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Mental Health and Law Enforcement Professionals: Trauma History, Psychological Symptoms, and Impact of Providing Services to Child Sexual Abuse Survivors

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A survey of 558 mental health and law enforcement professionals assessed current and past trauma experiences, exposure to traumatic client material, and the sequelae of both of those types of personal and professional trauma experiences. Results indicated that 29.8% of therapists and 19.6% of officers reported experiencing some form of childhood trauma. The two groups differed in their reports of psychological symptoms, trauma specific symptoms, and work-related post-traumatic stress disorder symptoms. There was some evidence that professionals with a history of child abuse reported significantly higher levels of symptoms that have been associated with trauma survivors in past research. However, more proximal variables seem to have greater relevance to current functioning. The implications for training and prevention of secondary traumatization are discussed.

Child sexual abuse is a serious social problem that affects nearly one third of all women and one sixth of all men in this country (Finkelhor, Hotaling, Lewis, & Smith, 1990). With increased awareness of the widespread nature of child sexual abuse, both mental health and law enforcement workers have demonstrated growing concern about several professional issues related to the provision of services to child sexual abuse survivors. Survey research on professional issues related to sexual abuse has investigated the routine inquiry and reporting practices of mental health practitioners (Finlayson & Koocher, 1991; Kalichman & Craig, 1991; Kalichman, Craig, & Follingstad, 1989, 1990; Pruitt & Kappius, 1992) as well as the attitudes and knowledge of mental health and law enforcement professionals regarding sexual abuse (Attias & Goodwin, 1985; Hibbard & Zollinger, 1990; Kovera, Borgida, Gresham, Swim, & Gray, 1993; Saunders, 1987, 1988; Trute, Adkins, & MacDonald, 1992). Similarly, the law enforcement literature has begun to address the importance of training officers to conduct sexual assault investigative interviews that are both comprehensive and victim sensitive (Mills, 1989; Olsen & Wells, 1991).

The trauma histories of mental health workers is one important area that has recently been addressed in the professional psychology literature. Pope and Feldman-Summers (1992) found that 33.1% of mental health professionals reported a history of sexual or physical abuse during childhood or adolescence, and 36.6% of participants reported experiencing some form of abuse during adulthood. Briere (1992) has hypothesized that professionals' own child abuse issues, including abuse-related countertransference, may adversely affect the competency of some therapists to provide services to abuse survivors. In addition, Figley (1993) warned that mental health professionals with personal histories involving traumatic experiences are at increased risk for the development of trauma symptoms as a result of their work with trauma survivors. However, this hypothesis is inconsistent with data recently reported by Elliott and Guy (1993) in a study of the current psychological functioning and prevalence of trauma history among professionals. Those researchers found no differences in levels of psychological distress between abused and nonabused mental health professionals. They also reported significantly higher frequencies of personal trauma in the histories of female mental health professionals compared with other professional women.

In addition to concern about the impact of professionals' own trauma history, there has also been increased speculation that professionals providing services to trauma survivors may be at risk for experiencing traumatic symptoms as a result of their exposure to traumatic material (e.g. Bloom, 1993; Munroe & Shay, 1993; Pearlman & Mac Ian, 1993). The term *secondary victimization* was originally used by Figley (1983) to describe the psychological impact on persons who come into close contact with survivors. Secondary trauma effects have been observed among family members of Holocaust survivors (Davidson, 1980) and among spouses and children of combat veterans (Rosenheck & Nathan, 1985; Solomon et al., 1992). Likewise,

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McCann and Pearlman (1990) have described the stress reactions experienced by therapists and researchers who are exposed to disclosures of traumatic images and material by clients and research participants as *vicarious traumatization.*

Previous conceptualizations of the impact of trauma work on professionals have included countertransference, "burnout" in therapists, and work-related posttraumatic stress disorder (PTSD) in law enforcement officers (Andersen, Christensen, & Petersen, 1991; McCaffery, Domingo, & McCaffery, 1989; McCann & Pearlman, 1990; McElroy & McElroy, 1991). In a discussion of the challenges of providing clinical services to sexual abuse survivors, McElroy and McElroy (1991) observed that negative countertransference feelings, such as experiencing a sense of inadequacy, frustration, and helplessness, may lead to ineffective treatment and distress in therapists. McCann and Pearlman (1990) have suggested that vicarious traumatization among professionals working with victims results from the inability for professionals to process traumatic clinical material. Moreover, those authors stated that "the potential effects of working with trauma survivors are distinct from those of working with other difficult populations because the therapist is exposed to the emotionally shocking images of horror and suffering that are characteristic of serious traumas" (McCann & Pearlman, 1990, p. 134).

