

TRAUMA THERAPISTS' QUALITY OF LIFE: THE IMPACT OF INDIVIDUAL AND
WORKPLACE FACTORS ON COMPASSION FATIGUE AND COMPASSION
SATISFACTION

By

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LIST OF TERMS

Burnout	A state of physical, emotional and mental exhaustion caused by long- term involvement in emotionally demanding situations.
Compassion fatigue	The behaviors and emotions resulting from a close, empathic connection with a traumatized or suffering person. Compassion fatigue involves PTSD-like symptoms in the therapist including emotional distress, cognitive shifts, and relational disturbances.
Compassion satisfaction	The pleasure derived from effectively helping others through psychotherapeutic work.
Compassion stress	The emotional energy from the empathic response and the desire to relieve the suffering of the client.
Control	Therapists' control over their work activities and decisions. Control is a factor associated with burnout.
Counseling psychologists	Professional therapists with a license in Psychology who have completed a doctoral degree from a Counseling Psychology program.
Countertransference	The emotional response a therapist has to a client related to personal issues and internal conflicts.
Empathy	A cognitive-affective state that involves both intellectually understanding the perspective of another person and experiencing the emotions of another person.
Empathic response	When the therapist uses empathic understanding to put him or herself into the phenomenological world of the client, experiencing the suffering and other emotions experienced by the client.
Negative clientele	Therapists' experience with aggressive, dangerous, or threatening client behaviors as well as clients with severe psychopathology and/or high lethality. Experience with negative clientele is a factor associated with burnout.
Overinvolvement	Therapists' feelings of being too involved (e.g., over-responsibility, excessive emotional involvement) in the care of their clients. Overinvolvement is a factor associated with burnout and is the opposite of disengagement.

Professional counselors	Professional therapists with a license to practice in Professional Counseling who have completed a master's, specialist, or doctoral degree in a Counseling or Counselor Education program.
Psychologists	Professional therapists with a license to practice in Psychology who have completed a master's or doctoral degree in Counseling or Clinical Psychology.
Social support	Assistance provided by significant others involving emotional support, information, social companionship and instrumental support.
Social workers	Professional therapists with a license to practice Clinical Social Work who have completed at least a master's degree in a Social Work program.
Trauma	When a person experienced or witnessed an event or events that involved actual or threatened death or serious injury or a threat to the physical integrity of self or others and is beyond one's ability to cope with current resources.
Trauma therapist	A therapist who spends a significant amount (at least 25% of caseload and 15-20% of total hours) of their client contact hours working with traumatized clients.
Vicarious traumatization	Changes in the therapist's worldview, psychological needs, belief systems, and cognitions as a result of empathic engagement with the clients' trauma material.
Vicarious posttraumatic growth	Positive psychological changes that individuals may experience as a result of an intimate, empathic relationship with someone who is struggling with highly stressful or traumatic life circumstances. Vicarious posttraumatic growth involves changes in beliefs about self, others, and the world.
Workplace support	One's professional peer group providing various forms of social support (e.g., emotional, instrumental, informational).

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Therapists working with trauma survivors can experience both psychological costs and benefits as a result of this work. The psychological cost of compassion fatigue involves symptoms of traumatic distress, cognitive shifts, and relational disturbances, whereas the psychological benefit of compassion satisfaction consists of pleasure derived from effectively helping clients in distress. In this study, relationships between individual factors (e.g., gender, ethnicity, personal trauma history, years of clinical experience, trauma training) and workplace factors (e.g., perceived control, overinvolvement, negative clientele, workplace support, amount of secondary exposure) were examined to determine their impact on levels of compassion fatigue and compassion satisfaction. Participants, who included 98 trauma therapists, completed an online survey consisting of the Professional Quality of Life Scale, the Psychologist's Burnout Inventory, the Stressful Life Experiences-Short Form and a demographics questionnaire. Multiple regression analyses revealed that control, overinvolvement, and secondary exposure were significantly related to compassion fatigue. Control and personal trauma history were significantly related to compassion satisfaction, accounting for substantial amounts of the variance of each dependent variable (i.e., compassion fatigue and compassion satisfaction).

CHAPTER 1 INTRODUCTION

Sometimes after a session, I will be traumatized...I will feel overwhelmed, and I can remember a particular situation with a sexually abused person where I—I just didn't want to hear any more of her stories about what actually happened. She seemed to want to continue to tell me those over and over and I remember feeling almost contaminated, you know, like I was abused (Bell, 1998; as quoted in Bell, Kulkarni, & Dalton, 2003).

Therapists working with clients coping with traumatic experiences provide an invaluable service to the clients and communities they serve. Working with this population requires the therapist to be extremely present, empathic, and skilled. It is highly emotionally-charged work that can be both draining and rewarding. What are the specific psychological costs of this type of caring? What are the psychological benefits? What factors influence how this type of work affects the professional? How do professional counselors who work with clients who have endured trauma maximize the benefits and minimize the costs?

The potential psychological costs of caring for mental health professionals are often referred to in the literature as compassion fatigue or secondary traumatic stress (Figley, 1995; Monroe et al, 1995), vicarious traumatization (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995), and burnout (Pines, 1993). The potential psychological benefits are labeled in the literature as compassion satisfaction (Stamm, 2002) or vicarious posttraumatic growth (Arnold, Calhoun, Tedeschi, & Cann, 2005). Various factors influence therapists' experience of positive or negative outcomes, including personal or individual factors, self-care strategies, workplace aspects, client characteristics, and social support (Figley, 2002). All of these factors impact the therapeutic relationship and the therapists' experience of positive or negative personal outcomes. Many of these factors are specific to the individual professional. Workplace factors also have a strong impact on therapists' personal psychological response to trauma work. Workplace factors, in contrast to individual factors, often can be altered on a systemic level to

positively affect a large number of professionals. Therefore, studies that consider individual as well as workplace factors are needed.

Of the terms used to describe the psychological costs of caring, the term compassion fatigue, previously referred to as secondary traumatic stress, consists of behaviors and emotions that often follow from helping a significant other who has experienced a traumatic event (Figley, 1993). Given the close connection that therapists have with their clients, they can be especially vulnerable to compassion fatigue. Compassion fatigue usually develops quickly following secondary exposure to trauma and includes re-experiencing of the client's traumatic event as it was recounted to them, avoidance or numbing of emotions, and physiological arousal. In comparison, burnout, which is defined as physical, emotional and mental exhaustion caused by long- term involvement in an emotionally demanding environment, often co-occurs with compassion fatigue (Pines and Aronson, 1988; Trippany, Kress, & Wilcoxon, 2004). Therapists with high levels of both burnout and compassion fatigue are at the greatest risk for negative outcomes, such as depression and PTSD (Stamm, 2005).

Why, more specifically, are mental health professionals working with trauma susceptible to negative consequences such as compassion fatigue and burnout? Much of these negative consequences, especially compassion fatigue, have been attributed to an essential foundation for forming a relationship with clients, empathy. Empathy as a cognitive-affective state leaves the therapist vulnerable to being traumatized by the client's suffering through their close connection (Figley, 1995). Following from this empathic connection, therapists, particularly those with a personal trauma history, may experience traumatic countertransference, which may include overidentification with the traumatized client and/or avoidance reactions (e.g., denial, minimization, disengagement) (Saakvitne, 1995; Wilson & Lindy, 1994). Depending upon how

these countertransference issues are dealt with, positive (e.g., compassion satisfaction) or negative (e.g., compassion fatigue) outcomes may occur.

Considering the consistent documentation of negative outcomes in the literature for therapists working with trauma, why would anyone want to do this work? The psychological benefits, or the energizing psychological rewards, that come from working with clients who are traumatized have been discussed more recently in the literature, represented by several concepts. Terms used in the literature include compassion satisfaction (Stamm, 2002; 2005), posttraumatic growth (Tedeschi & Calhoun, 1996), stress-related growth (Park, Cohen, & Murch, 1996), perceived benefits (McMillen & Fisher, 1998), and thriving (Abraido-Lanza, Guier, & Colon, 1998).

Concepts referring to positive psychological outcomes are linked with theories of both resilience and posttraumatic growth. Resilience, which is the ability to maintain a stable equilibrium in the face of adverse or traumatic experiences, is differentiated from recovery, which is equilibrium preceded by a period of decreased psychological functioning (Bonanno, 2004). Recent resilience literature purports that resilience is more common than has been described in previous literature (Bonanno, 2004). Thus, resilience or psychological growth should also be common in therapists working in highly stressful and traumatic environments. Resilience can occur through multiple pathways, including through individual traits such as hardiness as well as the use of repressive coping behaviors and positive emotions and laughter (Bonanno, 2004). Hardiness refers to a personality in which one is committed to a life purpose, belief that one has control over their surroundings, and the belief that one can grow from adversity (Kobasa, Maddi, & Kahn, 1982). Resilience theory provides a framework through which positive psychological outcomes for trauma therapists can be understood.

Tedeschi & Calhoun (1996; 2004) use the term posttraumatic growth (PTG) because it focuses more on major crises rather than lower level stress and emphasizes the role of the process of coping with the trauma as the vehicle for growth. When PTG occurs, it involves an increased appreciation for life in general, more meaningful relationships, an increased sense of personal strength, changed life priorities, and a richer existential or spiritual life (Tedeschi & Calhoun, 1996). This idea has recently been extended to describe positive consequences for therapists working with traumatized clients (Calhoun, Tedeschi, & Cann, 2005).

Compassion satisfaction has been described more generally as the pleasure derived from effectively helping others through psychotherapeutic work (Stamm, 2005). Stamm (2002) coined this term as a positive parallel to the negative effects related to compassion fatigue. Compassion satisfaction is similar to other terms used to describe positive outcomes associated with stress and trauma such as posttraumatic growth. However, the concept can be differentiated by its more specific focus on helpers (e.g., counselors, crisis responders). Compassion satisfaction has also been described as a sense of efficacy in one's work and one's ability to make a positive impact on the world (Stamm, 2002). Burnout and compassion fatigue, especially in combination, have been found to result in less efficacy and compassion satisfaction (Stamm, 2002).

Previous researchers have begun to identify related factors for negative outcomes, such as compassion fatigue. However, little research has been done to examine factors related to positive outcomes, such as compassion satisfaction. Several factors have been shown to impact the therapists' experience of trauma work and negative psychological outcomes. Individual factors commonly associated with compassion fatigue include the therapist's personal experience with trauma and amount of exposure to trauma clients (Schauben & Frazier, 1995; Pearlman &

MacIan, 1995). Therapists' personal trauma history in particular has been most consistently shown to be associated with compassion fatigue (Kassam-Adams, 1999; Pearlman & MacIan, 1995).

Other individual factors, such as gender and years of experience have had more inconsistent findings across studies. Ethnicity has not been systematically investigated as an individual factor associated with compassion fatigue most likely due to the lack of heterogeneity of ethnic background in samples collected. The ethnic background of the therapist may significantly impact their experience of compassion fatigue due to cultural influences on expression of traumatic responses and definition of trauma (Young, 2001).

Gender has been shown to be associated with compassion fatigue in some studies (Kassam-Adams, 1995; Meyers & Cornille, 2002; Wee & Myers, 2002), but not in others (e.g., Pearlman & MacIan, 1995). Years of clinical experience as a related factor for compassion fatigue and other negative psychological outcomes also had mixed findings in prior research, with some researchers finding a relationship (e.g., Cunningham, 2003), whereas others did not (e.g., Kassam-Adams, 1999). Individual factors, including gender, years of clinical experience, and personal trauma history, need to be re-evaluated to determine their relationship with compassion fatigue. Individual factors such as ethnicity and specialized trauma training need to be evaluated to determine their association with compassion fatigue.

When workplace factors have been examined, lack of availability of supervision or consultation and other forms of workplace support, lack of perceived control over work activities, working with more highly disturbed clientele with difficult client behaviors, overinvolvement with clients, and a larger number of hours spent with trauma clients have been associated with negative therapist outcomes (Ackerley et al., 1988; Kassam-Adams, 1995;

Pearlman & Maclan, 1995; Rupert & Morgan, 2005). Amount of exposure to traumatized clients, defined as a heavier caseload of trauma survivors with more weekly hours of client contact, was found to be related to compassion fatigue in many studies (e.g., Brady et. al, 1999; Chrestman, 1999; Kassam-Adams, 1999; Schauben & Frazier, 1995), but a few studies found no relationship (e.g., Cunningham, 2003; Landry, 2001). The majority of the literature concerning workplace factors and negative therapist outcomes involved examinations of burnout, rather than compassion fatigue. Therefore, a study is needed to determine the impact of workplace factors on both the negative and positive effects of trauma work (i.e., compassion fatigue and compassion satisfaction), rather than burnout.

The current study examined relationships between individual factors and workplace factors associated with compassion fatigue and compassion satisfaction. The researcher in the present study investigated how individual factors of personal trauma history, years of clinical experience, gender, ethnicity, and trauma training along with workplace factors of sense of control, overinvolvement, negative clientele, workplace support, and amount of secondary exposure impacted therapists' levels of compassion fatigue and compassion satisfaction. The practical significance of this study is to inform agencies and counseling centers on ways they can set up the work environment to minimize compassion fatigue and maximize compassion satisfaction for therapists.

Scope of the Problem

A growing number of mental health counselors are increasingly working with more clients who have experienced some form of trauma (Trippany, White Kress, & Wilcoxon, 2004). Common types of trauma experienced by clients and encountered vicariously by therapists include childhood sexual abuse, sexual assault, domestic violence, natural disasters, and school violence (Trippany, White Kress, & Wilcoxon, 2004). Recent widespread traumatic events, such

as the terrorist attacks of 9/11, Hurricane Katrina, the War on Terror, and the Virginia Tech shootings impact the number of people affected by traumatic events. Additionally, the media allows a greater number of people to be exposed to traumatic images through the news broadcasts depicting the traumatic events. Thus, more people may be traumatized or re-traumatized by the viewing of these media images. Because therapists are treating more traumatized clients, the topic of compassion fatigue is becoming more relevant and crucial to address.

Statistics that report the widespread nature of trauma signify the various types of trauma work as well as the high incidence of this work.

- It has been estimated that 1 in 6 women and 1 in 10 men will be victims of childhood sexual abuse (Trippany, White Kress, & Wilcoxon, 2004).
- One in five women (21 percent) reported being raped or physically or sexually assaulted in her lifetime (Commonwealth Fund, 1999).
- Nearly one-third of American women (31 percent) report being physically or sexually abused by a husband or boyfriend at some point in their lives (Commonwealth Fund, 1999).
- According to a recent survey, 20 percent of public schools have experienced one or more violent crimes such as sexual assault, robbery, and aggravated assault (US Department of Education and US Department of Justice, 2003).
- Disasters may include natural (e.g., earthquakes, tornadoes) or human made (e.g., war, criminal violence, public health disaster) and include traumatic reactions with similar, yet somewhat unique traumatic features.

As therapists are increasingly exposed to treating traumatized clients, it is assumed that the incidence of compassion fatigue may increase as well. As a result of secondary exposure to these traumatic events, the prevalence of extreme distress in therapists who work with traumatized clients has been increasing (Meldrum, King, & Spooner, 2002; Wee & Myers, 2002). One study found that 27 percent of therapists experienced extreme distress as a result of their work (Meldrum, King, & Spooner, 2002). Another study revealed that 64.7 percent of

trauma workers exhibited some degree of posttraumatic stress symptoms (Wee & Myers, 2002). Thus, therapists, especially those exposed to trauma through their work with clients, are at a greater risk for developing negative psychological outcomes such as compassion fatigue.

