

# Preventing Vicarious Trauma: What Counselors Should Know When Working With Trauma Survivors

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*Counselors in all settings work with clients who are survivors of trauma. Vicarious trauma, or counselors developing trauma reactions secondary to exposure to clients' traumatic experiences, is not uncommon. The purpose of this article is to describe vicarious trauma and summarize the recent research literature related to this construct. The Constructivist Self-Development Theory (CSDT) is applied to vicarious trauma, and the implications CSDT has for counselors in preventing and managing vicarious trauma are explored.*

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Counselors in virtually all settings work with clients who are survivors of trauma. Trauma can generally be defined as an exposure to a situation in which a person is confronted with an event that involves actual or threatened death or serious injury, or a threat to self or others' physical well-being (American Psychiatric Association, 2000). Client traumas frequently encountered in clinical practice include childhood sexual abuse; physical or sexual assault; natural disasters, such as earthquakes or tornadoes; domestic violence; and school and work-related violence (James & Gilliland, 2001). Many American counselors have recently been faced with a new population of traumatized clients secondary to the recent terrorist attacks on the United States. With estimates indicating that 1 in 6 women (Ratna & Mukergee, 1998) and 1 in 10 men will experience sexual abuse during childhood, and FBI estimates indicating that 1 in 4 women will be victims of sexual assault in their lifetime (Heppner et al., 1995), sexual victimization is one of the most commonly presented client traumas. Clients' reactions to traumas are typically intense fear, helplessness, or horror. As a result of the trauma, the person may experience severe anxiety or arousal that was not present prior to the trauma (American Psychiatric Association, 2000).

Counselors' reactions to client traumas have historically been characterized as forms of either burnout or countertransference (Figley, 1995). More recently, the term *vicarious trauma* (VT; McCann & Pearlman, 1990) has been used to describe counselors' trauma reactions that are secondary to their exposure to clients' traumatic experiences. The construct of VT provides a more complex and sophisticated explanation of counselors' reactions to client trauma and has implications for preventing counselors' VT reactions.

VT has been referred to as involving "profound changes in the core aspects of the therapist's self" (Pearlman & Saakvitne,

1995b, p. 152). These changes involve disruptions in the cognitive schemas of counselors' identity, memory system, and belief system. VT has been conceptualized as being exacerbated by, and perhaps even rooted in, the open engagement of empathy, or the connection, with the client that is inherent in counseling relationships (Pearlman & Saakvitne, 1995b). VT reflects exposure of counselors to clients' traumatic material and encompasses the subsequent cognitive disruptions experienced by counselors (Figley, 1995; McCann & Pearlman, 1990). These repeated exposures to clients' traumatic experiences could cause a shift in the way that trauma counselors perceive themselves, others, and the world. These shifts in the cognitive schemas of counselors can have devastating effects on their personal and professional lives. By listening to explicit details of clients' traumatic experiences during counseling sessions, counselors become witness to the traumatic realities that many clients experience (Pearlman & Mac Ian, 1995), and this exposure can lead to a transformation within the psychological functioning of counselors.

This article describes VT and how it differs from counselor burnout and countertransference. In addition, this article applies the Constructivist Self-Development Theory (CSDT) to VT, and discusses the implications CSDT has for preventing and managing counselor VT.

## VT, BURNOUT, AND COUNTERTRANSFERENCE

Previously, in the professional literature, the term VT was not used; such trauma was referred to as being either a form of burnout or a countertransference reaction (Figley, 1995; McCann & Pearlman, 1990). Recently, differences among the concepts of burnout, countertransference, and VT have been identified. There are several significant differences between burnout and VT. Burnout is described more as a result of the general psychological stress of working with difficult clients

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(Figley, 1995) versus VT, which is seen as a traumatic reaction to specific client-presented information. Also, vicarious traumatization occurs only among those who work specifically with trauma survivors (e.g., trauma counselors, emergency medical workers, rescue workers, crisis intervention volunteers), whereas burnout may occur in persons in any profession (McCann & Pearlman, 1990). VT and burnout also differ in that burnout is related to a feeling of being overloaded secondary to client problems of chronicity and complexity, whereas VT reactions are related to specific client traumatic experiences. Thus, it is not the difficult population with which the counselor works, but rather the traumatic history of a traumatized population that contributes to VT. Burnout also progresses gradually as a result of emotional exhaustion, whereas VT often has a sudden and abrupt onset of symptoms that may not be detectable at an earlier stage. Finally, on a personal level, burnout does not lead to the changes in trust, feelings of control, issues of intimacy, esteem needs, safety concerns, and intrusive imagery that are foundational to VT (Rosenbloom, Pratt, & Pearlman, 1995). It is important to note that many counselors working with traumatized populations experience general burnout as well as VT.