The phenomenon of work-related PTSD or burnout in law enforcement officers offers a parallel to vicarious traumatization in mental health professionals. Law enforcement officers involved in stressful crime assignments such as homicide and narcotics (McCaffery et al., 1989) and disaster-related rescue work (Andersen et al., 1991; Thompson & Solomon, 1991) are at increased risk for developing PTSD symptoms.

Although there has been a great deal of clinical attention focused on the phenomenon of secondary or vicarious traumatization, there has been a dearth of empirical research investigating the impact of trauma history and exposure to traumatic clinical material on professionals working with victims. To our knowledge, there have been only two published empirical reports documenting the effects on professionals of providing services to sexual abuse victims. Oliveri and Waterman (1993) retrospectively surveyed 21 clinicians involved in treating children sexually abused in two preschool settings. Therapists reported that they had experienced distress and PTSD symptoms secondary to their treatment of abused children 5 years earlier. In a study surveying the impact of working with sexual assault victims on police officers, Martin, McKean, and Veltkamp (1986) found that PTSD symptoms were significantly more prevalent among police officers dealing with rape victims and that the investigation of child abuse cases showed a trend toward a significant association with PTSD symptoms.

These two studies provide some preliminary evidence for the effects of exposure to trauma on professionals. However, their findings were limited by several methodological issues. First, both studies had small sample sizes and failed to include a comparison group of other professionals working with sexual abuse cases. Second, the impact of professionals' own personal trauma experiences were not addressed as a factor in professionals' reported trauma symptoms or their responses to trauma. Moreover, clinicians surveyed by Oliveri and Waterman (1993) were involved in highly publicized, stressful court cases, yet the impact of legal stress on therapists was not partialed out from other aspects of the trauma. Finally, trauma symptoms were not measured using well-validated assessment instruments.

It is clear from preliminary studies and clinical reports by professionals working in this area that a great deal more empirical research is needed. The purpose of this study was threefold. First, it provides an empirical investigation of the phenomenon of secondary traumatization and explores the impact on professionals of providing services to sexual abuse victims. Second, this study addresses two important questions raised by Pope and Feldman-Summers (1992): (a) To what extent does a personal trauma history influence professionals' specialization in providing services to abuse victims, and (b) to what extent does a personal trauma history affect how professionals respond professionally to sexually abused clients. Third, this study provides replication data on several issues recently addressed in the sexual abuse literature, including the prevalence of trauma in the histories of mental health professionals (Elliott & Guy, 1993; Pope & Feldman-Summers, 1992), the psychological adjustment of professionals (Elliott & Guy, 1993), and therapists' clinical practices related to sexual victimization inquiry (Pruitt & Kappius, 1992).

Method

Participants

A total of 558 mental health and law enforcement professionals were surveyed from a western state. Mental health participants were 164 licensed psychologists and 307 marriage and family therapists (MFT) recorded by the state licensing organizations. Law enforcement participants were 87 trained investigative police officers.

Of the 471 mental health professionals, 164 completed surveys were returned following the initial mailing, and 61 additional completed surveys were returned following a second mailing to nonresponders, yielding a sample of 225 mental health professionals. Twenty-one surveys were returned incomplete by subjects who reported that they were no longer working in the mental health field, and 20 surveys were returned by the postal service. After these surveys were subtracted from the total sample, the final response rate for mental health professionals was 52% (225 out of 430). The final response rate for law enforcement professionals (46 out of 87) was slightly over one half (53%). The rates of response by professionals in this study were consistent with previous survey research involving sexual abuse (e.g., Attias & Goodwin, 1985; Finlayson & Koocher, 1991; Pope & Feldman-Summers, 1992).