Compassion fatigue not only negatively impacts therapists, but also the clients they serve and the organizations in which they work. Compassion fatigue, as mentioned previously, involves symptoms similar to that of posttraumatic stress disorder (PTSD). Therapists who experience compassion fatigue may show symptoms such as re-experiencing the client's traumatized event, avoidance behaviors, diminished affect, hypervigilance, difficulty concentrating, physiological reactivity, and irritability (Figley, 1995). These symptoms may lead to a diminished capacity to provide effective psychotherapy to their clients. Thus, client care may suffer. Additionally, the therapist's personal relationships and home life may suffer as a result of these symptoms.

There are also significant negative impacts on the organization or workplace. First, high therapist turnover is a predictable outcome of compassion fatigue and other negative consequences (e.g., burnout) (Sexton, 1999). High therapist turnover impacts the workplace through greater need for training new workers and difficulty in creating a cohesive workplace community. Other outcomes for the workplace include a loss of energy, commitment, and optimism, which has a deleterious effect on the emotional culture of the work environment (Sexton, 1999). Thus, there is reason to be concerned for the psychological health and well-being of therapists working with traumatized clients and a necessity to find effective ways to help buffer them from stress and other negative consequences.

Theoretical Framework

There exists no single unifying theory for the constructs of compassion fatigue or compassion satisfaction. Although Figley (1995; 2002) proposed a model to describe the process

of developing compassion fatigue, a single underlying theoretical framework has not been discussed in literature on compassion fatigue nor compassion satisfaction. In this section, this researcher will build a theoretical framework that encompasses these relevant constructs.

Trauma Theory

The construct of compassion fatigue, also referred to as secondary traumatic stress, shares terminology associated with the symptomology of posttraumatic stress disorder (PTSD). Thus, the psycho-physiological theory of trauma response will be reviewed as it relates to the phenomenon that therapists experience vicariously through being closely connected with their clients' trauma material. PTSD involves three major categories of symptoms: (1) re-experiencing the event in sensory form; (2) avoidance of reminders of the trauma; (3) chronic hyperarousal in the autonomic nervous system (Rothschild, 2000). These symptoms also occur with compassion fatigue.

During the experience of a traumatic event, the limbic system in the brain activates the amygdala, which signals the hypothalamus, mobilizing the body to fight, flee, or freeze. The normal response to threat is halted by the production of cortisol. However, in persons with PTSD there is a deficiency in cortisol production which makes it more difficult to halt the body's alarm response (Rothschild, 2000). Thus, people with PTSD are more easily physiologically aroused and have greater difficulty returning to a resting state.

Memory is also affected by a traumatic experience. During a traumatic event, the hippocampus is suppressed, which is normally functioning in the processing and storage of events. The hippocampus is responsible for declarative or narrative memory which puts the memory in context and proper time and space. During a trauma, the amygdala is solely responsible for processing the event. The amygdala is responsible for implicit or sensory memory and is linked with highly charged emotions. Thus, traumatic memory is usually

experienced as flashbacks that have no accompanying narrative and are highly emotional (Rothschild, 2000). This explanation of the physiological response to trauma may shed light on therapists' experience of compassion fatigue. A major difference is that the traumatic event occurs in the client's recounting of the traumatic event, which the therapist is empathically connected with.

Empathy and Countertransference

Empathy has been defined as “the action of understanding, being aware of, being sensitive to, and vicariously experiencing the feelings, thoughts, and experience of another (Merriam-Webster's Collegiate Dictionary, 1998).” Empathic connection involves putting oneself into the phenomenological world of the client (Wilson & Lindy, 1994). Empathic connection is a foundational skill for all therapists and is necessary to build rapport and establish a safe and trusting environment in which healing can occur. However, in working with traumatic material, therapists may have difficulty maintaining enough emotional distance to protect them from vicariously experiencing the negative effects of the trauma.

The experience of compassion fatigue necessitates an empathic connection with a traumatized individual. The cognitive-affective theory of empathy describes empathy as a vicarious experiencing of another person's private world through both cognitively understanding and feeling the other person's lived experience (Rogers, 1959; Duan & Hill, 1996). According to this theory, there are two types of empathy: cognitive and affective (Gladstein, 1983). Cognitive empathy refers to intellectually taking the perspective of another person, whereas affective empathy denotes experiencing the emotions of the other person (Gladstein, 1983). Affective empathy is a central construct in Figley's (1995, 2002) model of compassion fatigue.

Countertransference, originally posited as part of psychodynamic theory, is a widely accepted phenomenon that can occur in the therapeutic context. Countertransference refers to

the activation of the therapists' unresolved issues through working with a client's material (McCann & Pearlman, 1990). Wilson and Lindy (1994) identified two types of defensive countertransference reactions common to trauma therapists: avoidance reactions and over-identification reactions. Avoidance reactions include denial, minimization, distortion, detachment and disengagement from the empathic connection. Over-identification involves idealization, enmeshment, and excessive advocacy for the client.

Constructivist Self-Development Theory

Constructivist Self-Development Theory (CSDT) is a useful theory for understanding the cognitive changes that occur for therapists experiencing trauma vicariously through therapeutic work with clients. CSDT asserts that human beings construct their own realities through development and use of cognitive schemas (McCann & Pearlman, 1990). These schemas include assumptions about self, others and the world which allow people to make sense of their experiences. Therapists may experience disruptions in these basic schemas of self, others, and the world through their work with trauma survivors (McCann & Pearlman, 1990).

CSDT outlines five components of the self that are affected through vicarious traumatization: (1) frame of reference; (2) self-capacities; (3) ego resources;

(4) psychological needs; and (5) cognitive schemas, memory, and perception (Pearlman & Saakvitne, 1995). These changes in the therapist's core beliefs can lead to feelings of helplessness and loss of control which can challenge the counselor's identity (Pearlman & Saakvitne, 1995).

Integrated Theoretical Framework

No single unifying theory exists to encompass the constructs of compassion fatigue, compassion satisfaction, and how the work environment impacts the occurrence of these phenomena. A physiological theory of trauma was explicated to account for the physiological

and behavioral symptoms associated with compassion fatigue. Physiological changes create a vicious cycle with changes in the cognitive system that is explained by the CSDT model. The unique exposure of the therapist to the client's trauma material is explained by the process of empathic connection and countertransference.

A theoretical and causal model for compassion fatigue was proposed by Figley (1995) and subsequently revised (Figley, 2002). The model rests on the assumption that empathy is an essential ingredient in the therapeutic relationship and is necessary to effectively work with clients (Figley, 2002). However, empathic engagement can also have costs, especially for therapists working with traumatized clients because it leaves the therapist vulnerable to indirectly experiencing the client's trauma.

Figley's (1995) compassion fatigue model contains ten key variables involved in the occurrence of compassion fatigue. First, the therapist must have the ability to empathize with the client and the empathic concern to motivate them to help others in need. Next, exposure to the client involves experiencing the emotional pain of the client through direct exposure. The empathic response occurs when the therapist uses empathic understanding to put him or herself into the phenomenological world of the client, experiencing the suffering and other emotions experienced by the client (Figley, 2002).

The therapist may then experience compassion stress, which is the "residue of emotional energy (p.1437)" from the empathic response and the desire to relieve the suffering of the client (Figley, 2002). When the therapist experiences compassion stress, it can develop into compassion fatigue unless protective factors are present. One of these protective factors is sense of achievement, which is the therapist's sense of satisfaction with his or her efforts to assist the client. Sense of achievement is consistent with the concept of compassion satisfaction which

thus fits within Figley's (1995) model. Another protective factor is disengagement.

Disengagement involves distancing oneself emotionally from the client's pain between sessions and letting go of thoughts and emotions concerning the client in order to live their life (Figley, 2002). The concept of disengagement in its opposite form is overinvolvement, which is related to the inability to disengage from the trauma of clients.

There are also several factors that can exacerbate the condition of compassion stress to develop into compassion fatigue. First, prolonged exposure to traumatized clients involves the therapist's ongoing sense of responsibility for relieving the suffering of the client over a period of time. Prolonged exposure, or amount of secondary exposure to traumatized clients, has been consistently associated with compassion fatigue in the literature (Kassam-Adams, 1995; Pearlman & Maclan, 1995). Second, traumatic recollections may occur, or memories associated with the client's trauma material that elicits an emotional reaction for the therapist. Third, disruptions in the therapist's life (e.g., illness, life changes) that would normally be manageable but may compound compassion stress to lead into compassion fatigue (Figley, 2002).

Need for the Study

The occurrence of compassion fatigue and other negative psychological outcomes for trauma therapists have been well-documented in the literature (e.g., Maslach, 1993; McCann & Pearlman, 1990; Salston & Figley, 2003). However, most research has focused on individual characteristics (e.g., gender, amount of experience, personal trauma history) associated with these concepts rather than on the characteristics of the workplace (Bell, Kulkarni, & Dalton, 2003), with inconsistent findings. Though research on the construct of burnout has begun to focus on factors in the workplace that are associated with burnout (e.g., Ackerley et al., 1988; Rupert & Morgan, 2005), more research is needed on the organizational correlates of compassion fatigue and compassion satisfaction. Numerous studies have recommended

interventions at the organizational level (e.g., Sexton, 1999; Collins and Long, 2003), however it is unknown to what extent these interventions occur in different work settings or how much they help.

Although factors associated with negative psychological outcomes for therapists have been discussed in the literature, there has been little focus on factors associated with positive psychological outcomes for therapists (e.g., compassion satisfaction). A broader understanding of contextual factors related to both compassion fatigue and compassion satisfaction is needed (Salston & Figley, 2003). In the current study, this researcher examined the relationship between individual factors (i.e., personal trauma history, years of clinical experience, gender, ethnicity, trauma training) and workplace factors (i.e., control, overinvolvement, negative clientele, workplace support, amount of secondary exposure) and compassion fatigue and compassion satisfaction. Results demonstrated the extent to which workplace factors in addition to individual factors account for the variance in compassion fatigue as well as compassion satisfaction.

Research Problem

The main problems that was addressed in the present study involved assessing the impact of individual and workplace factors on the experience of negative psychological outcomes (i.e., compassion fatigue) and positive outcomes (i.e., compassion satisfaction) for therapists who work with traumatized clients. To explore this problem, five workplace factors known to be associated with burnout were assessed: (1) control, (2) overinvolvement, (3) negative clientele, (4) workplace support, (5) amount of secondary exposure (Ackerley et al., 1988). Individual factors of gender, ethnicity, personal trauma history, years of experience, and trauma training were also assessed to better account for variance in compassion fatigue. The population of interest was Professional Counselors, Psychologists, and Social Workers working with

traumatized client populations. The outcome of the study was intended to address the question of how individual factors and workplace factors were related to levels of compassion satisfaction and compassion fatigue.

Research Questions

The following research questions were proposed in this study:

1. What is the relationship among workplace factors (e.g., control, overinvolvement, negative clientele, workplace support, amount of secondary exposure) and compassion fatigue?
2. What is the relationship among workplace factors (e.g., control, overinvolvement, negative clientele, workplace support, amount of secondary exposure) and compassion satisfaction?
3. Does the addition of workplace factors (e.g., control, overinvolvement, negative clientele, workplace support, amount of secondary exposure) significantly improve the variance accounted for by individual factors (e.g., gender, ethnicity, personal trauma history, years of experience, trauma training) in compassion fatigue and compassion satisfaction?

CHAPTER 2 LITERATURE REVIEW

Therapists, particularly those working with clients healing from traumatic events, have the potential for rewarding, growth-enhancing experiences as well as negative consequences such as burnout and psychological distress as a result of their therapeutic work (Maslach & Leiter, 1997). It is understandable that trauma therapists have the potential to experience extreme stress due to the high demands of their work, including empathic strain from repeated exposure to clients' traumatic material and emotional pain. Cushway and Tyler (1996) have observed consistent levels of moderate to significant distress among mental health practitioners. Numerous other studies have found similarly high levels of traumatic stress in therapists (e.g., Brady et al., 1999; Kassam-Adams, 1999; Chrestman, 1999). Overall distress is mediated by both risk and resiliency factors including the therapist's personal characteristics, characteristics of the client and the trauma, the therapist's attempts to cope, and the environment in which the therapy takes place (Dutton & Rubenstein, 1995; Figley, 1995; Chrestman, 1999). These risk and resiliency factors impact the therapeutic relationship and the therapists' consequent experience of positive or negative personal and professional outcomes.

Trauma counselors are trained to work with clients in the aftermath of traumatic events (Dutton & Rubenstein, 1995). A traumatic stressor is defined diagnostically as "when a person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury or a threat to the physical integrity of self or others (American Psychiatric Association, p.427)." Each person's experience of trauma is different. Trauma therapists may experience psychological distress through effects of their exposure to clients' traumatic material (Dutton & Rubenstein, 1995).

Why are therapists who work with traumatized clients vulnerable to negative consequences? First, therapists display empathy as a major resource in helping their clients. Empathy helps the therapist understand and emotionally connect with the client's experience, but it also leaves the therapist vulnerable to being traumatized by the client's trauma material as a result of this intimate connection (Figley, 1995). The concept of empathy has been defined in a variety of ways throughout years of theoretical writings on the topic (Duan & Hill, 1996). Rogers (1959) defined empathy as a process of feeling as if one actually were that other person. The cognitive-affective theory of empathy describes empathy as a vicarious experiencing of another person's private world through both cognitively understanding and feeling the other person's lived experience (Rogers, 1959; Duan & Hill, 1996).

A cognitive-affective state of empathy can be broken down and described in two parts (Gladstein, 1983). First, cognitive empathy refers to intellectually taking the perspective of another person. Second, affective empathy denotes experiencing the emotions of the other person (Gladstein, 1983). Affective empathy was focused on in Figley's (1995, 2002) model of compassion fatigue as one of the central constructs.

Aspects of working with trauma survivors in therapy that make the trauma therapist susceptible to negative outcomes include increased awareness of the potential for trauma in their own life, the difficulty of working through clients' powerful emotions and mistrust in therapy, clients' reenactments of earlier relationships projected onto the therapist, and the helplessness that ensues when therapists witness the recounting of the client's traumatic experiences (Pearlman & Saakvitne, 1995). Therapists' own history of traumatic events and unresolved issues related to these experiences may increase their risk for negative consequences. Therapeutic countertransference, especially as it relates to the therapist's unresolved traumas, has

been related to the risk of negative outcomes for therapists. Saakvitne (1995) defines countertransference as “the affective, ideational, physical responses a therapist has to a client...and the therapist’s conscious and unconscious defenses against affects, intrapsychic conflicts and associations around the former (p.23).” Wilson and Lindy (1994) identified two types of defensive countertransference reactions common to trauma therapists: avoidance reactions and over-identification reactions. Avoidance reactions include denial, minimization, distortion, detachment and disengagement from the empathic connection. Over-identification involves idealization, enmeshment, and excessive advocacy for the client. Countertransference reactions can be useful tools to increase understanding of the client and can be effectively processed through supervision and consultation (Pearlman & Saakvitne, 1995). Depending upon how countertransference issues are dealt with, the therapist can experience either positive or negative consequences both personally and in the therapeutic interaction.