Despite these contrasts, VT and burnout share similar characteristics. Both VT and burnout may result in physical symptoms, emotional symptoms, behavioral symptoms, work-related issues, and interpersonal problems. In addition, both VT and burnout are responsible for a decrease in concern and esteem for clients, which often leads to a decline in the quality of client care (Raquepaw & Miller, 1989).

Like the construct of burnout, countertransference is also distinct from VT. Countertransference refers to a counselor's emotional reaction to a client as a result of the counselor's personal life experiences (Figley, 1995). VT, however, is a direct reaction to traumatic client material and is not a reaction to past personal life experiences. The differences between countertransference and VT are not always distinct. Although VT may involve countertransference issues (e.g., the counselor being a trauma survivor), VT is not inherent in, nor does it equate to, countertransference (Figley, 1995). An additional difference between countertransference and VT is that countertransference is specific to the counselors' experiences during or around counseling sessions, whereas VT effects transcend the session, thus affecting all aspects of counselors' lives.

Countertransference and VT, although distinct in conceptualization, are related to one another. As a counselor experiences increasing levels of VT, the related disruptions in cognitive schemas become part of the counselor's unconscious personal material that may then result in countertransference reactions toward the client (Saakvitne & Pearlman, 1996). These differences among VT, countertransference, and burnout indicate that VT is a unique construct that is worthy of consideration apart from the concepts of burnout and countertransference. The management and prevention of burnout reactions and countertransference have been addressed in the literature (James & Gilliland, 2001), yet these issues are rarely addressed with regard to VT. De-

spite VT's apparent importance and uniqueness, there is a paucity of research and literature exploring ways in which counselors working with traumatized clients can prevent VT reactions from developing.

## VT AND CSDT

As previously stated, VT has a unique progression. One theory that can be used to explain this progression is the CSDT (McCann & Pearlman, 1992; Pearlman & Saakvitne, 1995a). The premise of this theory is that individuals construct their realities through the development of cognitive schemas or perceptions, which facilitate their understanding of surrounding life experiences. CSDT supports the notion that changes in these cognitive schemas, or the perceived realities of counselors, occur as a result of interactions among clients' stories and counselors' personal characteristics (Saakvitne & Pearlman, 1996). In this self-development process, counselors are active in creating and structuring their individual perceptions and realities. CSDT "emphasizes the adaptive function of individual behavior and beliefs, and the individual's style of affect management" (Pearlman & Saakvitne, 1995a, p. 56), thus indicating that counselors' VT reactions to client-presented traumas are normal and adaptive.

CSDT further purports that human cognitive adaptation occurs in the context of interpersonal, intrapsychic, familial, cultural, and social frameworks. According to CSDT, counselor VT experiences are normal counselor adaptations to recurrent client-presented traumatic material. Essentially, CSDT proposes that irrational perceptions develop as self-protection against these emotionally traumatic experiences. In addition, CSDT suggests that the effects of these changes in counselors' cognitive schemas are pervasive (i.e., have the potential to affect every area of the counselor's life) and cumulative (i.e., potentially permanent because each traumatized client the counselor encounters reinforces these changes in cognitive schemas; McCann & Pearlman, 1990).

According to CSDT, there are five components of the self and how the self and one's perceptions of reality are developed: (a) frame of reference; (b) self-capacities; (c) ego resources; (d) psychological needs; and (e) cognitive schemas, memory, and perception (Pearlman & Saakvitne, 1995a). These CSDT components reflect the areas in which counselors' distorted beliefs and VT reactions occur. Saakvitne and Pearlman (1996) proposed that the interpersonal components of CSDT (i.e., frame of reference, self-capacities, ego resources, psychological needs, and memory system) are the most vulnerable to symptomatic adaptation (e.g., disruptions in previous belief systems as a result of clients' trauma material) in the emergence of VT in counselors.

In discussing the first component of CSDT, frame of reference, McCann and Pearlman (1990) wrote that "a meaningful frame of reference for experience is a fundamental human need" (p. 141). The frame of reference is generally defined as an individual's framework, or context, for understanding and viewing the self and the world (Pearlman & Saakvitne, 1995b).