Measures

Therapist Response Questionnaire (TRQ). The TRQ is a 110-item self-report inventory, modified from the Therapist Reaction Questionnaire (Kelly, 1993), which was used to survey clinicians in the Oliveri and Waterman (1993) study. The TRQ assessed respondents' professional background and caseload, clinical activities related to sexual abuse cases, perceived effects of clinical work with sexual abuse survivors on psychological functioning, use of coping strategies to deal with such effects, and personal trauma history. Items identified the percentage of professionals' total current caseload reporting a history of child sexual abuse, practices in assessing clients' sexual abuse history, and perceptions of the importance of addressing sexual abuse in therapy. The effects of clinical work on mental health professionals' general psychological functioning and PTSD symptoms were assessed using a series

of 7-point Likert scales. General psychological functioning included items assessing areas such as disturbances in sleep, appetite, attention, mood, unusual fears, and problems with relationships and work. PTSD symptoms were assessed using items based on the diagnostic criteria for that disorder in the revised third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III-R; American Psychiatric Association, 1987).

Negative clinical responses to sexually abused clients were defined as the total number of the following self-reported behaviors: inattentiveness or dissociating during sessions, lack of empathy, and feelings of guilt related to one's limitations as a professional. In contrast to specific behaviors related to direct client contact, coping responses that occurred outside of sessions were also assessed. Twenty-eight potential coping strategies in the areas of professional assistance, assistance from others, assistance from inner sources, and social action were evaluated. Positive coping included a number of strategies such as supervision, use of therapy, education, and consultation. Negative coping was defined as the total number of the following coping strategies self-reported by professionals: using drugs or alcohol, attempting to forget about clients' disclosures of traumatic material, acting out aggression against significant others, and withdrawing from others. Finally, professionals' perceived level of personal stress over the previous 6 months, personal therapy experiences, and history of childhood and adult trauma were assessed.

Law Enforcement Response Questionnaire (LERQ). The LERQ, a modified version of the TRQ, is a 105-item self-report inventory designed with the assistance of a group of law enforcement professionals to assess the unique investigative experiences of police officers. The following variables were assessed by the LERQ: demographic information, professional work history, investigative caseload, the effects of investigating sexual assault cases on psychological functioning and PTSD symptoms, the use of coping strategies, and personal therapy and trauma history.

Trauma Symptom Checklist-40 (TSC-40). The TSC-40 (Briere & Runtz, 1989) is a brief, self-report instrument that assesses the extent and nature of trauma specific symptoms. It contains six subscales: Anxiety, Depression, Dissociation, Sexual Abuse Trauma Index, Sexual Problems, and Sleep Disturbance. Composite TSC-40 scores yield an alpha of .90, indicating reasonable overall reliability, and the mean internal consistency for the subscales is .69 (Elliott & Briere, 1992). The TSC-40 has been shown to discriminate abused from nonabused individuals within both clinical and nonclinical samples (Bagley, 1991; Briere & Runtz, 1989; Elliott & Briere, 1992), and has also been demonstrated to assess the cumulative effects of trauma in both clinical and nonclinical samples (Polusny, Pistorello, Bechtle, & Follette, 1992).

Survey Procedures

All licensed psychologists and marriage and family therapists in a western state were mailed a cover letter requesting their participation in the study, TRQ and TSC-40 survey materials, and a stamped addressed return envelope. To conduct a second mailing to nonresponders, return envelopes were coded and immediately separated from survey materials upon receipt by the investigators. Several weeks after the initial mailing, all nonresponders were mailed a second letter encouraging their participation and a second set of survey materials. *t* tests between professionals responding to the first and second mailing did not reveal differences on several relevant variables, including personal trauma history, the percentage of therapists' current caseload reporting a sexual abuse history, and total TSC-40 scores. Therefore, surveys from the two mailings were pooled for analyses. Similar procedures were used for the law enforcement sample. Survey materials, including a cover letter, LERQ, TSC-40, and stamped return envelope were mailed to law enforcement professionals. All responses were anonymous and confidential.

Results

Demographic and Professional Data

Mental health professionals. Fifty-three percent of mental health professionals were female, and the mean age of respondents was 47.96 years (SD = 8.11). Approximately half of mental health professionals reported possessing their doctorate (n = 107) and half reported possessing a master's degree (n = 108) as the highest degree earned. Doctoral-level licensed psychologists reported significantly more years of clinical experience than MFTs, $t(211) = 5.77$ ($p < .001$).

The average number of clients seen per week by mental health professionals was 23.25 (SD = 12.55) with a range of 0 to 68 clients. Consistent with findings in the literature, mental health professionals reported that 42% of clients in their current caseload reported having a history of child sexual abuse. Of these sexually abused clients, the majority were adult (81%) and female (86%). In this sample, 81.9% of therapists reported that they routinely inquire about a history of abuse, and the majority of mental health professionals (81.1%) reported that they believed more clients were reporting sexual abuse histories in recent years. In addition, 96.9% of therapists agreed that it was very important to address sexual abuse issues in therapy.