Therapeutic work can also be extremely rewarding and contribute to therapists’ personal growth and spiritual transformation. Therapists have reported enjoying creativity, strength, and witnessing the resilience of survivors which led to a sense of spiritual growth and deeper intimate relationships with significant others (Schauben and Frazier, 1995; Pearlman & Saakvitne, 1995; Arnold, Calhoun, Tedeschi, & Cann, 2005). The literature reviewed contains studies predominantly concerning the negative effects for trauma counselors, however recent literature has begun to explore the positive effects for counselors.

There are many explanatory factors for therapists’ positive and negative psychological outcomes including individual, workplace, and client factors (Figley, 1995). The following literature review is organized as follows: review of the negative and positive effects of trauma on the therapist, associated factors, theoretical foundations, interrelationships between positive and

negative effects, and a discussion of workplace factors that impact therapists' psychological outcomes.

Negative Effects of Trauma on the Therapist

Various terms have been described in the literature on the negative effects of psychotherapeutic work with traumatized clients. It is important to review, define and differentiate how these various terms clarify constructs related to how working with traumatized clients negatively impacts therapists. The following terms have been used to describe the negative effects for counselors: vicarious traumatization (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995); traumatic countertransference (Herman, 1992); burnout (Pines, 1993); and compassion fatigue or secondary traumatic stress disorder (Figley, 1995). These terms are often used interchangeably to describe the variety of potential negative effects for counselors working with trauma victims. The terms vicarious traumatization and burnout will be reviewed and differentiated from compassion fatigue, which will also be defined and discussed. Relevant literature for each of these constructs will also be reviewed in the following section. These three terms related to negative therapist outcomes were chosen for this literature review because current theoretical and empirical literature frequently utilizes these terms as compared to other terminology previously used to describe negative effects for the trauma therapist.

Vicarious Traumatization

Vicarious traumatization has been defined as “the transformation in the inner experience of the therapist...as a result of empathic engagement with the clients' trauma material (McCann & Pearlman, 1990, p.145).” In the process of providing therapy for clients exposed to trauma, the traumatic material can begin to affect the therapist's worldview, emotional and psychological needs, belief systems, and cognitions (Pearlman & Saakvitne, 1995). This process is viewed as normal and inevitable when therapists work with clients healing from traumatic events.

Although inevitable, if vicarious traumatization is not addressed and worked through (e.g., in supervision, consultation, or personal therapy), serious negative effects can occur in the therapist both personally and professionally (Pearlman & Saakvitne, 1995).

Vicarious traumatization stems from a theoretical framework in constructivist self-development theory (CSDT), which is a developmental interpersonal theory (Pearlman & Saakvitne, 1995). The underlying philosophical position of this theory is the constructivist notion that individuals construct their own realities. A main assumption of this theory is that the meaning of the traumatic event relates to the survivor's experience of the event. A second assumption is that the individual's early development is primary in their way of interacting with self and others. CSDT also assumes that survivors' symptoms are adaptive strategies developed for psychological survival in the face of traumatic events (Pearlman & Saakvitne, 1995).

Five areas of the self are expected to be affected by trauma, reflecting both experiential and cognitive realms (Saakvitne, Tennen, & Affleck, 1998). First, the individual's frame of reference is disrupted, including the way of understanding self and the world and sense of spirituality. Second, the survivor's self-capacity to recognize, tolerate, and integrate affect are disrupted. Third, ego resources are affected, which disrupt one's ability to meet their psychological needs in mature ways. This category also includes cognitive and social skills. Fourth, disruptions occur in cognitive schemas in areas of trust, safety, control, esteem, and intimacy. Finally, perceptual and memory systems are affected, including neuro-chemical and sensory changes (Saakvitne, Tennen, & Affleck, 1998). This theoretical position has been used to describe the effects of compassion fatigue as well as posttraumatic growth that occur for the therapist working with traumatized clients (Saakvitne, Tennen, & Affleck, 1998).

Schauben & Frazier (1995) explored the psychological effects of female counselors working with sexual violence survivors. Counselors who had more survivors of sexual violence in their caseload reported greater PTSD symptoms, higher levels of vicarious traumatization, and more disrupted beliefs. Counselors reported using active coping strategies (e.g., seeking instrumental and social support) that were more adaptive than coping by behavioral disengagement.

Pearlman & Maclan (1995) examined vicarious traumatization with male and female self-identified trauma counselors. The researchers found that newer therapists, especially those not receiving supervision, and therapists with a personal trauma history experienced the most negative outcomes. The most frequent disruptions experienced by therapists were in self-intimacy and other-esteem. Participants with more time devoted to trauma work had fewer disruptions in self-trust.

Lee (1995) explored vicarious traumatization in marriage and family therapists (Jenkins & Baird, 2002). These therapists reported a mean of 63% of clients with a diagnosis of PTSD. It was found that the more hours spent with exposure to clients' traumatic material, the greater the intrusion scores. Thus, more secondary exposure to trauma through therapeutic work was associated with intrusive thoughts and images related to the client's traumatic material.

To summarize, studies related to vicarious traumatization have found that therapist who worked primarily with trauma clients experienced various levels of vicarious traumatization. Factors that differentiated therapists who experienced higher levels of vicarious traumatization include experience with personal trauma, lack of experience with trauma clients, lack of supervision, a heavier caseload of trauma clients, and a greater number of hours spent with trauma clients. Methodological limitations in these studies include mostly female, Caucasian

samples and low response rates using a survey design methodology. Additionally, vicarious traumatization was measured through various questionnaires, not a psychometrically sound, multi-item measure of this construct.

Burnout

The term burnout was coined by Freudenberger (1974). Currently, there is no standard definition of burnout (Edwards et al., 2000). Pines and Aronson (1988) define burnout as “a state of physical, emotional and mental exhaustion caused by long- term involvement in emotionally demanding situations (p.9).” Burnout is differentiated from vicarious traumatization and compassion fatigue as being a more gradual process that results from long term emotional exhaustion (Figley, 1995). Burnout is not limited to those who treat traumatized populations, whereas the other terms (e.g., vicarious traumatization, compassion fatigue) are specific to work with these populations.

Skovholt (2001) has identified two types of burnout. Meaning burnout occurs when therapists feel that the calling of caring for others through fostering their emotional healing and development no longer gives sufficient meaning to the therapists’ life. Meaning burnout can also occur when the practitioner no longer feels that their work is helpful to clients. Meaning burnout can occur due to workplace factors such as case and paperwork overload, client relapses, or agency dysfunctions that prevent the therapist from practicing in the way they prefer. Caring burnout refers to a decreased ability to professionally attach with clients as a result of depleted energy from previous attachments and separations from past clients (Skovholt, 2001). This cycle of attachment and separation can be psychologically draining for the practitioner. Also, continuous contact with clients who seem unappreciative can lead helpers to view future clients in more negative terms, which negatively affects the therapeutic relationship and the therapists’ overall well-being (Corey, 1989).

Maslach (2001) identified a model consisting of three main aspects of burnout:

(1) emotional exhaustion; (2) depersonalization; (3) declines in sense of personal accomplishment (Maslach, 2001). Emotional exhaustion is the defining feature of burnout. The depersonalization dimension involves cynicism and interpersonal distancing. The reduced personal accomplishment dimension refers to a sense of incompetence and lack of achievement and productivity in one's work (Maslach, 2001).

Kahill (1988) reviewed empirical research on burnout symptoms and identified five main categories of burnout symptoms. The first category is physical symptoms consisting of fatigue, headaches, sleep disturbance, and other somatic problems. The second category, emotional symptoms, includes anxiety, depression, irritability, and guilt. Third, behavioral symptoms occur including pessimism, aggression, callousness, and substance abuse problems. Fourth is work-related symptoms involving poor work performance, absenteeism, tardiness, low morale, and resigning from work. The final category is interpersonal symptoms, consisting of communication problems, social withdrawal, loss of positive feelings toward one's clients leading to depersonalized and intellectualized therapeutic interactions.

Numerous studies have been conducted on the topic of work-related burnout. Several of these studies will be reviewed in this section. Etzion (1984) explored the relationship between burnout and social support. Support was found to be significantly negatively correlated with burnout. Social support in the therapist's personal life was found to be more effective in burnout prevention for females, whereas social support at work was found to be more beneficial for males. Women were found to have higher levels of burnout than men in this sample.

A study by Ackerley *et al.* (1988) sampled doctoral-level psychologists and found that over one third of their sample experienced high levels of burnout. Factors related to burnout

included therapists who were younger, low-income, with little experience in personal psychotherapy who experienced a lack of control in their work environment and felt overcommitted to their clients. The study was limited to a sample of doctoral-level psychologists.

Raquepaw and Miller (1989) examined levels of burnout among psychologists and social workers. They found that agency therapists had higher levels of burnout. They also found that therapists' caseloads did not predict burnout, but their level of satisfaction with their caseloads was predictive. The sample size in this study, however, was smaller than in comparable studies on the topic.

In summary, the lack of a universal definition has been a problem in effectively studying burnout in mental-health workers. Similar to vicarious traumatization, studies found those therapists who were younger and less experienced had higher levels of burnout. Additional explanatory factors were a sense of lack of control, overcommitment to clients, and work in agency settings. Gender differences also were found, with women experiencing higher levels of burnout. Social support was found to be an important preventive factor for burnout. Methodological limitations of these studies include low response rates and primary reliance on self-report.

Compassion Fatigue

Compassion fatigue, previously referred to as secondary traumatic stress, has been defined by Figley (1995) as “the natural consequent behaviours and emotions resulting from knowing about a traumatizing event experienced by a significant other – the stress resulting from helping a traumatized or suffering person (p.7).” This term has its roots in the term compassion, which is defined as “a feeling of deep sympathy and sorrow for another who is stricken by suffering or

misfortune, accompanied by a strong desire to alleviate the pain or remove its cause (Webster's Encyclopedia, 1989, p.299).”

Compassion fatigue is viewed as an acute reaction of PTSD-like symptoms as a result of empathic strain and exposure of helpers to the experiences of their clients (Figley, 1995; Pearlman & Saakvitne, 1995). Other symptoms include feelings of helplessness, confusion, isolation from supporters and experiences of intrusive, avoidance and arousal symptoms. Recovery, similar to onset, is usually faster than recovery from work-related burnout (Figley, 1995). Compassion fatigue, or secondary traumatic stress reactions, similar to vicarious traumatization, is considered inevitable to some extent with trauma work (Herman, 1992).

Figley (1995) proposed and subsequently revised (Figley, 2002) a theoretical model of compassion fatigue. The model assumes that empathy is necessary to effectively work with clients (Figley, 2002). Although essential, empathic engagement can also have costs, especially for therapists working with traumatized clients. Figley's (1995) model contains ten factors related to the occurrence of compassion fatigue. First, the therapist must have the ability to empathize with the client and empathic concern for the client. Next, exposure to the client must occur, which involves experiencing the emotional pain of the client. Next, the empathic response occurs in which the therapist uses empathic understanding to put him or herself into psychological world of the client, experiencing the emotions that are felt by the client (Figley, 2002).

The therapist may then experience compassion stress, which is described as the “residue of emotional energy (p.1437)” from the empathic response and the desire to relieve the suffering of the client (Figley, 2002). Compassion stress can develop into compassion fatigue unless protective factors are present. One of these factors is sense of achievement, which is the

therapist's sense of satisfaction with his or her efforts to help the client. Another protective factor is disengagement, which involves distancing oneself emotionally from the client's pain in order to live their life (Figley, 2002).

There are also several factors that can exacerbate the condition of compassion stress to lead it to develop into compassion fatigue. First, prolonged exposure, which involves the therapist's feelings of responsibility for relieving the suffering of the client over a period of time, is a risk factor. Second, traumatic recollections, or emotional memories associated with the client's trauma material, can exacerbate compassion stress. Third, disruptions in the therapist's life (e.g., illness, life changes) that can compound with compassion stress to develop into compassion fatigue (Figley, 2002).

Figley (1995) conducted a meta-analysis of current compassion fatigue literature and categorized it into three main areas: (1) indicators of psychological distress; (2) cognitive shifts; (3) relational disturbances. The first area involves distressing emotions (e.g., depression, anxiety, fear, anger, shame), flashbacks or nightmares, numbing of affect and avoidance, somatic complaints (e.g., sleep problems, headaches), addiction or compulsive behaviors, physiological arousal (e.g., hypervigilance), and impairment in day to day functioning. The second area, cognitive shifts, involves changes in core beliefs related to trust, safety, power, and personal control which arise as a result of exposure to clients' traumatic experiences. Herman (1992) introduced the concept of witness guilt, in which therapists experience guilt for enjoying life while their clients have experienced such horrible traumatic events. Third, relational disturbances include the therapist's personal relationships suffering as a result of alterations in trust and intimacy (Clark & Gioro, 1998). Relationships with clients are also affected through either overidentification or detachment, negatively affecting the therapeutic alliance. Therapists

may also emotionally detach from their support systems and relationships with significant others (Dutton & Rubinstein, 1995).

Landry (2001) and Wee and Myers (2002) studied compassion fatigue in mental health workers responding to the Oklahoma City bombing in 1995 (Creamer & Liddle, 2005). Landry (2001) found that compassion fatigue was related to empathy but not to years of experience with trauma survivors or social support involvement. Wee and Myers (2002) showed men having higher compassion fatigue symptoms. Numerous studies have found a relationship between compassion fatigue and therapist personal history of trauma (Kassam-Adams, 1995; Pearlman & MacIain, 1995), whereas others have not (Schauben & Frazier, 1995). Reasons for these mixed findings include lack of a standard way to measure personal trauma history. Suggestions have been made for this construct to be measured on a scale rather than as a dichotomous variable (Creamer & Liddle, 2005).

Several studies have found a relationship between heavier caseloads of trauma survivors and compassion fatigue (Brady et al., 1999; Chrestman, 1999; Schauben & Frazier, 1995). Positive correlations have been found between compassion fatigue and reduced longevity of career, larger caseloads, increased contact with clients, and long working hours (Beaton & Murphy, 1995).

Gender of the therapists was associated with compassion fatigue in some studies (Kassam-Adams, 1995; Meyers & Cornille, 2002; Wee & Myers, 2002), but not in others (Pearlman & MacIain, 1995). Two studies found that women reported more compassion fatigue symptoms than men (Kassam-Adams, 1995; Meyers & Cornille, 2002) and one found that men reported more symptoms (Wee & Myers, 2002). These studies have often had predominantly female and

Caucasian samples. Years of therapeutic experience had mixed findings, with some studies finding a relationship (Cunningham, 2003), whereas others did not (Kassam-Adams, 1999).

Methodological limitations to explain these contradictory findings include lack of diversity in samples (i.e., mostly mainly female Caucasian samples) and reliance on different measures of trauma history and exposure to trauma clients. All studies utilized a survey methodology with varying return rates and are therefore limited due to unknown factors associated with those who did not respond. The most consistent findings in these studies were the relationship between both amount of trauma clients in the caseload and personal trauma history of the therapist and compassion fatigue.

Although related terms for negative psychological outcomes are often used interchangeably in the literature, there are some significant differences between the terms. Vicarious traumatization is often used to refer to the negative cognitive effects, whereas compassion fatigue encompasses cognitive, emotional, somatic, and behavioral outcomes. Burnout is differentiated from compassion fatigue as being a more gradual process that results from long term emotional exhaustion (Figley, 1995). Burnout is not limited to those who treat traumatized populations, whereas the other terms are limited to work with these populations. Finally, traumatic countertransference can be differentiated from other terms as warning signs or risk factors for compassion fatigue rather than symptomology of compassion fatigue.