The frame of reference encompasses one's identity, worldview, and belief system and is the foundation for viewing and understanding the world and self. It also involves cognitive processing of causality and attribution. Any disruptions in an established frame of reference can create disorientation for the counselor and potential difficulties in the therapeutic relationship. For example, in attempting to understand a client's pain, counselors discussing a traumatic event may conclude that the victim was actually to blame, an outcome that will likely revictimize the client. Such an outcome might be the result of the counselor's frame of reference not accommodating the possibility of a blameless victim.

Self-capacities, the second component of CSDT, are "inner capabilities that allow the individual to maintain a consistent, coherent sense of identity, connection, and positive self-esteem" (Pearlman & Saakvitne, 1995a, p. 64). These self-capacities allow individuals to manage emotions, sustain positive feelings about themselves, and maintain relationships with others. Self-capacities are susceptible to disruptions when a counselor experiences VT and may result in counselors experiencing a loss of identity, interpersonal difficulties, difficulty controlling negative emotions or avoiding exposure to media that conveys the suffering of others, or feelings of being unable to meet the needs of significant others in their lives. The inability to tolerate negative emotions could have pronounced implications for counselors attempting to serve trauma survivors.

The third component of CSDT, ego resources, allows individuals to meet their psychological needs and relate to others interpersonally (Pearlman & Saakvitne, 1995a). Some of these resources include (a) ability to conceive consequences, (b) ability to set boundaries, and (c) ability to self-protect. Disruptions affecting these ego resources may promote symptoms such as perfectionism and overextension at work. Counselors may also experience an inability to be empathic with clients, a condition that poses a variety of practical and ethical dilemmas, particularly for services to trauma survivors.

The fourth and fifth components of CSDT are psychological needs and cognitive schemas. These include safety needs, trust needs, esteem needs, intimacy needs, and control needs. These needs reflect basic psychological needs of individuals, as well as how individuals process information related to these needs in developing their cognitive schemas about themselves and others (Pearlman & Saakvitne, 1995a). As discussed in this article, these psychological needs can be very helpful in understanding VT and how to prevent VT in counselors. A discussion of each of these aspects and their relationship to VT is reflected in the following sections.

### **Safety Needs**

A sense of security is basic to safety needs. Counselors experiencing VT may feel there is no safe haven to protect them from real or imagined threats to personal safety. According to Pearlman (1995), higher levels of fearfulness, vulnerability, and concern may be ways in which this disruption in safety needs is manifested. Counselors experiencing

VT may be overly cautious regarding their children or may feel an overwhelming need to take a self-defense course, install a home alarm system, or carry mace or a rape whistle for protection. The following segment of an interview with a counselor experiencing VT, after working with a sexual trauma survivor, illustrates this point with vivid clarity:

I suddenly find myself more critical of the quality of locks in my home and replace them with better ones. The car door is always locked when I am driving. I am more careful with whom I speak in public. I find myself wondering why that guy is walking toward me and clutch my keys ready to strike out if I have to. I question the motives of others much more readily and never assume they mean no harm to me. (Astin, 1997, p. 106)

### **Trust Needs**

According to CSDT, trust needs include self-trust and other trust. Trust needs reflect an individual's ability to trust her or his own perceptions and beliefs, as well as to trust others' ability to meet his or her emotional, psychological, and physical needs; in other words, trust needs refer to a form of attachment or a "healthy dependency" (Pearlman & Saakvitne, 1995a, p. 71). All people, according to CSDT, have a natural need to trust themselves and others.

A counselor's inherent trust needs make him or her vulnerable to VT. In other words, the exposure to repeated client trauma shakes the trusting foundations upon which the counselor's world rests. For example, a counselor may have a caseload of clients who were recently exposed to a terrorist act by a minority group and, hence, may have his or her trusting foundation shaken and may become suspicious of all minority group members. This suspiciousness may even transcend previously trustworthy relationships with minority group members. In addition, counselors experiencing VT are vulnerable to self-doubt and inhibited self-trust, often prompting them to question their ability to judge and intervene effectively with clients. Such trust difficulties frequently promote negative effects in relation to esteem needs.

### **Esteem Needs**

The need for esteem is characterized by value for self and value for others (Pearlman, 1995). Counselors experiencing VT may feel inadequate and question their own abilities to help someone. Esteem for others can be compromised as counselors are faced with the ability of people to be cruel and for the world to be unfair.