Law enforcement professionals. The majority of law enforcement respondents were male (89%) with a mean age of 40 years (SD = 6.81). All but 15 law enforcement officers reported earning a college degree. Degrees were master's (n = 2), bachelor's (n = 15), and associate's degrees (n = 12). On average, respondents reported 15.5 years (SD = 6.62) of law enforcement experience and 5.2 years (SD = 4.19) of experience investigating child sexual abuse cases.

Law enforcement professionals reported being involved in an average of 13.86 (SD = 12.86) investigative cases per week. The majority of current investigative caseloads involved child sexual assault cases (38%). Other types of cases included child physical abuse (16%), property crimes (16%), crimes against persons (15%), adult sexual assault (13%), and homicide (4%). Table 1 presents the percentages of male and female law enforcement officers who reported experiencing work-related stress.

Personal Trauma History

The frequencies of various types of trauma experiences partitioned by profession and gender are reported in Table 2. Overall, 29.8% of mental health professionals and 19.6% of law en-

Table 1
Percentage of Male and Female Law Enforcement Participants Reporting Work-Related Stress

Type of stress	Men	Women
Involvement in shooting	46.3	20.0
Physical confrontation	85.4	100.0
Officer complaints	65.9	20.0
Trouble with peers/supervisor	56.1	40.0
On the job injury	48.8	60.0
Emotional/psychological abuse	29.3	40.0

Table 2
Percentage of Male and Female Participants Reporting Trauma Histories

	Mental health professionals		Law enforcement professionals	
Type of trauma	Men	Women	Men	Women
Childhood trauma	23.1	36.1	17.1	40.0
Child sexual abuse	10.6	19.3	7.3	20.0
Child physical abuse	18.3	24.4	12.2	20.0
Emotional/psychological abuse	39.4	51.3	9.8	60.0
Adult sexual assault	0.0	7.6	0.0	20.0
Violence or abuse by spouse or partner	4.8	16.0	12.2	20.0
Military combat service	14.4	0.0	22.0	0.0
Natural disaster	3.8	6.7	26.8	0.0
Robbery/mugging	12.5	12.6	7.3	0.0
Accidental disasters	19.2	8.4	22.0	0.0
Other traumatic experience	22.1	15.1	19.5	40.0

forcement officers reported experiencing some form of physical or sexual abuse as children. Professionals who report such a history will be referred to as having a child abuse history (CAH), and professionals not reporting a history of physical or sexual abuse during childhood will be referred to as NCAH.

Psychological Symptoms

Table 3 illustrates the TSC-40 composite scores, TSC-40 subscale scores, general psychological distress scores, PTSD scores, and levels of personal stress for mental health and law enforcement professionals. Mental health professionals generally reported low levels of traumatic symptoms and psychological distress and moderate levels of personal stress. Law enforcement professionals reported significantly higher levels of trauma symptoms, as measured by the TSC-40, $t(269) = 6.89$ ($p < .001$), general psychological distress, $t(269) = 3.76$ ($p < .001$), and PTSD symptoms, $t(266) = 7.65$ ($p < .001$), than did mental health professionals. With approximately 70% of all professionals reporting high levels of stress, mental health and law enforcement professionals did not differ in their perceived level of personal stress over the previous 6 months.

Impact of Childhood Trauma History

The impact of personal trauma history on professionals' current psychological symptoms was also investigated. Both mental health and law enforcement professionals reporting a history of physical or sexual abuse during childhood had significantly higher levels of trauma-specific symptoms than did profession-

Table 3
Psychological Symptoms and Stress Amongst Mental Health and Law Enforcement Professionals

	Mental health professionals (n = 225)		Law enforcement professionals (n = 46)		
Psychological symptoms	*M*	*SD*	*M*	*SD*	*t*
TSC-40 total score	13.84	11.14	28.24	18.83	6.98*
Anxiety	2.56	2.53	5.50	4.14	6.34*
Depression	4.02	3.29	6.28	5.04	3.83*
Dissociation	1.42	1.74	3.54	2.80	6.70*
Sexual Abuse Trauma Index	1.31	1.85	3.70	2.99	7.08*
Sexual Problems	2.35	3.23	4.59	4.14	4.07*
Sleep Disturbance	3.82	3.25	7.76	5.60	6.50*
Psychological distress[a]	25.76	14.39	34.26	11.67	3.76*
PTSD total score[b]	26.42	12.61	43.37	16.51	7.65*
Personal stress[c]	4.83	1.59	5.15	1.59	1.25