In conclusion, the research on negative effects of therapeutic work with traumatized clients has found significant percentages of practitioners experiencing various negative consequences, although these percentages vary from study to study. Relationships between factors of personal trauma history and amount of exposure to traumatized clients, and social support have been found consistently across constructs. In many of the studies reviewed, the primary method of

investigation has been through surveys with low response. Lack of a standard definition for burnout and lack of a standard instrument for measuring vicarious traumatization may have led to mixed findings related to these constructs.

Review of Positive Effects

Whereas there has been a plentiful amount of literature concerning the negative effects of psychotherapy with traumatized clients, there is a paucity of research to date on the positive effects of this type of work. Positive consequences have been mentioned in the literature somewhat tangentially in the context of a more thorough coverage of negative consequences (Arnold, Calhoun, Tedeschi, & Cann, 2005). This overemphasis on negative consequences shapes the reality that trauma work is primarily negative and hazardous. A paradigm shift is occurring in psychotherapy through the postmodern movement, which has focused attention on client strengths rather than pathologies. Similarly, a paradigm shift seems to be occurring in the literature related to the consequences for therapists working with trauma populations. In the following section, a review of the literature on positive consequences of therapeutic work, including trauma work, will be presented along with an introduction to the constructs of vicarious posttraumatic growth and compassion satisfaction.

A useful framework for understanding the possibility of positive psychological outcomes for trauma therapists is resilience theory. Resilience refers to the ability to maintain a stable psychological equilibrium in the face of adverse or traumatic experiences. It is differentiated from recovery, which is equilibrium preceded by a period of decreased psychological functioning (Bonanno, 2004). Recent resilience literature supports the notion that resilience is more common than has been described in previous literature (Bonanno, 2004). Thus, resilience or psychological growth should also be possible, even likely, in therapists working with

traumatized clients. Resilience can occur through multiple pathways. Resilience can occur due to individual traits such as hardiness, which is a personality profile consisting of commitment to a life purpose, belief that one has control over their surroundings, and belief that one can grow from adversity (Kobasa, Maddi, & Kahn, 1982). Resilience can also occur through repressive coping, which involves the tendency to avoid painful memories and emotions. Finally, the expression of positive emotions and laughter in the face of adversity are related to resilience (Bonanno, 2004). Given the common experience of and the multiple pathways to resilience, it is necessary to explore associated factors to increase growth and resilience for trauma therapists.

Herman (1992) reported that therapists deepen their sense of integrity through trauma work and appreciate life more fully. She also stated that these therapists take life more seriously, have a greater understanding of others, have deeper and more intimate relationships and feels inspired by their clients' courage. Pearlman and Saakvitne (1995) discussed the increased sense of connection with others that grows from the intimacy of working with clients healing from trauma. Other rewards include spiritual growth, increased respect for the resilience of the human spirit, and learning from witnessing the strength exhibited by clients (Pearlman and Saakvitne, 1995).

Schauben and Frazier (1995), in their survey of female counselors working with sexual violence survivors, found that 45% of counselors reported enjoyable aspects of their work, such as creativity, strength, and witnessing the resilience of survivors. They also reported joy in seeing clients grow from their adversity and experienced growth and change in themselves as a result of their work with survivors. Finally, counselors reported feeling good about the importance of their work. These early results were obtained through qualitative methods. This study contributed to the understanding of the positive psychological outcomes for therapists.

However, a broader understanding of the phenomenon of positive growth through trauma work is still needed, particularly through quantitative methods.

Stamm (1998) purported that not all trauma workers experience distress and negative consequences. He surmised that some therapists may have protective mechanisms that enhance and maintain their well-being. King et al. (1998) stated that hardiness and social support are key protective mechanisms (Collins & Long, 2003). Hardiness, as previously discussed, refers to a personality profile consisting of control, commitment, and viewing change as a challenge (King et al., 1998).

Another study focused on vicarious traumatization in female psychotherapists found that practitioners who treated more survivors of sexual abuse had more existentially and spiritually satisfying lives (Brady et al., 1999). The authors surmised that work with survivors of sexual abuse may force therapists to challenge constructs of meaning and their faith in a way that may have promoted growth. Exposure to trauma material may temporarily produce a spiritual crisis for therapists but often results in a stronger and healthier sense of spiritual well-being (Brady, Guy, Poelstra, & Brokaw, 1999). It is also possible that people who are more spiritual are drawn to trauma work due to the focus on spiritual issues that often arises for trauma survivors. Limitations of this study are that the sample consisted of female psychologists primarily in private practice settings (58%).

The construct of posttraumatic growth has recently been extended to include trauma therapists' experience of this phenomenon vicariously. The construct of posttraumatic growth was developed by Tedeschi and Calhoun (1996) and involves three basic categories: changes in self-perception, interpersonal relationships, and philosophy of life. The conceptual model of posttraumatic growth for clients who directly experience a traumatic event includes an increased

appreciation for life in general, more meaningful relationships, an increased sense of personal strength, changed life priorities, and a richer existential or spiritual life (Tedeschi & Calhoun, 1996).

Although positive consequences of psychotherapy for therapists has been mentioned tangentially in the literature on negative outcomes, one study by Arnold, Calhoun, Tedeschi, and Cann (2005) attempted to qualitatively explore positive consequences of therapeutic work and the concept of vicarious posttraumatic growth for therapists. These researchers used a convenience sample of licensed psychotherapists from various disciplines. All 21 therapists interviewed mentioned some positive consequences of their therapeutic work. The most frequently reported positive consequence was observing clients' posttraumatic growth, which contributed to their own growth and development. They also reported trait-oriented changes in themselves, such as increased sensitivity, compassion, insight, tolerance, and empathy. Many therapists (76%) said that trauma work impacted their spiritual growth and 48% reported a deepened appreciation of the human spirit. Although these therapists also mentioned negative consequences from their work, all of them also mentioned many positive outcomes. Because a small sample was used with a qualitative method, the findings in this study cannot be generalized to other populations of therapists. Additional studies are needed using quantitative methods for exploring vicarious posttraumatic growth in therapists.

Compassion satisfaction has been described as the enjoyment derived from effectively helping others through psychotherapeutic work (Stamm, 2005). Stamm (2002) developed this term while revising the Compassion Fatigue Self Test (Figley, 1995; Figley & Stamm, 1996) to include positive aspects that parallel the negative effects of compassion fatigue. Compassion satisfaction has also been described as a sense of efficacy in one's work (Stamm, 2002). Stamm

(2002) additionally described compassion satisfaction as the happiness that comes from being able to make the world a closer reflection of what one wants it to be (Stamm, 2002).

Although little empirical research has been conducted on compassion satisfaction, some preliminary related factors have been purported. Compassion satisfaction is proposed to be related to the protective factors of hardiness and good social support (King et al., 1998). Stamm (2002) surmised that positive collegial support in the workplace could enhance compassion satisfaction and decrease compassion fatigue and other negative consequences through enhancing therapists' sense of competency. Preliminary research on compassion satisfaction indicated that burnout and compassion fatigue, especially in combination, result in less of a sense of efficacy and lower levels of compassion satisfaction (Stamm, 2002).

Interrelationships among Positive and Negative Effects

Recent studies examined the interrelationships between compassion fatigue, compassion satisfaction, and burnout (Conrad & Kellar-Guenther, 2006). Compassion satisfaction refers to one's sense of enjoyment and fulfillment in their therapeutic work. Conrad and Kellar-Guenther (2006) surveyed child protective service workers to determine their levels of compassion fatigue, compassion satisfaction, and burnout. The researchers found that approximately half of their participants had high (i.e., raw score of 36-40) or very high (i.e., raw score of 41-115) levels of compassion fatigue. Additionally, 70% of participants had "good potential" for compassion satisfaction (i.e., raw score of 82-99), which seemed to moderate the effects of burnout, of which significantly lower levels were found. Participants with high compassion satisfaction had lower levels of both compassion fatigue and burnout.

More research is needed to determine the interrelationships between the positive effects (compassion satisfaction) and the negative effects (compassion fatigue) of psychotherapeutic work with traumatized populations. Additionally, to add to the literature on positive effects of

psychotherapeutic work, there needs to be more information on how to enhance positive outcomes as well as prevent negative outcomes.

Workplace Factors

Overall psychological outcomes are mediated by both risk and protective factors including the therapist's personal characteristics, characteristics of the client and the trauma, the therapist's attempts to cope, and aspects of the work environment in which the therapy takes place (Dutton & Rubenstein, 1995; Figley, 1995; Chrestman, 1999). The interactions between these factors influence the therapeutic relationship. The relationship between workplace factors and positive and negative outcomes for counselors will be discussed in more detail in this section.

There is a significant impact, especially in agency settings, on organizations in which therapists are affected by negative consequences of therapeutic work. First, high-turnover is a predictable outcome of burnout and other negative consequences. There is likely to be a loss of energy, commitment, and optimism, which has a deleterious effect on the work environment (Sexton, 1999). The more negative countertransference effects experienced by therapists, the greater the possibility that issues of clients will be played out within the organization. Given that negative consequences such as vicarious traumatization and compassion fatigue are considered inevitable outcomes of trauma work, this raises issues of occupational health and safety within the workplace (Sexton, 1999).

Maslach and Leiter (1997) take a strong work-climate view with respect to the causes of burnout and other negative effects on the counselor. They see burnout as an interaction between the person and his or her work environment. Six sources of burnout include work overload, lack of control, insufficient rewards, breakdown of community, unfairness, and significant value conflicts (Maslach & Leiter, 1997). First, work overload refers to long work hours and seeing more clients than one can successfully manage. Second, a sense of lack of control, or having no

voice concerning policies in the workplace or treatment of clients, also seems to negatively impact therapists. Third and fourth, insufficient rewards, such as low wages for counselors in many settings, may bring about feelings of unfairness. Fifth, counselors often feel alienated from one another, leading to a sense of breakdown of community and social support in the workplace. Sixth, value conflicts may occur between the professional goals of the practitioner and policies in the setting in which he or she works (Maslach & Leiter, 1997).

Additional work-related factors related to burnout are lack of challenge on the job, role ambiguity, low professional self-esteem, difficulties in providing services to clients, and negative attitudes toward the profession (Solderfeldt, Solderfeldt, & Warg, 1995). Personal factors that interact with these work-related factors include chronic minor hassles in daily living, family income, attitudes toward the profession, years of experience, and low education (Solderfeldt, Solderfeldt, & Warg, 1995).

The studies reviewed previously have yielded numerous inconsistent results concerning individual associated factors due to flaws in methodology and measurement. Factors related to the workplace that influence therapist outcomes have been somewhat more consistent in the literature. Private practice therapists have been consistently found to have lower levels of burnout than agency therapists (Ackerley et al., 1988; Hellman & Morrison, 1987; Vredenburgh, Carlozzi, & Stein, 1999; Rupert & Morgan, 2005). This difference has been attributed to several factors, including independent practitioners having greater control over their work, less paperwork, and less disturbed clients (Rupert & Morgan, 2005).

Vredenburgh, Carlozzi, & Stein (1999) surveyed 521 psychologists (52.1% response rate) and also found that private practitioners had the lowest levels of emotional exhaustion and higher levels of personal accomplishment (i.e., lower levels of burnout). Additionally, they found

positive correlations between client load and sense of personal accomplishment and non-significant correlations between client load and emotional exhaustion or depersonalization. They also found that males had higher levels of depersonalization than females. Hellman & Morrison (1987) found that therapists in private practice experienced less personal depletion but more stress. They also found that therapists with more disturbed clients reported more stress. Methodological flaws may account for the differences in findings, including survey methods with low response rates, small samples, and samples limited to primarily female, Caucasian, doctoral-level psychologists.

Rupert & Morgan (2005) conducted a large national survey of 571 doctoral psychologists in solo private practice, group private practice, and agency settings. Overall, the researchers found similar burnout rates as those found by Ackerley and colleagues (1988). Solo and group practitioners had lower overall levels of burnout, including dimensions of emotional exhaustion and sense of personal accomplishment. The researchers used ANCOVA to measure differences with age as a covariate, since agency workers tended to be younger and less experienced which has been found to be related to burnout. Solo and group private practitioners reported a greater sense of control over their work, less negative client behavior, more direct pay clients, and more overinvolvement with clients. Level of exhaustion was positively related to number of hours worked, paperwork hours, percentage of managed care clients, negative client behaviors, and overinvolvement with clients.

Ackerley, Burnell, Holder, and Kurdek (1988) conducted a study examining various correlates of burnout, including demographics, objective work characteristics, types of work activities, types of client issues, and factors within the therapy setting. The researchers found that various subcomponents of burnout were positively related to younger age of the therapist,

agency work, and work with couples and as a clinical supervisor. A final category of predictors of burnout examined in this study was specific aspects of the work setting itself. Four factors associated with the work setting were included in the development of the Psychologist's Burnout Inventory (PBI), which is a 15 item survey on a 7-point Likert scale. The four subscales were first conceptually derived and were upheld through factor analysis procedures. The four subscales of the PBI are negative clientele (e.g., high lethality, psychopathology, resistance, non-compliance), perceived control (e.g., initiative, control over work activities), workplace support (e.g., sharing responsibilities, ability to consult), and overinvolvement (e.g., overly responsible for clients, taking work home). Ackerley and colleagues (1988) found that all four subcomponents of the PBI were related to various subscales of the Maslach Burnout Inventory (MBI; Maslach & Jackson, 1986).

To summarize findings concerning workplace factors and negative therapist outcomes, the work setting has been consistently found to have an impact on burnout for therapists. Specifically, independent practitioners have lower levels of burnout. Factors that have been related to lower levels of burnout include a greater sense of control over their work, less paperwork, less disturbed clients, and a more manageable caseload (e.g., severity of cases and number of clients seen).

Although there have been several studies conducted on workplace factors associated with burnout, there have been no such empirical studies on workplace factors associated with compassion fatigue or compassion satisfaction. There has been recent literature surrounding recommended changes in the workplace for preventing compassion fatigue. However, these recommendations have not been empirically explored. These recommendations will be discussed in the following section.

Recommendations for Therapists and the Workplace

Recommendations in the literature for fostering positive outcomes and mitigating negative effects include the need for mentor and peer support, involvement in diverse activities, and creating health-promoting work environments (e.g., Skovholt, 2001). More extensive research has been conducted on therapist self-care, which could be built in to the workplace to promote positive outcomes for counselors. Proactive strategies recommended for therapist self-care include being able to anticipate emotional distress, maintaining personal awareness, developing a plan of action if problems arise, maintaining a support network, participating in organizational memberships and meetings, and seeking mental health consultation (Morrissette, 2001).

Several additional strategies for mitigating negative effects for therapists have been suggested in the literature. Stamm and Pearce (1995) proposes positive collegial support systems in the workplace to provide “structural and functional social support (Collins & Long, 2003, p.422).” Figley (1989) recommends making time for pleasure, staying involved in professional activities for support, and setting realistic goals and boundaries. Cerney (1995) encourages seeking regular supervision or consultation to process painful client material and personal emotions or cognitions that may be perceived as overwhelming. Other recommendations include seeking social support, journaling, progressive relaxation, physical activity, diet, spiritual strength, involvement in activities of interest, and achieving balance in life (Salston & Figley, 2003). It is recommended to have crisis intervention available and offered continuously on a voluntary basis (Salston & Figley, 2003).