### **Intimacy Needs**

Intimacy needs are defined as "the need to feel connected to oneself and others" (Pearlman & Saakvitne, 1995a, p. 62). Pearlman (1995) described consequences of disruptions in this area as feelings of emptiness when alone, difficulty enjoying time alone, an intense need to fill alone time, and avoidance and withdrawal from others. VT may cause a counselor to push away or become increasingly dependent on significant persons in his or her life.

### **Control Needs**

Control needs are related to self-management; when schemas are disrupted regarding sense of control, the resulting beliefs and behaviors may be helplessness and/or overcontrol in other areas. "These beliefs lead to distress as we [counselors] question our ability to take charge of our lives, to direct our future, to express our feelings, to act freely in the world" (Pearlman & Saakvitne, 1995a, p. 292).

The memory system of each individual is basic to his or her perception of life. Pearlman and Saakvitne (1995a) identified five aspects of the memory system: (a) verbal memory (cognitive narrative), (b) imagery (pictures stored in the mind), (c) affect (emotions experienced), (d) bodily memory (physical sensations), and (e) interpersonal memory (resulting dynamics in current interpersonal relationships). With traumatic experiences, each aspect of memory can represent a fragment of a traumatic event. Without therapeutic integration of these aspects, the fragments interfere with one's awareness and perception. Therefore, through empathic engagement with the client, the counselor is vulnerable to experiencing VT and intrusion from clients' descriptions of memories.

These recollections can remain with the counselor long after the therapy session has ended, even to the point of introducing thoughts and images that involve the counselor having nightmares of being raped. Astin (1997) wrote that she would imagine a rapist coming toward her—much as the rapist had approached the victimized client. The author suggested that intrusive images are associated with normal perceptual processing for traumatic events but, due to the painful emotions involved, resist assimilation into memory as simple events to become actual mental representations. To combat these intrusive thoughts and images, the counselor may turn to numbing, avoidance, and denial. However, avoidance and numbing provide only temporary relief. Astin further suggested that these intrusive images need to be examined, rather than suppressed or overshadowed, to make them less painful and intrusive for the counselor.

### **PROFESSIONAL AND PERSONAL CONSEQUENCES OF VT**

Constructivist self-development theory and recent research suggest that the experience of VT is significant for counselors on both a personal and professional level. A concern for the personal functioning of trauma counselors is the increased awareness of the reality and occurrence of traumatic events. This reality makes counselors more aware of their vulnerability. Safety and security are threatened when counselors become cognizant of the frequency of trauma, often resulting in a loss of feeling in control as a result of hearing clients' stories in which the control was taken from them. In addition, the helplessness of a counselor to change past trauma can challenge, or even shatter, the counselor's identity (Pearlman & Saakvitne, 1995b).

VT can also affect how counselors relate to their friends and family. Counselors affected by VT may be less emotionally accessible due to a decrease in access to emotions (Saakvitne &

Pearlman, 1996). Intimacy with partners may become difficult as guilt and intrusive thoughts related to a client's abuse become present when engaging in intimacy. Counselors may also experience overwhelming grief, which may create a sense of alienation from others (Herman, 1992). Herman reported that counselors who worked with survivors of the Nazi Holocaust reported feeling "engulfed in anguish" or "sinking into despair" (p. 144). Finally, the counselor may experience changes in esteem for self and others (Saakvitne & Pearlman, 1996).

The impact of VT on counselors, if unacknowledged, can present ethical concerns (Saakvitne & Pearlman, 1996). The potential for clinical error and therapeutic impasse increases as the vulnerability that counselors experience increases. The disruptions in cognitive schemas may lead to counselors compromising therapeutic boundaries (e.g., forgotten appointments, unreturned phone calls, inappropriate contact, abandonment, and sexual or emotional abuse of clients). Counselors may feel anger toward their clients when they have not complied with some idealized response to therapy (Herman, 1992). Counselors may begin doubting their skill and knowledge and potentially lose focus on clients' strengths and resources (Herman, 1992). In addition, counselors may avoid discussion of traumatic material or be intrusive when exploring traumatic memories by probing for specific details of the client's abuse or pushing to identify or confront perpetrators before the client is ready (Munroe, 1995).

