have the opportunity to win one of four Amazon.com gift cards. The four winners will be selected randomly at the completion of this study. If you would like to enter to win, please follow the link below where you will be asked to provide your email address.

If you would NOT like to enter this drawing, please do NOT enter your email address.

[Insert link here]

APPENDIX L

IRB Approval Letter