Note. TSC-40 = Trauma Symptom Checklist-40; PTSD = posttraumatic stress disorder.
[a] Score based on the sum of 11 items each ranging from *never* (1; e.g., never experience unusual fears) to *often* (7). [b] Score based on the sum of 16 items each ranging from *never* (1) to *often* (7). [c] Ratings ranged from *very little stress* (1) to *extreme stress* (7).
* $p < .0001$.

als not reporting these forms of childhood trauma, $t(117) = 2.42$ ($p < .05$); $t(44) = 2.71$ ($p < .05$), respectively.

To investigate whether a history of child abuse was associated with professionals' clinical or investigative behavior related to sexual abuse cases, we compared CAH and NCAH professionals on several clinically relevant variables.

Mental health professionals. Mental health professionals who reported a history of childhood physical or sexual abuse were not significantly different from NCAH mental health professionals on the following variables: the percentage of their current caseload reporting an abuse history, the percentage of their clients actively working on sexual abuse issues, and the number of negative responses to child sexual abuse survivors. Moreover, CAH therapists reported using significantly more positive coping behaviors to deal with sexual abuse cases, $t(182) = 3.25$ ($p < .001$).

Law enforcement professionals. Law enforcement officers reporting a history of childhood abuse reported significantly higher proportions of their caseloads involving child sexual abuse investigation, $t(36) = 2.02$ ($p < .05$), greater use of negative coping strategies, $t(38) = 2.86$ ($p < .01$), as well as the use of more positive coping strategies, $t(30) = 2.14$ ($p < .05$), than nonabused law enforcement professionals. However, we found no significant differences in the number of negative responses to investigating sexual abuse cases reported by abused and nonabused officers.

Use of Coping Strategies to Deal With Sexual Abuse Cases

Table 4 shows the frequencies of coping responses used by mental health and law enforcement professionals. Education related to sexual abuse, supervision, consultation, and humor were the most frequently endorsed coping responses used by professionals working with sexual abuse cases.

Secondary Traumatization

The phenomenon of secondary (or vicarious) traumatization was investigated by identifying variables that predicted posttraumatic symptoms in both mental health and law enforcement professionals. To identify such predictors, we used stepwise multiple regression. The dependent variable was the TSC-40 total score. The following variables were explored as independent predictor variables: total number of personal trauma experiences, level of personal stress, use of negative coping strategies to deal with sexual abuse cases, work-related stress, negative clinical responses to survivors, and professionals' percentage of caseload reporting child sexual abuse.

Mental health professionals. Significant multiple correlations were obtained for use of negative coping ($R^2 = .188$, adjusted $R^2 = .184$, $p < .0001$), level of personal stress ($R^2 = .255$, adjusted $R^2 = .247$, $p < .0001$), and negative clinical response to sexual abuse cases ($R^2 = .288$, adjusted $R^2 = .277$, $p < .0001$). Professionals' personal trauma history and the percentage of their caseload reporting a sexual abuse history was not significantly predictive of trauma symptoms.

Law enforcement professionals. Significant multiple correlations were obtained for negative response to investigating sexual abuse cases ($R^2 = .476$, adjusted $R^2 = .458$, $p < .0001$), level of personal stress ($R^2 = .592$, adjusted $R^2 = .562$, $p < .0001$), and personal trauma history ($R^2 = .656$, adjusted $R^2 = .616$, $p < .0001$). The proportion of law enforcement professionals' investigative work involving sexual abuse, use of negative coping strategies, and work-related stress were not predictive of traumatic symptoms.

Discussion

The results of this study provide new evidence on the impact of providing services to sexual abuse survivors and supports existing research on the prevalence of personal trauma histories and psychological functioning of mental health professionals. Additionally, this study expands the existing literature on service providers in that it also examines law enforcement professionals working with sexual abuse victims.