The work environment should create a space of acceptance in which therapists do not feel ashamed for having negative reactions (Sexton, 1999). Additional suggestions for the work environment include “clinical supervision and consultation, case conferences, peer process groups, personal psychotherapy made available without penalty, trauma therapy training,

professional development and regular organizational team meetings (Sexton, 1999, p.399).” The work environment should be an atmosphere of acceptance, and non-judgmental support (Neuman & Gamble, 1995). Collins and Long (2003) also articulate the necessity of a work culture that values and supports its staff. Additionally, these authors proposed self-awareness programs, clinical supervision, and confidential counseling services available.

Munroe et al. (1995) proposed a team treatment model for preventing compassion fatigue. These researchers proposed the formation of treatment teams to meet the psychological needs of staff. Three main tenets underlie the model: (1) the acceptance of the reality of secondary trauma, (2) therapist responses are natural and valuable processes, (3) each team member can be an observer as to how other team members are responding to secondary trauma. They suggest that this community can serve to “absorb the traumatic experience of an individual by diffusing its effects among many people and demonstrating that the survivor’s feelings are understood (p.215).” Teams are recommended to meet at least two and a half hours per week to cover administrative and clinical issues.

Need for the Study

While its existence has been well-documented, most research on compassion fatigue has focused on individual correlates (e.g., gender, years of experience, personal trauma history) rather than characteristics of the organization (Bell, Kulkarni, & Dalton, 2003). Research on the construct of burnout has begun to focus on factors in the workplace associated with burnout (e.g., Ackerley et al., 1988; Rupert & Morgan, 2005), but more research is needed on workplace factors related to compassion fatigue and compassion satisfaction. Numerous studies have recommended interventions to prevent compassion fatigue in the workplace (e.g., Sexton, 1999; Collins and Long (2003), however no empirical data supports these recommendations.

A broader understanding of contextual factors related to compassion fatigue and compassion satisfaction is needed (Salston & Figley, 2003). Measures of control, overinvolvement, negative clientele, workplace support, and amount of exposure will be assessed to determine relationships between compassion fatigue and workplace factors.

As previously stated in this literature review, there exists a gap in the research concerning positive effects of psychotherapeutic work and factors associated with these positive outcomes. The present study attempted to address this gap by including a measure of compassion satisfaction to determine this construct's relationship with workplace factors.

To begin to create a model of workplace factors and compassion fatigue and compassion satisfaction, individual factors need to be accounted for. Individual factors found to relate to compassion fatigue are personal trauma history and years of experience (e.g., Bell, Kulkarni, & Dalton, 2003). Additional individual factors with more mixed findings need to also be accounted for. These individual factors are gender, ethnicity, and trauma training.

This study will contribute to the literature by elucidating the impact of workplace factors as well as individual factors on the psychological outcomes (i.e., compassion fatigue and compassion satisfaction) for therapists working with trauma clients. These results should have important implications for organizations by demonstrating aspects of the workplace, both structural and functional, that can be altered so as to help prevent therapists from developing compassion fatigue and to encourage their experience of compassion satisfaction.

CHAPTER 3 METHODOLOGY

The purpose of this study was to examine the relationships among workplace variables (e.g., control, overinvolvement, negative clientele, workplace support, secondary exposure), individual variables (e.g., gender, ethnicity, personal trauma history, years of clinical experience, trauma training) and levels of compassion fatigue and compassion satisfaction for Professional Counselors, Psychologists, and Social Workers working with traumatized clients and/or clients in crisis. Workplace variables were analyzed to determine if there are any explanatory properties for compassion fatigue and compassion satisfaction, while including the individual variables of therapists' gender, ethnicity, personal trauma history, years of clinical experience, and trauma training experience in the model. The study specifically explored (a) the relationships among levels of control, overinvolvement, negative clientele, workplace support, and amount of secondary exposure and compassion fatigue, (b) the relationships among levels of control, overinvolvement, negative clientele, workplace support, amount of secondary exposure and compassion satisfaction, and (c) changes in variance of compassion fatigue and compassion satisfaction when workplace variables (e.g., control, overinvolvement, negative clientele, workplace support, amount of secondary exposure) are added to individual variables (gender, ethnicity, personal trauma history, years of clinical experience, trauma training).

Levels of compassion fatigue and compassion satisfaction were measured using the Professional Quality of Life Scale (ProQOL; Stamm, 2005; see Appendix A). The Professional Quality of Life Scale consists of 30 questions measured on a 6-point scale intended to measure three core components of therapists' quality of life in their professional work: compassion fatigue, compassion satisfaction, and burnout. Workplace variables were measured using the Psychologist's Burnout inventory (PBI; see Appendix B), which was developed by Ackerley et.

al (1988). The Psychologist's Burnout Inventory is a 29-item scale measured on a 7-point scale intended to assess for the presence of four workplace factors related to burnout: Control, Overinvolvement, Support, and Negative Clientele. A fifth workplace variable, therapists' amount of secondary exposure to traumatized clients, was measured through asking the following question: How many hours per week are spent working directly with clients who have been traumatized? Gender and ethnicity were measured in a demographics section. The individual variable of therapists' personal trauma history was measured by the Stressful Life Experiences—Short Form (Stamm, 1997, see Appendix C). Years of clinical experience was measured through an open question asking how many years the therapist has been doing clinical work including internship and practicum experiences. Finally, trauma training was assessed by a closed question asking if the participant has had any specialized training in working with traumatized populations.

This chapter contains a description of the methodology utilized in the collection and analysis of data in this study. Included are a description of the research design and relevant variables, research hypotheses, population, sample, sampling procedures, instrumentation, data collection procedures, and proposed data analysis procedures.

Research Design and Relevant Variables

A survey design utilizing correlational and comparative methods was used in this study. The dependent variables are compassion fatigue and compassion satisfaction, which were measured by the Professional Quality of Life Scale (Stamm, 2005). The ProQOL scale yields three sub-score scales for each of the three components of professional quality of life: Compassion fatigue, Compassion satisfaction, and Burnout. The Burnout subscale was not used in this study since it is not one of the variables being investigated.

The independent variables in this study include workplace variables of control, overinvolvement, negative clientele and workplace support, which were measured by the Psychologist's Burnout Inventory (PBI; Ackerley et. al, 1988) and amount of secondary exposure, which was measured by asking about the amount of hours per week spent in direct contact with traumatized clients. The other independent variables in this study are the individual variables of gender, ethnicity, personal trauma history, measured by the Stressful Life Experiences—Short Form (Stamm, 1997), years of clinical experience, measured by a question about the number of years working as a therapist, and trauma training, measured by a question about specialized training working with traumatized clients.

Research Hypotheses

The following null hypotheses were tested in this study:

- H1 There is no variance in compassion fatigue explained by workplace variables (i.e., control, overinvolvement, negative clientele, workplace support, and amount of secondary exposure).
- H2 There is no variance in compassion satisfaction explained by workplace variables (i.e., control, overinvolvement, negative clientele, workplace support, and amount of secondary exposure).
- H3 There is no change in variance of compassion fatigue when workplace variables are added to a model including individual variables (i.e., gender, ethnicity, personal trauma history, years of clinical experience, trauma training).
- H4 There is no change in variance of compassion satisfaction when workplace variables are added to a model including individual variables (i.e., gender, ethnicity, personal trauma history, years of clinical experience, trauma training).

The expected directions of the association between higher levels of compassion fatigue and workplace variables based upon prior research was as follows: lower levels of perceived control, higher levels of overinvolvement, higher levels of negative clientele, lower levels of perceived support, and higher levels of secondary exposure are expected. Individual variables were expected to relate to higher levels of compassion fatigue as follows: more personal trauma

history, less years of clinical experience, and no trauma training. The expected direction of the association between higher levels of compassion satisfaction and workplace variables based on prior research was as follows: higher levels of perceived control, lower levels of overinvolvement, lower levels of negative clientele, higher levels of perceived support, and lower levels of secondary exposure are expected. Individual variables were expected to relate to higher levels of compassion satisfaction as follows: less personal trauma history, more years of clinical experience, and having specialized trauma training. The individual variables of gender and ethnicity were exploratory due to mixed findings or lack of exploration in previous literature.

Population and Sample

The population to which participants in the present study were intended to generalize consists of therapists working with clients healing from traumatic experiences. To estimate this population, professionals from the International Society for Traumatic Stress Studies were chosen as the population from which to draw a sample. The International Society for Traumatic Stress (ISTSS) is an international, multi-disciplinary professional organization dedicated to the development and advancement of the field of traumatic stress. The ISTSS was founded in 1985. ISTSS currently has approximately 2,200 members from a variety of disciplines, including psychiatrists, psychologists, social workers, counselors, nurses, researchers, administrators, and clergy.

A secondary sample was obtained from the Association for Traumatic Stress Specialists (ATSS). This sample was included when sampling from the ISTSS did not yield the anticipated number of responses. The ATSS is also an international, multi-disciplinary professional organization focused on providing training, certification, and education for those who provide emotional care to trauma survivors. ATSS was founded in 1987 and currently has 585 members who are actively involved in crisis intervention, emergency, response, or long term treatment of

PTSD. Members come from a variety of disciplines including emergency responders, psychologists, psychiatrists, social workers, counselors, victim assistance staff, and clergy. The main difference between ISTSS and ATSS may be a primary focus on research (ISTSS) versus practice (ATSS).

Sampling Procedure

The participants in this study included a representative sample of Professional Counselors, Psychologists, and Social Workers who were contacted from the ISTSS member registry. In order to obtain a representative sample, a list of potential participants was obtained through using the search engine function of the member registry. The following settings were isolated due to relevance to the desired population: public health facility/non-university; private health/mental health practice; nongovernmental organization; veteran's organization; university non-educator. From the lists of names obtained through this search, all participants with at least a master's degree were selected, excluding medical doctors due to the focus of the current study on the population of trauma counselors, social workers, and psychologists.

To obtain a representative sample from the ATSS population, the ATSS office manager was contacted to explore potential sampling methods. This investigator was not granted access to an e-mail list, however it was agreed that a mass e-mail be sent out to ATSS members inviting them to participate in the study including a summary and purpose of the study.

Of the initial 311 potential participants contacted through the ISTSS, 53 participants were obtained and completed the entire survey, with a response rate of 17%. Eight potential participants partially completed the survey. Only the data from the 53 participants who fully completed the survey were included in the data analyses. Of the 585 ATSS members contacted through a mass e-mail, 68 participants were obtained who completed the entire survey. The response rate for the ATSS sample was 11.62%. Thirteen members who partially completed the

survey were not included in the data analyses. Finally, 23 participants were removed from the sample who indicated that their profession was “other” than Psychologist, Professional Counselor, or Social Worker.

A proposal for this study was submitted to the University of Florida Institutional Review Board (UFIRB). A survey including the instruments selected and a demographic questionnaire was created on a website. The link to the survey as well as a letter of consent requesting participation was e-mailed to selected participants. The survey included (a) the Professional Quality of Life Scale (measures compassion fatigue, compassion satisfaction, and burnout), (b) the Psychologist’s Burnout Inventory (measures workplace factors of control, overinvolvement, negative clientele, and workplace support) and one item about the amount of secondary exposure they experience in their work, (c) the Stressful Life Experiences Screening – Short Form (measures personal trauma history), and (d) a demographics questionnaire, including gender, age, ethnicity, years of clinical experience, and trauma training.

Instrumentation

The instruments that were used in this study include the Professional Quality of Life Scale (ProQOL; Stamm, 2005; see appendix A), the Psychologist’s Burnout Inventory (PBI; Ackerley et. al., 1988; see appendix B), and the Stressful Life Experiences Screening-Short Form (SLES; Stamm, 1997; see appendix C). Each of these instruments are available for public use.

Professional Quality of Life Scale (ProQOL)

The Professional Quality of Life Scale is the revised version of the Compassion Fatigue Self Test (Figley, 1995). The CFST was revised due to psychometric problems and the negative connotation associated with the name of the instrument (Stamm, 2005). The ProQOL is the third revision of the original Compassion Fatigue Test (CSF; Figley, 1996). The revision addressed previous issues of separating the constructs of burnout and vicarious trauma and reducing

participant strain by shortening the scale from 66 to 30 items. Items that met both high item-to-scale criteria and were most theoretically relevant to the subscale construct were retained. The revision was based on over 1000 participants from multiple studies (Stamm, 2005).

The ProQOL is measured on a 5-point Likert-type scale ranging from never (0) to very often (5). There are three subscales: compassion fatigue, compassion satisfaction, and burnout. A sample item from the Compassion Fatigue subscale is, “*I feel as though I am experiencing the trauma of someone I have helped.*” In the Compassion Satisfaction subscale, a sample item is the following: “*I get satisfaction from being able to help people.*” The Burnout subscale consists of items such as, “*I feel connected to others.*” Across all three subscales, five items are reverse-scored.

Scale distributions for each subscale are generally unimodal and symmetric. However, the compassion satisfaction subscale is skewed toward the positive side and the compassion fatigue subscale is skewed toward the side involving little disruption (Stamm, 2005). Alpha reliabilities for each subscale are as follows: Compassion Satisfaction subscale = .87; Burnout alpha = .72; and Compassion Fatigue alpha = .80.

Construct validity has been well-established in over 200 articles in peer-reviewed journals (Stamm, 2005). Convergent validity using the multi-trait multi-method analysis (Campbell & Fiske, 1959) demonstrated that the ProQOL does measure separate constructs. Shared variances between the subscales are generally small. Compassion Satisfaction and Burnout have 5% shared variance. Compassion Satisfaction and Compassion Fatigue have only 2% shared variance. Shared variance among Burnout and Compassion Fatigue is slightly higher at 21%, reflecting the distress common in both conditions (Stamm, 2005).

The ProQOL has been tested on general healthcare workers (including counselors and psychologists), child and family workers, and school personnel. Possible scores range from 0 to 50 for each of the three subscales. The average score for the Compassion Satisfaction subscale is 37. The average score for the Burnout subscale is 23. For the Compassion Fatigue subscale, the average score is 13.

Psychologist's Burnout Inventory (PBI)

The PBI is a 15-item survey on a 7-point Likert scale. This format is identical to that of the Maslach Burnout Inventory (MBI; Maslach & Jackson, 1986). The following four subscales were conceptually derived: control (3 items), workplace support (3 items), types of negative clientele (6 items), and overinvolvement with clients (3 items).

Control refers to the amount of perceived personal control an individual feels they have over their work activities. A sample item is evidenced by the following: *"I have control over what I do and when I do it during the work day."* The Workplace Support subscale measures the amount of perceived support (e.g., emotional, instrumental, and informational) an individual receives from coworkers and/or supervisors. The following is a sample item from the Workplace Support subscale: *"I receive constructive feedback from coworkers or supervisors."* Negative Clientele refers to the severity of client issues as well as difficult client behaviors. For example, *"I work with clients who defensively withdraw and withhold,"* is a sample item. Overinvolvement refers to the professional taking on a disproportionate amount of effort and responsibility in the therapeutic process and being unable to disengage (i.e., taking the work home with them). A sample item is: *"I find myself feeling responsible for my client's well-being."*

To test validity of the scale, principal-component factor analysis was performed with varimax rotation (Ackerley et. al, 1988). Four eigenvalues were obtained greater than 1 (2.69,

1.93, 1.70, and 1.28), which accounted for 18%, 13%, 11%, and 9% of the total variance, respectively. A scree test indicated that all four factors should be retained (Ackerley et. al, 1988).