Other hazards the client may be subjected to when the counselor is experiencing VT include irritability of the counselor, decreased ability to attend to external stimuli, misdiagnosis, and "rescuing" by the counselor (Munroe, 1995). In addition, the client may attempt to protect the counselor, which may create an ethical bind based on exploitation of the client. Any of these effects can be damaging to the client. Therefore, addressing the occurrence of VT is imperative for counselors.

### **IMPLICATIONS FOR COUNSELORS: PREVENTING VT**

CSDT as applied to VT has numerous implications for counselors who work with traumatized clients and are thus at risk for VT. Being aware of the risk of VT and applying the CSDT model to one's experiences may prevent VT. More specifically, counselors can apply the CSDT model to their own experiences, thus preventing negative professional and personal consequences and encouraging self-care. The following sections describe ways that counselors can engage in the prevention of VT through self-care.

#### **Caseload**

Counselors who work primarily with trauma survivors experience a greater measure of VT than counselors with a general caseload who may see only a few trauma survivors (Brady, Guy, Poelstra, & Brokaw, 1997; Chrestman, 1995; Cunningham, 1999; Kassin-Adams, 1995; Pearlman & Mac Ian, 1993; Schauben & Frazier, 1995). Trippany, Wilcoxon, and Satcher (2003) found that sexual trauma counselors who reported

an average of 14 to 15 clients per week did not have statistically significant experiences of VT. This finding suggests that the management of counselors' caseloads through limiting the number of trauma clients per week may minimize the potential vicarious effects of working with traumatized clients. This implication is consistent with the research of Hellman, Morrison, and Abramowitz (1987), who reported that counselors indicated less work-related stress with a moderate number of clients on a weekly caseload than with a higher number of regularly scheduled clients.

### **Peer Supervision**

Peer supervision groups serve as important resources for trauma counselors (Catherall, 1995). Sharing experiences of VT with other trauma counselors offers social support and normalization of VT experiences. This normalization lessens the impact of VT, which in turn amends cognitive distortions and helps counselors maintain objectivity. Other benefits include reconnecting with others and sharing potential coping resources (Catherall, 1995). Pearlman and Mac Ian (1993) found that 85% of trauma counselors reported discussion with colleagues as their most common method of dealing with VT. Peer supervision methods are helpful in providing trauma counselors with validation and support, in providing them with the opportunity to share new information related to therapeutic work, and in allowing them to vent their feelings (Oliveri & Waterman, 1993). Talking to colleagues about their experience in responding to trauma offers trauma workers support in dealing with aftereffects (Dyregrov & Mitchell, 1996). Peer supervision has also been found to decrease feelings of isolation and increase counselor objectivity, empathy, and compassion (Lyon, 1993).

Peer supervision offers several benefits to trauma counselors. First, consultation with colleagues provides an opportunity for counselors to examine their perspective, thus aiding in decreasing cognitive disruptions. Peer supervision also gives counselors an opportunity to debrief and express reactions regarding client stories (Catherall, 1995). Whereas limits of confidentiality prevent counselors from being able to debrief with support systems, peer supervision serves as a medium for counselors to debrief in an ethical manner. Furthermore, supervision helps alleviate issues of countertransference and traumatic reactions (Rosenbloom et al., 1995). "It is important for caregivers to have a variety of peer support resources to allow easy access to share with others the burden of bearing witness to traumatic events" (Yassen, 1995, p. 194). Discussion of therapeutic successes in formal peer supervision helps to reaffirm a counselor's confidence in his or her clinical skills (Pearlman & Saakvitne, 1995b).

### **Agency Responsibility**

Agencies that employ counselors who provide services to clients with traumatic histories have a responsibility to help their clinicians decrease the effects or occurrence of VT (Pearlman & Saakvitne, 1995b). Formal measures of informed

consent regarding risks of providing trauma counseling services can be used as a standard employment procedure when considering new counselors. In addition, professional development resources should be available for trauma counselors, including (a) opportunities for supervision, (b) consultation, (c) staffing, and (d) continuing education. Pearlman and Saakvitne (1995b) further suggested that provision of employee benefits could decrease the impact of VT, including (a) insurance for personal counseling, (b) paid vacations, and (c) limiting the number of trauma survivors on the counselor's caseload. In addition, Chrestman (1995) found empirical evidence suggesting that increased income correlated positively with a decrease in symptoms of psychological distress. Thus, pay raises may help trauma counselors acknowledge success as a counselor.