The prevalence of child sexual abuse and its impact on general psychological well-being has been acknowledged by both mental health workers and the general public in recent years. In this study, the majority of therapists reported that they routinely inquire about a history of sexual abuse during the course of therapy, which is consistent with findings reported by Pruitt and Kappius (1992). Moreover, nearly all of the mental health professionals (96.9%) surveyed indicated that it is important to address abuse issues in treatment.

Professionals have become increasingly aware of the importance of addressing their own trauma histories to enhance both personal well-being and professional efficacy. A substantial amount of childhood physical and sexual abuse was reported by both mental health and law enforcement professionals. Over 36% of female therapists and 23% of male therapists reported some form of childhood trauma, and 40% of female officers and 17% of male officers reported such a history during childhood. These results are consistent with findings reported by Pope and Feldman-Summers (1992), which estimated that one third of all mental health professionals had experienced childhood abuse. However, these percentages are not remarkably different from what one would expect to find in the general population. Consistent with Elliott and Guy's (1993) research findings, our study did not suggest that individuals with a history of child abuse are particularly likely to enter the helping professions.

Mental health professionals reported relatively low levels of general psychological distress, trauma symptoms, and PTSD symptoms despite reporting moderate levels of personal stress. Law enforcement professionals, however, were significantly more distressed than mental health professionals on all measures of psychological symptoms. One possible explanation for our finding is that a large proportion of mental health professionals (59.1%) reported participating in some personal therapy. Law enforcement professionals, on the other hand, reported less use of personal therapy (15.6%). Given the high levels of stress reported by respondents and the difficult professional demands of the populations sampled, it is important that adequate preventive measures be identified. Peer support networks, employee assistance programs, and personal therapy represent some possible vehicles for reducing the negative impact of work-related stressors.

Contrary to suggestions made by some writers in the popular

Table 4
Percentage of Mental Health and Law Enforcement Professionals Reporting Use of Coping Strategies

Type of coping strategy	Mental health professionals	Law enforcement professionals
Professional assistance		
Individual supervision	58.0	18.2
Consultation with colleague	95.9	72.7
Individual psychotherapy	32.2	6.8
Couples/family therapy	10.8	2.3
Physician	18.4	18.6
Attorney	25.6	22.7
Clergy	15.7	13.6
Police	24.4	15.9
Assistance from others		
Spouse/partner	65.4	61.9
Family/other relatives	14.2	7.0
Friends	42.7	32.6
Support groups	13.7	7.0
Assistance from inner sources		
Thinking about other things	45.1	65.1
Attempting to forget	18.6	42.2
Withdrawing from others	24.2	42.9
Meditation/yoga	44.4	4.7
Prayer	38.3	34.9
Social action		
Involvement with media	17.8	22.7
Involvement in advocacy	41.6	35.7
Involvement with legislative change	36.7	31.7
Involvement with public education	51.9	54.5
Involvement in education of other professionals	62.0	62.8
Taking an active role in investigating sexual abuse cases	—	86.0
Miscellaneous resources		
Educating self	95.8	93.0
Educating others	73.0	76.7
Using humor	83.2	83.7
Using alcohol	8.0	15.9
Using drugs	1.9	4.7
Using aggression against significant others	4.8	11.4

literature, we found that having a history of childhood trauma was not associated with differences in mental health professionals' clinical activities. First, therapists with an abuse history were no more likely than therapists without that history to specialize in the treatment of sexual abuse survivors. Second, in the treatment of sexual abuse cases, therapists with a history of child abuse did not report significantly higher levels of negative clinical responses, such as dissociating during therapy sessions, than therapists not reporting an abuse history. Similar to results reported by Oliveri and Waterman (1993), professionals reported using a variety of coping behaviors to deal with sexual abuse cases. It is encouraging to note that CAH mental health professionals used a number of positive coping strategies to deal with their responses to sexual abuse cases. Positive coping techniques that seemed particularly helpful, as reported by respondents, were consultation with colleagues, education of self and others about abuse, assistance and support from others, and the use of humor. Moreover, there have been increasingly aggressive efforts within the legal system to involve therapists' own trauma histories in determining professional competency. The findings of the current study do not reflect negatively on the competency of CAH therapists to provide services to sexual abuse survivors.