Stressful Life Experiences Screening-Short Form

The Stressful Life Experiences Screening-Short Form (Stamm, 1997) was designed to identify traumatic stressors as a clinical tool or for research purposes. The SLES-Short Form provides a list of 20 possible traumatic life experiences. The participant is instructed to enter a zero if they did not experience the event or enter a score between 1 (a little like my experience) and 10 (exactly like my experience). A sample item is *“I have witnessed or experienced a serious accident or injury.”* The instrument can also be used on a dichotomous scale in which participants enter 0 if they did not experience the event and 1 if they did experience the event. A total score is calculated whether the scale is used on a 0 to 1 scale or a 0 to 10 scale.

The original SLES (Stamm, 1996) was normed on military physical health care workers (n = 15). After data collection and analysis, the initial items were revised and reduced. The second norm group included mental health care workers (n = 30) and university students (n = 30). Internal consistency was .7 and item-to-scale correlations were generally low (e.g., between .0 and .3). Low item-to-scale correlations and lack of changes in overall alpha reliability of the scale indicate a single overall construct is being measured by the scale (Stamm et. al, 1996).

Data Analysis

There are a total of 12 variables that were investigated in this study: 2 variables measuring compassion fatigue and compassion satisfaction as measured by the ProQOL, 5 variables measuring workplace factors as measured by the PBI and amount of secondary exposure to trauma clients as measured by percentage of time spent with these clients per week, and 5 individual variables measuring gender, ethnicity, personal trauma history as measured by the

SLES, years of clinical experience as measured by years of therapeutic work including during graduate school, and trauma training as measured by whether or not the participant had any specialized training in working with traumatized clients. The relationships among these variables were analyzed using multiple regression/correlation (MRC) analyses.

The first step in data analyses involved obtaining descriptive statistics for the sample. This was done through calculation of means and standard deviations for all continuous variables and frequency distributions for demographic categorical variables. The second step in the analysis was to calculate reliability (Cronbach's alpha) coefficients for the subscales of each instrument used in the study.

The final step in the data analyses was to test the hypotheses presented. The first hypothesis examined the relationships among workplace variables and compassion fatigue. This hypothesis was tested using a multiple regression procedure. For this analysis, compassion fatigue was considered the dependent variable and the workplace variables (e.g., control, overinvolvement, negative clientele, workplace support, and amount of secondary exposure) were considered the independent variables.

The second hypothesis concerned the relationships among workplace variables and compassion satisfaction. This hypothesis was also tested using a multiple regression procedure. In this regression equation, compassion satisfaction was considered the dependent variable and workplace variables (e.g., control, overinvolvement, negative clientele, workplace support, and amount of secondary exposure) were considered the independent variables.

The third hypothesis examined the change in variance of compassion fatigue after workplace variables were added to a model including individual variables. The hypothesis was to be tested using a stepwise multiple regression procedure. In this regression equation,

compassion fatigue was considered the dependent variable and individual variables (e.g., gender, ethnicity, personal trauma history, years of clinical experience, trauma training) were considered the independent variables. Individual variables were to be entered into the stepwise regression procedure, followed by workplace variables (e.g., control, overinvolvement, negative clientele, workplace support, and amount of secondary exposure) to examine change in the variance of compassion fatigue.

The fourth hypothesis examined the change in variance of compassion satisfaction after workplace variables were added to a model including individual variables. The hypothesis was tested using a stepwise multiple regression procedure. In this regression equation, compassion satisfaction was considered the dependent variable and individual variables (e.g., gender, ethnicity, personal trauma history, years of clinical experience, trauma training) were considered the independent variables. Individual variables were entered into the stepwise regression procedure, followed by workplace variables (e.g., control, overinvolvement, negative clientele, workplace support, and amount of secondary exposure) to examine change in the variance of compassion satisfaction.

To test the third and fourth hypotheses, beta coefficients were examined to see if workplace variables significantly improved the variance associated with both compassion fatigue and compassion satisfaction. For all analyses, the Type I error rate was set at 0.05.

CHAPTER 4 RESULTS

Results of the data analyses that were conducted for the current study are described below. First, sample demographics will be described, followed by measurement reliabilities, then Pearson product correlations for each of the variables in the study, and finally the results of regression analyses that were conducted to test each of the four hypotheses concerning the relationships between compassion fatigue and compassion satisfaction with individual (e.g., gender, ethnicity, years of clinical experience, personal trauma history, trauma training) and workplace variables (e.g., amount of secondary exposure, control, overinvolvement, workplace support, negative clientele).

Demographics

The final sample that was used for data analysis consisted of 98 trauma therapists (73 female, 25 male). The sample also was primarily Caucasian, 91.8% (N = 90), followed by Latino, 3.1% (N = 3), Other, 3.1% (N = 3), and African American, 2.0% (N = 2).

Participants were asked to report their profession, which consisted of primarily psychologists, 50.0% (N = 49), followed by social workers, 26.5% (N = 26), and professional counselors, 23.5% (N = 23). Some participants indicated their profession as “other” (N = 23) and these completed surveys were eliminated from the current analyses because the target population for the current study was trauma therapists defined as members of the following professions: Professional Counselor, Social Worker, Psychologist. Participants who indicated that their profession was “other” were assumed to be members of other professions who work with traumatized individuals such as emergency responders, victim advocates, clergy, or school personnel, and were therefore removed from the sample used for data analysis. Additionally, participants reported their primary professional activities as “mostly counseling/therapy and or

other clinical activities,” 77.6% (N = 76), followed by “teaching and/or research activities” 11.2% (N = 11), “supervisory/administrative” 8.2% (N = 8), other 2.0% (N = 2), and “case management,” 1.0% (N = 1). Participants were also asked to report their clinical work environment. Participants reported their work setting as primarily working with other professionals, 66.3% (N = 65) followed by being the only professional in their work environment 33.7% (N = 33).

With respect to the dependent variable of compassion fatigue, participants reported an average score of 11.03 (SD = 6.13). For the dependent variable of compassion satisfaction, participants reported an average score of 40.87 (SD = 5.59).

Descriptive statistics for the individual independent variables are as follows: The average total number of years of clinical experience was 18.53 (SD = 9.09). The variable related to trauma training was not included in further analyses because 99.0% of participants reported having trauma training, with only 1.0% indicating no professional training. The mean score for personal trauma history was 55.09 (SD = 33.19).

Descriptive statistics for workplace independent variables will be described in this section. The average amount of secondary exposure to trauma (measured by amount of time that participants worked with trauma clients per week) was 16.98 (SD = 11.27). Three participants reported a range of hours (e.g., 15-20 hours) as their response to this item. In order to include this data in the analyses, the mean was taken from the range of scores reported by the participant and used in the current analyses. The mean score for perceived control was 3.23 (SD = 2.58). The workplace variable of overinvolvement was 6.98 (SD = 3.47). Participants’ average score for workplace support was 6.63 (SD = 3.57). Finally, participants reported an average score of

18.80 (SD = 6.24) for the workplace variable of negative clientele. Sample demographics related to the independent variables are presented in Tables 4-1 and 4-2.

Measurement Reliabilities

Measurement reliabilities for the Professional Quality of Life Scale (ProQOL; measuring Compassion Satisfaction and Compassion Fatigue), the Psychologist's Burnout Inventory (PBI; measuring Control, Workplace Support, Types of Negative Clientele, and Overinvolvement), and Stressful Life Experiences Scale (SLES; measuring Personal Trauma History) appear in Table 4-3. Chronbach's coefficient alpha for the ProQol Compassion Satisfaction subscale = .87 and Compassion Fatigue subscale alpha = .82. This finding is comparable to previous reports by Stamm, (2005) (.87 and .80, respectively).

Reliability for the PBI, Psychologist's Burnout Inventory, indicated an alpha level of .68 for the Control subscale, .55 for the Workplace Support subscale, .79 for the Types of Negative Clientele subscale, and .64 for the Overinvolvement (see Table 3). The alpha level for the overall PBI was .63. There have been no previous reliability analyses conducted on the PBI so there is no existing psychometric information upon which to compare these values. Due to the weaker nature of the alpha levels on the Control, Workplace Support, and Overinvolvement subscales, attempts were made to improve the internal reliability by removing poorly inter-related items. However, the removal of any single poorly performing item failed to increase the alpha level significantly. Therefore, the subscales were not modified and were used in their published form for the current analyses.

Reliability analyses for the Stressful Life Experiences Scale (SLES; Stamm, 1996) revealed a Chronbach's coefficient alpha of .82 for the overall score on the SLES. This reliability coefficient is comparable to that found by Stamm (.70). Results of the reliability analyses are found in Table 4-3.

Correlational Analyses

Pearson Product Moment correlations, using a criterion level of .05 (1-tailed), were computed between the two dependent variables (i.e., compassion satisfaction and compassion fatigue) and each of the independent variables related to individual (i.e., gender, ethnicity, years of clinical experience, personal trauma history, trauma training) and workplace factors (i.e., secondary exposure, control, overinvolvement, workplace support, negative clientele) in an attempt to confirm that significant relationships existed among study variables and to determine independent variables to include in the regression analyses.

Compassion fatigue was significantly positively correlated with the workplace variables, control ($r = 0.34, P \leq .001$) and overinvolvement ($r = 0.26, P \leq .010$), and these relationships were in the expected directions. That is, lower reported levels of control and higher levels of overinvolvement were related to higher levels of compassion fatigue. Compassion fatigue was also significantly positively correlated with amount of secondary exposure ($r = 0.37, P \leq .001$). Higher levels of secondary exposure to trauma were also related to higher levels of compassion fatigue. There was no significant correlation between compassion fatigue and other workplace variables: Types of negative clientele, workplace support, personal trauma history, or the individual variables related to years of clinical experience, gender, or ethnicity. Thus, these variables were not included in the subsequent regression equation. See Table 4-4 for a correlation matrix of the independent and dependent variables examined in the current study.

Compassion satisfaction was significantly negatively correlated with the workplace variables, control ($r = -0.47, P \leq .001$) and overinvolvement ($r = -0.25, P \leq .013$). That is, higher reported levels of control and lower levels of overinvolvement were related to higher levels of compassion satisfaction. Compassion satisfaction was also positively correlated with

personal trauma history as measured by the SLES ($r = .24, P \leq .016$) and participants' reported years of clinical experience ($r = .22, P \leq .027$). Personal trauma history was not related to compassion satisfaction in the expected direction. It was expected that lower levels of personal trauma history would be associated with higher levels of compassion satisfaction. However, it was found that higher levels of personal trauma history were associated with higher levels of compassion satisfaction. Compassion satisfaction was not significantly correlated with the workplace variables related to types of negative clientele, workplace support, amount of secondary exposure, or the individual variables of gender or ethnicity. Thus, these variables were not included in the subsequent regression equation. Also, examination of the correlation matrix revealed that the independent variables were correlated with each other at less than .50, suggesting a minimal risk of multicollinearity and associated Type I error. See Table 4-4 for a correlation matrix of the independent and dependent variables examined in this study.

Regression Analyses

Tests of skewness and kurtosis were conducted on the data to assess that it was in line with the normality assumptions of multiple regression. Results of these analyses indicate that the assumptions for multivariate normality were met. All skewness and kurtosis estimates for the variables fell within the generally accepted values of 2 and -2.

Gender and ethnicity were not included in the regression analyses because there were too few participants (e.g., less than 25) in the different gender and ethnic groups to support their inclusion as individual variables with meaningful contributions. This decision was based on the statistical assumption of attempting to balance the complexity of investigation while maintaining meaningful and comprehensible results (e.g., fewer predictors with more meaningful results and

lower risk of experimenter-wise errors). Thus, the removal of these variables served to increase power and reduce the probability of Type II errors (Cohen & Cohen, 1983).

Hypothesis 1: Relationships among workplace variables and compassion fatigue

The first hypothesis concerned the relationship between workplace variables (e.g., control, overinvolvement, and amount of secondary exposure) and compassion fatigue. It was expected that therapists with less perceived control over their work activities, more overinvolvement with their clients, and greater amount of secondary exposure would have higher levels of compassion fatigue. In order to test the first hypothesis, a multiple linear regression analysis was conducted to determine whether therapist workplace variables were significantly related to compassion fatigue.

The scores reported by participants on the Control and Overinvolvement subscales accounted for significant variation in compassion fatigue scores, $F(3, 91) = 12.17, p < .001$ (*adjusted* $R^2 = .263$). The standardized beta coefficient for the Control subscale ($\beta = 0.244$) was in the positive direction and was significant, $t(91) = 2.64, p < .010$. The standardized beta coefficient for the Overinvolvement subscale ($\beta = 0.241$) was significant and in the positive direction, $t(91) = 2.59, p < .011$. Lastly, the standardized beta coefficient for amount of secondary exposure ($\beta = .386$) was significant and in the positive direction, $t(91) = 4.29, p < .001$. The direction of calculated effects indicated that the less a therapist endorsed a sense of control over their workplace, more overinvolvement with clients, and more secondary exposure, the more likely that the therapist was to have higher self-reported levels of compassion fatigue. This finding supported the hypothesis that the workplace variables, control, overinvolvement, and amount of secondary exposure are related to higher levels of compassion fatigue in therapists. This significant finding was represented by a large effect size, accounting for approximately 26% of the variance in compassion fatigue.

Hypothesis 2: Relationships among workplace variables and compassion satisfaction

According to the second hypothesis, workplace variables (e.g., control and overinvolvement) would be related to compassion satisfaction. It was anticipated that therapists with greater perceived control over their work activities and less overinvolvement with their clients would have higher levels of compassion satisfaction. Thus, to test the second hypothesis, a multiple linear regression analysis was conducted to determine if therapist workplace variables were significantly related to compassion satisfaction.

The scores reported by participants on the Control and Overinvolvement subscales accounted for significant variation in compassion satisfaction scores, $F(4, 93) = 9.92, p < .001$ (*adjusted R*² = .269), as well. The standardized beta coefficient for the Control subscale ($\beta = -0.414$) was in the negative direction and was significant, $t(93) = -4.58, p < .001$. The standardized beta coefficient for the Overinvolvement subscale ($\beta = -0.122$) was also in the negative direction but was not significant, $t(93) = -1.33, p < NS$. The direction of calculated effects indicated that the more a therapist endorsed a sense of control over their workplace, the more likely the therapist was to have higher ratings of compassion satisfaction. This finding supported the hypothesis that the workplace variable of control is related to higher levels of compassion satisfaction in therapists, with the substantial effect size of approximately 27% of the variance accounted for.

Hypothesis 3: Relationships among individual and workplace variables and compassion fatigue

The third hypothesis addressing changes in variance of compassion fatigue after workplace and individual variables were added to the model was not conducted because no significant correlations were found between compassion fatigue and the individual variables (e.g., personal trauma history, years of clinical experience).

Hypothesis 4: Relationships among individual and workplace variables and compassion satisfaction

The fourth and final analysis was designed to test the hypothesis that workplace variables and individual variables were significantly related to therapists' compassion satisfaction. More specifically, the individual variables (e.g., personal trauma history and years of clinical experience) were entered into the stepwise regression procedure, followed by workplace variables (e.g., control and overinvolvement) to examine the change in the variance of compassion satisfaction. Thus a stepwise linear regression analysis was conducted to determine whether the independent variables (e.g., individual followed by workplace variables) influenced therapist ratings of the dependent variable (e.g., compassion satisfaction).