### **Education and Training**

Training focused on "traumatology" is vital for trauma counselors and can decrease the impact of VT (Pearlman & Saakvitne, 1995b). In a study by Follette, Polusny, and Milbeck (1994), 96% of mental health professionals reported that education regarding sexual abuse was imperative to effective coping with difficult client cases. Chrestman (1995) also found empirical evidence that supported use of additional training to decrease the symptomatology of posttraumatic stress disorder in counselors working with trauma clients. Furthermore, Alpert and Paulson (1990) suggested that graduate programs for mental health professionals need to incorporate training regarding the impact of clients' childhood trauma and its effects on VT.

### **Personal Coping Mechanisms**

The impact of VT can be decreased when counselors maintain a balance of work, play, and rest (Pearlman, 1995). This balance includes socializing with friends and family, being involved in creative activities, and being physically active. Participation in the aforementioned activities may aid in preserving a sense of personal identity. Because of their restorative nature, rest and leisure activities (e.g., taking vacations) are important in decreasing the effects of VT (Pearlman, 1995). Moreover, VT may affect counselors' ability to trust others; therefore, a strong social support network can help to prevent VT and may also help soothe VT reactions. In addition, participation in activities that increase counselors' personal tolerance level, including journaling, personal counseling, meditation, and obtaining emotional support from significant others, allows reconnection to emotions.

### **Spirituality**

The damage of vicarious traumatization is often related to the counselor's sense of spirituality (Pearlman & Saakvitne, 1995a). The VT experience results in a loss of a sense of meaning and often fractures cognitive schemas and counselors' worldview. Without a sense of meaning, counselors may become cynical, nihilistic, withdrawn, emotionally numb,

hopeless, and outraged (Herman, 1992; Pearlman & Saakvitne, 1995a). "The defenses employed to protect oneself from knowledge of people's capacity for cruelty . . . have their own costs" (Pearlman & Saakvitne, 1995a, p. 288). These defenses, produced from changes in cognitive schemas regarding one's view of the world (i.e., the world is good; people are good), create a reorganization in the counselor's spirituality. As a result, the counselor may experience sorrow, confusion, and despair.

Research indicates that counselors with a "larger sense of meaning and connection" (Pearlman & Saakvitne, 1995b, p. 161) are less likely to experience VT. In a survey of trauma counselors, 44% reported that spirituality provided an effective coping mechanism in dealing with the effects of their work (Pearlman & Mac Ian, 1993). Finding meaning can help trauma counselors alleviate the impact of VT. Astin (1997) reported that working with rape victims has made her more aware of the potential for harm, thus making her more prudent. She wrote, "My rape clients have given me a gift without knowing it . . . I don't live in a fantasy world and I take active steps to reduce risk and vulnerability" (Astin, 1997, p. 107). In addition, Wittine (1995) suggested that counselors with a strong sense of spirituality are more likely to accept existential realities and their inability to change the occurrence of these realities. Wittine further suggested that counselors' acceptance of these existential realities allows them to be more present with their clients.

More specifically, counselors who are at risk for developing VT can use whatever source brings them a sense of spirituality. Organized religions, meditation, and volunteer work are just a few examples of activities that may facilitate a sense of spirituality. Ultimately, it is up to the individual counselor to determine how he or she will choose to develop his or her sense of spirituality.

## CONCLUSION

Vicarious traumatization is a significant concern for counselors providing services to traumatized clients. Counselors' cognizance of potential changes in their beliefs about self, others, and the world may have a preventative function regarding VT. This awareness can aid counselors in protecting themselves against the consequential effects of helping those with traumatic histories. An awareness of personal reactions to VT may allow counselors to implement self-care strategies to ameliorate such effects, thus minimizing potential ethical and interpersonal difficulties.

In addition, it is important that supervisors and administrators overseeing counselors working with trauma survivors consider the impact that VT may have on counselors and take an active preventative role. Supervisors have a responsibility to use their knowledge about VT to prevent counselor VT and to facilitate counselor mental health through providing a supportive and VT-preventative environment. Encouraging peer support groups, educating counselors on the impact of client traumas on counselors, diversifying counselor caseloads, encouraging counselor respite and relaxation, and encouraging counselors' sense of spirituality and wellness

are several means of providing support for at-risk counselors. Professional counselors have many strengths and resources that are used to help traumatized clients—applying these resources to themselves, as a means of preventing VT, will surely facilitate their own wellness.

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