A history of personal trauma appears to have some influence on the investigative activities of law enforcement officers. Law enforcement officers with a childhood abuse history reported higher proportions of sexual abuse investigation within their caseloads, suggesting an increased likelihood of specializing in abuse investigation. Although these CAH professionals also reported the use of more positive coping strategies, they also reported more negative coping such as using drugs or alcohol, withdrawing from others, and attempting to forget difficult case material. The use of these forms of negative coping provides some evidence for the importance of educating law enforcement professionals about the risks involved in this type of investigative work. That education should also include the presentation of preventative, positive coping strategies. In addition, the use of personal therapy for dealing not only with work stress, but also personal issues, should be destigmatized for professionals in this area.

Another major finding that emerged from this study was the impact of exposure to traumatic clinical material on professionals. This phenomenon has also been referred to by some authors as vicarious or secondary traumatization. Variables that emerged as predictors of trauma symptoms, as measured

by the TSC-40, differed for mental health and law enforcement professionals. An interesting finding for mental health professionals was that the proportion of therapists' current caseload involving sexual abuse and their own personal trauma history were not predictive of trauma symptoms. However, the negative coping responses of the therapist outside of session, as well as in-session responses that are not as likely to be clinically useful, and the level of personal stress that the therapist is currently experiencing were more important in influencing the formation of posttrauma symptoms. For law enforcement officers, personal stress, personal trauma history, and negative responses to investigating sexual abuse cases were predictive of trauma symptoms.

These findings may be analogous to the "good news, bad news" message. The good news is that for mental health professionals, having a personal trauma history does not appear to negatively impact the therapist's response to trauma work. Additionally, we were not able to detect a threshold for doing trauma work, beyond which therapists themselves would exhibit trauma-specific symptoms. The bad news is that the stress that therapists report as part of their personal lives and the ways that they use to cope with stress both in and out of session is related to the trauma symptoms they report. However, even in this bad news we find some good. This study points to the importance of education and training for professionals providing services related to sexual abuse. Approximately 96% of mental health professionals and 93% of law enforcement officers reported that educating themselves about sexual abuse was an important way of coping with difficult sexual abuse cases. As a part of therapists' training experiences, educators must teach more effective ways of managing the rigors of demanding clinical work. This training could be incorporated into formal graduate coursework on the topic of child sexual abuse. As noted by Alpert and Paulson (1990), training that specifically addresses the issue of child sexual abuse is greatly needed in graduate programs. Those authors have outlined ideas that would be useful in such a course.

Although this research provides important empirical documentation on the issue of trauma and its impact on professionals working with abuse survivors, we should mention several limitations of this study. The evaluation of professionals' behavior during interactions with survivors relies solely on professionals' self-report of their in-session behavior. It would be important to know if an outside observer or supervisor would evaluate their behavior similarly. That is, the therapist or interviewer may be blind to the very behaviors that might represent negative reactions to their clients or their clients' trauma material. This emphasizes the importance of addressing these sensitive issues while the therapist is still in a training milieu and in continued consultation with colleagues after training is completed.

Another limit to these findings involves gender discrepancies between professions. Approximately half of therapists were female, whereas the majority of law enforcement officers were male. Although differences between mental health and law enforcement professionals may be influenced by gender differences, the distribution of gender between professions in our study was representative of these two professions.

As with any survey research, the findings of this study may be influenced by response bias. Although the response rates by professionals in this study were consistent with previous survey research, we are unable to make inferences about the nonresponding professionals. However, note that we found no significant differences between responders to a first and second mailing on several relevant variables (i.e., personal trauma history, the percentage of therapists' current caseload reporting a sexual abuse history, and total TSC-40 scores).

In addition, this study surveyed mental health and law enforcement professionals from a western state. Although there is no reason to believe that there would be significant regional differences, some caution should be used in generalizing these findings to professionals from other regions. Finally, since a cross-sectional design was used in this study, no causal inferences can be made from these findings. Although the survey used in this study was not designed to address factors involved in the career decisions of trauma survivors, the interesting question of how people choose various professions deserves further research.

This study resulted from ongoing discussions that occurred in both our research and clinical meetings about the impact of doing intensive trauma work. As McCann and Pearlman (1990) have noted, professionals engaged in trauma work are exposed to imagery that is shocking and horrific. Such input is likely to change dramatically one's views of what is possible in the world. These changes in "worldview" have important implications for the therapist's personal and professional life. On a personal level, many professionals have found that working toward cultural changes that decrease the prevalence of victimization has empowering and healing effects. Moreover, at the professional level it is important to conduct additional research that identifies factors that increase therapists' resiliency to cope with the important work of assisting trauma survivors.

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