Stepwise multiple regression was utilized to investigate whether individual and workplace variables were related to therapist reported compassion satisfaction. The decision rule was established that a variable must account for a change in R^2 of 2% or more and must be significant at the $p < .05$ level to be included in the final regression equation. Individual variables in the initial regression equation included personal trauma history, years of experience, control and overinvolvement. The final equation for compassion satisfaction contained only three variables, personal trauma history, years of clinical experiences, and the control subscale, and yielded a multiple R of .54 ($F = 12.54, p = .001$) accounting for approximately 26% of the total variance in compassion satisfaction scores. The standardized beta coefficient for the individual variable, personal trauma history ($\beta = 0.198$) was in the positive direction and was significant, $t(94) = 2.22, p < .029$. The standardized beta coefficient for the individual variable, participants' reported years of clinical experience ($\beta = 0.133$) was in the positive direction but was not significant, $t(94) = 1.48, p < NS$. The standardized beta coefficient for the Control subscale ($\beta = -0.445$) was in the negative direction and was significant, $t(118) = -5.08, p < .001$.

Summary

Statistical evidence from correlational analyses indicated significant relationships between compassion fatigue and workplace variables of control, overinvolvement, and amount of secondary exposure. Compassion satisfaction was positively related to workplace factors (i.e., control and overinvolvement) and individual variables (i.e., personal trauma history and years of clinical experience). All significant correlations were in the expected directions except for the correlation between personal trauma history and compassion satisfaction, which was correlated in the opposite direction as was expected (e.g., higher levels of personal trauma history were associated with higher levels of compassion satisfaction).

Three regression analyses were conducted to test three of the four hypotheses (i.e., Hypotheses 1, 2, and 4) concerning the relationships between individual and workplace variables and the dependent measures of compassion fatigue and compassion satisfaction. Statistical evidence from regression analyses to test Hypothesis 1 (i.e., *There is no variance in compassion fatigue explained by workplace variables*) indicated that therapists with less of a sense of control over their workplace, more overinvolvement with their clients, and more secondary exposure to client's trauma had higher levels of compassion fatigue, accounting for approximately 26% of the variance. Results from the regression analyses conducted to test Hypothesis 2 (i.e., *There is no variance in compassion satisfaction explained by workplace variables*) indicated that therapists who endorsed more of a sense of control had higher ratings for compassion satisfaction, accounting for approximately 27% of the variance.

Analyses were not conducted to test Hypothesis 3 (i.e., *There is no change in variance of compassion fatigue when workplace variables are added to a model including individual variables*) because correlations among compassion fatigue and individual variables were not significant. Hypothesis 4 (i.e., *There is no change in variance of compassion satisfaction when*

workplace variables are added to a model including individual variables) involved a stepwise regression with results indicating that therapists with more of a sense of control over their work environment, higher reported years of clinical work experience, and more personal trauma in their history had higher ratings of compassion satisfaction. The final equation accounted for approximately 26% of the variance in compassion satisfaction.

Table 4-1. Descriptive Statistics for Categorical Individual Variables

Variable	Frequency (f)	Percentage (%)
Gender		
Male	25	25.5
Female	73	74.5
Ethnicity		
African American	2	2.0
Caucasian	90	91.8
Latino	3	3.1
Other	3	3.1
Specialized Trauma Training		
Yes	97	99.0
No	1	1.0

Table 4-2. Descriptive Statistics for Continuous Individual and Workplace Variables

Independent Variable	N	Mean	SD
Individual Variables			
Years of Clinical Experience	98	18.53	9.09
Personal Trauma History	98	55.09	33.19
Workplace Variables			
Secondary Exposure	95	16.98	11.27
Control	98	3.23	2.58
Overinvolvement	98	6.98	3.47
Workplace Support	98	6.63	3.57
Negative Clientele	98	18.80	6.24

Table 4-3. Measurement Reliabilities for ProQOL, PBI, and SLES

Scale	N	Minimum	Maximum	Mean	SD
ProQOL					
Comp Fatigue	98	1	36	11.03	6.13
Comp Satisfaction	98	21	50	40.87	5.59
PBI					
Neg Clientele	98	3	33	18.80	6.24
Support	98	0	17	6.63	3.57
Overinvolvement	98	0	15	6.98	3.47
Control	98	0	11	3.23	2.58
SLES					
SLES Total	98	0	180	55.09	33.19

Note. ProQOL = Professional Quality of Life Scale; Comp Fatigue = Compassion Fatigue; Comp Satisfaction = Compassion satisfaction; PBI = Psychologists Burnout Inventory; Neg Clientele = Negative Clientele; SLES = Stressful Life Experiences Scale.

Table 4-4. Pearson Product Moment Correlations between Independent and Dependent Variables

Variables	1	2	3	4	5	6	7	8	9
1. CompSat	—								
2. CompFat	-.169	—							
3. SecondExp	.086	.371*	—						
4. Years	.223*	-.107	-.022	—					
5. TraumaHx	.243*	.152	.149	.213*	—				
6. NegClient	-.082	.118	.320**	-.165	.015	—			
7. Support	-.162	-.058	-.166	.027	-.021	-.328**	—		
8. OverInvol	-.250*	.258*	-.134	-.175	.019	.383**	-.179	—	
9. Control	-.467**	.338**	.073	-.108	-.037	.100	-.006	.271**	—

Note. CompSat = Compassion Satisfaction; CompFat = Compassion Fatigue; SecondExp = Amount of Secondary Exposure; Years = Years of Clinical Experience; TraumaHx = Personal Trauma History; NegClient = Negative Clientele; Support = Workplace Support; OverInvol = Overinvolvement.

*p < .05

**p < .01

CHAPTER 5 DISCUSSION

Overview of the Study

The purpose of this study was to examine the relationships among workplace variables (e.g., control, overinvolvement, negative clientele, workplace support, amount of secondary exposure), individual variables (e.g., gender, ethnicity, personal trauma history, years of clinical experience, trauma training) and levels of compassion fatigue and compassion satisfaction for Professional Counselors, Psychologists, and Social Workers working with traumatized clients.

The study specifically addressed (a) the relationships among levels of control, overinvolvement, negative clientele, workplace support, amount of secondary exposure and compassion fatigue; (b) the relationships among levels of control, overinvolvement, negative clientele, workplace support, amount of secondary exposure and compassion satisfaction, and (c) changes in variance for compassion fatigue and compassion satisfaction when workplace variables (e.g., control, overinvolvement, negative clientele, workplace support, amount of secondary exposure) were added to a model including individual variables (e.g., gender, ethnicity, personal trauma history, years of clinical experience, trauma training).

Discussion of Descriptive Statistics

The target population for this study consisted of Psychologists, Professional Counselors, and Social Workers who work with trauma survivors in a clinical environment. Obtaining a sample of therapists from among the members of the International Society of Traumatic Stress Studies (ISTSS) and Association for Traumatic Stress Specialists (ATSS) was identified by the primary investigator as an appropriate method for gaining a representative sample from the desired population. Members were invited to participate through e-mail invitation which described the study and included a link to complete the survey. The survey included (a) the

Professional Quality of Life Scale (Stamm, 2005) (b) the Psychologist's Burnout Inventory (Ackerley et. al., 1988), (c) the Stressful Life Experiences Screening – Short Form (Stamm, 1997), and (d) a demographics questionnaire, including gender, age, ethnicity, years of clinical experience, amount of secondary exposure (i.e., as measured by weekly hours of client contact with trauma survivors), and trauma training, as well as several questions to assess whether those who completed the survey accurately estimated the population. A non-experimental, correlational design was utilized to test the research hypotheses, which were stated in the null form and tested at the .05 level of significance.

The participant sample consisted of 98 therapists, who were primarily female (74.5%) and Caucasian (91.8%). This high percentage of female Caucasians in a sample of therapists is similar to samples in other studies (e.g., Kassam-Adams, 1995; Pearlman & MacJan, 1995; Schauben & Frazier, 1995) indicating that this may be a somewhat accurate representation of the population with respect to gender and ethnicity. However, the skewed percentage of Caucasian females in the sample may indicate that members of this gender and ethnic group may be more likely to respond to surveys and/or to be members of professional organizations such as ISTSS and ATSS. It is also possible that the overrepresentation of females is a function of gender norms for expression of emotions and emotional vulnerability. Traditional gender norms dictate that it is more socially acceptable for women to express emotions and admit emotional vulnerability than it is for men. Therefore, females may have been more likely to acknowledge that they may be negatively impacted by trauma work and more open to disclosing this in the survey for the present study. The lack of participation of males in this study may have impacted results and the ability to accurately detect gender effects. Since there was a lack of diversity

within the sample, ethnicity and gender were not able to be used as individual independent variables in this study.

Several items were included in the demographics questionnaire to ensure a representative sample of the desired population. First, participants were asked how they identify their profession (e.g., Psychologist, Professional Counselor, Social Worker, or Other). The final sample consisted primarily of Psychologists (50.0%), followed by Social Workers (26.5%), and Professional Counselors (23.5%). Approximately 19% of those who initially completed the survey indicated “Other” as best describing their profession. Respondents indicating “Other” were deleted in order to accurately represent the target population.

Second, participants were asked to report their primary professional activity (e.g., Counseling/Therapy, Teaching/Research, Supervisory/Administrative, Case Management, and Other). The aim was to survey clinicians who were actively engaged in clinical activities. The majority of participants in the sample identified their primary professional activity as counseling or therapy (77.6%). This percentage was judged by the primary investigator to be sufficient in estimating the target population for the following reasons: (1) the vast majority of the sample was primarily engaged in clinical activities (77.6%) and (2) the other 22.4% were assumed to be either previously engaged in clinical work or engaged in part-time clinical work. The assumption that most of the sample was at least engaged in some type of clinical work was based on examination of the number of reported hours of clinical contact with clients, in which all but 2 participants indicating some weekly clinical contact with traumatized clients. Finally, participants primarily indicated that they worked with other professionals (66.3%) rather than alone (33.7%).

The mean score for the workplace variable of perceived control was 3.23 (SD = 2.58). This score was comparable to previous studies (e.g., M = 2.59; Ackerley et. al., 1988). The workplace variable of overinvolvement was a mean score of 6.98 (SD = 3.47), which is somewhat lower than scores found in prior studies (e.g., M = 9.52; Ackerley et. al., 1988). Participants' average score for workplace support was 6.63 (SD = 3.57), which is also comparable to prior studies (e.g., M = 5.02 and M = 7.28; Ackerley et. al., 1988). Finally, participants reported a mean score of 18.80 (SD = 6.24) for the workplace variable of negative clientele, which is slightly lower than mean scores found in previous research (e.g., M = 23.76; Ackerley et. al., 1988). Thus, overall mean scores for the workplace variables as measured by the Psychologist's Burnout Inventory in the current study are comparable to scores found by Ackerley and colleagues (1988).

Amount of secondary exposure, the average amount of time that participants worked with trauma clients per week, was 16.98 hours (standard deviation = 11.27). The array of responses for this item was from 0 to 50 hours, which represents a wide variety in the amount of secondary exposure among participants. This variety of responses indicates that participants in this study ranged from no clinical interactions with trauma clients (N = 2) to full-time clinical contact, with the average respondent being more of a part-time clinician. These more part-time clinicians may have been also involved in other workplace activities in addition to client contact (e.g., supervisory, paperwork). Since all but 2 participants were actively engaged in direct clinical work with traumatized clients, this researcher determined that the sample accurately reflected the desired population with respect to clinical involvement. Therapists reported an average of approximately 18 years of experience (standard deviation = 9.09), with a range from 1 to 36

years. This wide range of clinician's experience among the participants indicates that the sample included novice to senior clinicians.

The average total score for personal trauma history, as measured by the SLES (Stamm, 1997), was 55.09 (SD = 33.19). The total score possible for the SLES-Short Form is 200, which would indicate that the participant experienced all 20 trauma experiences (i.e., a score of 10 for each item meaning "exactly like my experience"). Thus, the therapists who participated in this survey had some trauma experiences, but not substantially high amounts of trauma experiences. The individual variable of trauma training was not able to be used in further analyses because 99% of participants indicated they had some type of trauma training. This finding further demonstrates that the sample for the present study consists primarily of specially trained trauma therapists, whereas the entire population of trauma therapists may include more therapists who are not specially trained.

For the dependent measure of compassion fatigue, therapists in the current study reported an average score of 11.03 (SD = 6.13). The mean score found for compassion fatigue in this study is comparable to normative data provided by Stamm (2005), in which the mean score for compassion fatigue was 13 (SD = 6.3). According to categories of risk levels devised by Conrad and Kellar-Guenther (2006), this compassion fatigue score was considered to be very low risk. In Conrad and Kellar-Guenther's (2006) study, more than 50% of child protection workers who were studied fell into the high risk category (i.e., total score of 51 to 75). Thus, the population of child protection workers was found to be more high risk for negative outcomes than participants in the current study. Other researchers have found more varying levels of compassion fatigue (e.g., $M = 28.78$, $SD = 13.15$; Stamm, 2002). In the current study, trauma therapists were studied as identified through their participation in a trauma-specific professional organization. It

is possible that members of these organizations fare slightly better due to their high motivation and vested interest in the field as evidenced by their participation in the organization. In future studies, efforts should be made to access a different sample to estimate the population or to control for these potentially related factors (e.g., motivation level, interest in the field).

For the dependent variable of compassion satisfaction, participants reported an average score of 40.87 (SD = 5.59). According to Stamm's (2005) normative data for compassion satisfaction, the average score in this study is similar to that found in the normative data ($M = 37$, $SD = 7.3$). According to Conrad and Kellar-Guenther's (2006) rating system for compassion satisfaction, this level was considered to be low potential (i.e., a range from 0 to 63). Approximately 50% of child protection workers in their study were placed in the category of "good potential" for compassion satisfaction. This higher average level of compassion satisfaction is similar to another study that utilized data from South African professionals trained in crisis de-briefing, mental health caregivers, and Canadian rape crisis workers (i.e., $M = 92.10$, $SD = 16.04$; as analyzed by Stamm, 2002). Thus, respondents in the current study seemed to have slightly lower levels of compassion satisfaction as well.

Discussion of Correlational Relationships among Variables

Several significant correlational relationships were found among study variables. First, higher levels of the dependent variable of compassion fatigue were found to be related in the following directions to the following independent variables: less perceived control over the workplace, more overinvolvement with clients, and more secondary exposure to traumatized clients. All correlations found for compassion fatigue were consistent with the expected directions of the relationships based on prior research.

Second, higher levels of the dependent variable of compassion satisfaction were found to be associated in the following directions to the following independent variables: more perceived

control over the work environment, less overinvolvement with clients, more years of clinical experience, and greater amount of personal trauma experiences. Findings that more compassion satisfaction was related to more perceived control, less overinvolvement, and more years of clinical experience were consistent with the expected directions of the relationships. However, the association between compassion satisfaction and personal trauma history was counter to the anticipated direction of the relationship.

For both compassion fatigue and compassion satisfaction, perceived control was found to be an important factor. Therapists who perceived that they had the ability to use their own initiative at work, were able to structure their work day, and meet their own work expectations had both lower levels of compassion fatigue and higher levels of compassion satisfaction. Compassion fatigue was also associated with more secondary exposure, operationally defined as the amount of weekly client contact hours. Specifically, therapists who saw more clients had higher levels of compassion fatigue. Compassion fatigue was also related to overinvolvement, with therapists who reported that they take their work home, take on excessive responsibility for their clients, and feel they work harder for change than their clients having higher levels of compassion fatigue.

Compassion satisfaction was also related to overinvolvement, but in the opposite direction as compassion fatigue. In addition to perceived control, compassion satisfaction was related to the individual factor of years of clinical experience. Therapists with more years of experience were associated with higher levels of compassion satisfaction. The expected direction of the relationship between the dependent variables and years of clinical experience was as follows: more experience would be associated with lower levels of compassion fatigue and higher levels of compassion satisfaction. Prior research measuring years of clinical experience and negative

therapist outcomes (e.g., burnout, vicarious traumatization, compassion fatigue) indicated mixed findings, with some studies detecting a significant positive relationship (e.g., Ackerely et. al., 1988; Pearlman & MacIan, 1995), and some studies detecting no relationship (e.g., Kassam-Adams, 1999). No prior studies have focused on years of clinical experience and compassion satisfaction or other positive therapist outcomes.

It was expected that therapists with more personal trauma history would have lower levels of compassion satisfaction. Research findings have indicated a consistent relationship between higher levels of personal trauma and higher levels of compassion fatigue (e.g., Pearlman & MacIan, 1995; Kassam-Adams, 1995). The positive relationship found between compassion fatigue and personal trauma history suggests that, for this group of trauma therapists, those who have experienced significant traumas in their life may find trauma work with clients particularly satisfying and rewarding.

This finding also indicates an indirect relationship between compassion fatigue and compassion satisfaction, rather than a direct inverse relationship as was originally proposed by Stamm (2002). In previous studies, higher levels of personal trauma history were shown to be associated with higher levels of compassion fatigue, whereas the present study found higher levels of personal trauma history to also be associated with higher levels of compassion satisfaction. If the relationship between compassion fatigue and compassion satisfaction were direct and inverse, it would be expected that the relationship between personal trauma history and compassion satisfaction would be negative (i.e., in the opposite direction as was found). An indirect relationship between compassion fatigue and compassion satisfaction has been alluded to in recent studies (Conrad & Kellar-Guenther, 2006), whereas the original construct of compassion satisfaction was developed to be a positive parallel to the construct of compassion

fatigue (Stamm, 2002). In the current study, personal trauma history was uniquely related to compassion satisfaction, but was not a relevant factor for compassion fatigue. It is possible that depending upon how therapists uniquely respond to and process their personal trauma experience, they may either have compassion satisfaction or compassion fatigue. Therapists in the current study may have more effectively coped with and/or processed their personal trauma and thus had more positive outcomes (i.e., compassion satisfaction) than negative outcomes (i.e., compassion fatigue).

Previous researchers (e.g., Conrad & Kellar-Guenther, 2006) have found that compassion satisfaction may have a moderating effect, with compassion satisfaction being associated with lower levels of compassion fatigue. Although the current researcher did not find a correlational relationship between compassion fatigue and compassion satisfaction, findings indicate that the workplace variables of perceived control and overinvolvement are conversely related to each of the dependent variables. Because the current study is correlational, it is unable to be determined whether certain levels of overinvolvement and control cause compassion fatigue or compassion satisfaction or whether the two dependent variables cause therapists to have less or more perceived control and more or less overinvolvement. Findings in the current study indicate that the relationship between compassion fatigue and compassion satisfaction may be mediated by the workplace variables of control and overinvolvement.

Discussion of Hypotheses

Relationships among Control, Overinvolvement, Negative Clientele, Workplace Support, amount of Secondary Exposure, and Compassion Fatigue

The first hypothesis was a null statement about the relationships between the workplace variables of control, overinvolvement, and amount of secondary exposure and compassion fatigue. Examination of the results of the data analysis conducted revealed that therapists with

less perceived control over their work activities, more overinvolvement with clients, and a higher amount of secondary exposure reported higher levels of compassion fatigue. Thus, the null hypothesis was rejected. Workplace variables related to control, overinvolvement and amount of secondary exposure accounted for a substantial amount of variance in compassion fatigue. Therefore, there is a strong association among the workplace factors of perceived control, overinvolvement with clients and amount of exposure to client's trauma material with therapists' experience of compassion fatigue.

The relationship between amount of secondary exposure and compassion fatigue found in this study is consistent with Lee's (1995) findings for the relationship between secondary exposure and vicarious traumatization. Several other studies have reported an association between therapists' amount of secondary exposure (i.e., operationalized as higher trauma clients on their caseloads) and their levels of compassion fatigue (Brady et. al, 1999; Chrestman, 1999; Schauban & Frazier, 1995). The workplace variables of control and overinvolvement are consistent with studies about the relationship between workplace variables and burnout (Ackerley et. al, 1988). Ackerley et. al (1988) found that lack of control in the workplace and overcommitment to clients was associated with more burnout. In a more recent study, Rupert and Morgan (2005) found that solo and group private practitioners had less burnout related to more control in the workplace. These previous research findings involving control, overinvolvement, and secondary exposure are related to the findings for compassion fatigue in the present study due to a focus on negative psychological outcomes for therapists. Although these constructs differ in some respects (e.g., speed of onset, length of recovery, specific symptomology), all are negative psychological outcomes for therapists.

The remaining workplace variables related to negative clientele and workplace support were not included in the regression analysis because no significant correlational relationships were found between these variables and compassion fatigue. Studies examining workplace support, social support, and other negative outcomes for therapists working with traumatized clients (e.g., vicarious traumatization and burnout) have often found an inverse relationship between these negative outcomes and support (Etzion, 1984; Pearlman & MacJan, 1995). However, a study by Landry (2001) did not find a relationship between compassion fatigue and social support. These researchers utilized different scales to measure support and perhaps different operational definitions of social support. Further investigation into how social support mitigates compassion fatigue is needed, using clearly defined constructs and psychometrically strong scales to measure workplace and other forms of social support.

In the current study, the researcher did not find any association between negative client behaviors and compassion fatigue, which indicates that the variable of negative clientele (e.g., client behaviors/conditions such as high lethality, major psychopathology, resistance in therapy, and non-compliance with aspects of therapeutic treatment) may not be related to the experience of compassion fatigue. However, Rupert and Morgan (2005) found that working with less negative or disturbed clientele was associated with lower levels of burnout for psychologists who worked independently and in group private practice. The lack of findings for a relationship between negative clientele and compassion fatigue may be due to the different experience and onset of burnout versus compassion fatigue. Burnout tends to have a more gradual and insidious onset than compassion fatigue, which is a more acute trauma response triggered by clients' traumatic material (Figley, 1995). Thus, negative client behaviors, as measured by the

Psychologist's Burnout Inventory (e.g., making suicidal statements, being late for appointments), may not have any association with the experience of compassion fatigue as compared to burnout.

In discussing prior research associated with other negative therapist outcomes (e.g., burnout), it should be noted that these studies were not focused on trauma therapists, whereas the present study was specific to therapists working with a significant amount of traumatized clients. This difference in specific populations may account for some disparity in findings between some prior research and the findings in the current study.

Relationships among Control, Overinvolvement, Negative Clientele, Workplace Support, amount of Secondary Exposure, and Compassion Satisfaction

The second hypothesis was a null statement about the relationships between workplace variables (e.g., control and overinvolvement) and compassion satisfaction. Therapists with greater perceived control over their work activities and less overinvolvement with clients were found to have higher levels of compassion satisfaction. Thus, for the second hypothesis, the null hypothesis was rejected. However, regression analyses indicated that overinvolvement was not significantly related to compassion satisfaction, whereas control was significantly related.

The relationship between control and compassion satisfaction found in this study is consistent with previous research and theoretical propositions about the correlates of positive psychological outcomes for therapists. For example, one qualitative analysis by Schauben and Frazier (1995) revealed that a majority of therapists felt their work is important. Therefore, it follows that therapists who perceive high levels of control over their work activities and responsibilities may feel better about the importance of that work. Stamm (2002) proposed that positive collegial support should combat a decreased sense of competency and control. Thus, the finding of a positive relationship between control and compassion satisfaction, which is related to a sense of competency, is consistent with Stamm's (2002) assertion. Although the finding of a

relationship between control and compassion satisfaction was consistent with Stamm (2002), the finding that support was not related to compassion satisfaction was inconsistent with Stamm (2002).

In the current study, significant relationships between negative clientele, workplace support, and amount of secondary exposure were not found. Findings of this study are inconsistent with assertions of other researchers that social support and positive collegial support are associated with compassion satisfaction (Stamm, 2002). With respect to negative clientele and amount of secondary exposure, there does not appear to be a relationship between these factors and compassion satisfaction. However, negative clientele and secondary exposure have been shown to be associated with negative reactions for therapists (e.g., compassion fatigue, burnout), to which compassion satisfaction was constructed to be a positive parallel. The difference between factors that have been associated with compassion fatigue and those associated with compassion satisfaction further indicates that the relationship among these two factors (i.e., compassion fatigue and compassion satisfaction) is not a direct and/or inverse one and may be more complex with, as yet undetermined, mediating and or moderating factors.

Also, as mentioned previously, many prior studies related to workplace variables and negative therapist outcomes were focused on general therapists rather than trauma therapists. This difference in specific populations may account for some inconsistencies between significant findings of relationships between some of the workplace variables and compassion fatigue and compassion satisfaction. Since the current study was focused on compassion fatigue and compassion satisfaction, which are trauma specific, the population of therapists who work with trauma survivors was targeted.

Relationships among Individual and Workplace Variables and Compassion Fatigue

The third hypothesis was a null statement about changes in variance for compassion fatigue after workplace variables were added to a model including individual variables. A stepwise regression was to be used to test this hypothesis; however initial correlational analyses revealed no significant relationships between compassion fatigue and any individual variables (e.g., gender, ethnicity, trauma training, personal trauma history, years of clinical experience).

The results from the initial correlational analyses of the relationships between compassion fatigue and individual variables are inconsistent with some research concerning related factors of negative psychological outcomes for trauma therapists. First, personal trauma history has been frequently found to be positively associated with negative therapist outcomes. Vicarious traumatization and compassion fatigue have been shown to be associated with more personal trauma history (Pearlman & MacIain, 1995; Kassam-Adams, 1995). However, one study did not find a relationship between compassion fatigue and personal trauma history (Schauben & Frazier, 1995). Schauben and Frazier (1995) concluded that future studies could be improved by including a scale to measure personal trauma history rather than a dichotomous variable (i.e., whether they have experienced personal trauma or not). The use of a scale to measure the extent to which a therapist had encountered trauma in their own life was used in the present study based on the suggestion of Schauben and Frazier. The lack of variance in responses (i.e., the majority of respondents indicated low levels or no trauma in their history) found in this study related to personal trauma experiences may have contributed to the lack of detection of a significant relationship. These results also may indicate that when using a valid scale to measure personal trauma history as a continuous variable, no relationship exists between personal trauma history and compassion fatigue. Thus, previous detection of a relationship between personal trauma history and compassion fatigue may have been due to measuring personal trauma as a

dichotomous variable (e.g., related to confusion about the definition of trauma, inaccurate measurement of personal trauma).

It is unknown whether therapists in this study have “worked through” or processed their traumatic experiences as well as the subjective severity of their trauma experiences, which may have accounted for the lack of findings of a relationship between personal trauma history and compassion fatigue. Specifically, if therapists effectively processed their personal trauma, they may not be as high risk for developing compassion fatigue. Also, it is unknown whether participants experienced the events indicated on the Stressful Life Events Scale – Short Form (Stamm, 1997) as traumatic, which can be subjective. Future researchers should attempt to account for these potentially related factors (e.g., processing of trauma, subjective severity of the trauma).

In the current study, a predominately female and Caucasian sample was obtained. The relationship between gender and ethnicity and compassion fatigue was not examined because of the lack of diversity with respect to gender and ethnicity in the sample. Previous research examining gender and compassion fatigue as well as other negative outcomes (e.g., burnout and vicarious traumatization) has revealed mixed findings. Specifically, some researchers found a significant relationship (e.g., Etzion, 1984; Kassam-Adams, 1995; Meyers & Cornille, 2002), whereas others did not (e.g., Wee & Myers, 2002). No studies to date have indicated ethnicity as a related factor of compassion fatigue, most likely due to lack of ethnic diversity in samples of previous research. Future studies should use specific methods (e.g., quota sampling) to obtain a more diverse sample to examine gender and ethnicity effects. In the current study, the primary investigator attempted to obtain a diverse sample by surveying members of an international organization. However, due to this researcher not using a specific sampling method such as

quota sampling, the organization members who completed the surveys were predominantly female and Caucasian.

A significant relationship between compassion fatigue and years of clinical experience also was not found. Prior studies that have examined vicarious traumatization and burnout have found an association between less clinical experience and higher levels of these negative psychological outcomes (e.g., Pearlman & MacIain, 1995; Etzion, 1984). Only one known study revealed a significant relationship between compassion fatigue and years of clinical experience (Landry, 2001). These findings indicated that there may be differences between the constructs of vicarious traumatization, burnout, and compassion fatigue that is related to years of clinical experience. The relationship between negative psychological outcomes for therapists and years of clinical experience may be related to a potential mediating variable that could be examined in future studies.

As reviewed in detail in the discussion of Hypothesis One results, there were no significant relationships between the workplace variables of negative clientele or workplace support and compassion fatigue.

Relationships among Individual and Workplace Variables and Compassion Satisfaction

The fourth and final hypothesis was a null statement about changes in variance for compassion satisfaction after workplace variables (e.g., control, overinvolvement) were added to a model including individual variables (e.g., personal trauma history and years of clinical experience). Thus, the fourth null hypothesis was rejected. The final regression model included personal trauma history and control as the factors that best accounted for variance in compassion satisfaction. Though years of clinical experience was correlated with compassion satisfaction and was retained in the regression equation, the relationship was not shown to be statistically significant by the regression analysis. Because therapists with more personal trauma experience

were found to have had higher levels of compassion fatigue in prior research findings, it was expected that therapists with more personal trauma experiences in this study would have lower levels of compassion satisfaction. However, it was found that therapists with more experiences of personal trauma had *higher* levels of compassion satisfaction. Thus, the findings of the current study do not support or contradict prior research on the topic of compassion satisfaction. Findings associated with perceived control and compassion satisfaction were discussed previously in the discussion of Hypothesis Two.

Theoretical Implications

Findings of the present study lend substantial support to several of the theories underlying the constructs of compassion fatigue and compassion satisfaction. The research findings that higher levels of compassion fatigue were strongly related to less perceived control in the workplace, more overinvolvement with clients, and more secondary exposure provide support for aspects of Figley's (1995) causal model for compassion fatigue and Maslach and Leiter's (1997) work-climate perspective. An additional discovery that higher levels of compassion satisfaction were related to more perceived control and greater experience with personal trauma can be explained by aspects of resilience theory, posttraumatic growth, and cognitive self-development theory.

Figley's (1995) Compassion Fatigue model outlines a process for the development of compassion fatigue, beginning with exposure to a trauma survivor, then empathic connection, and then the development of compassion stress. Compassion stress may become the more severe form of compassion fatigue when protective factors (e.g., sense of achievement and disengagement) are not present and/or exacerbating factors (e.g., prolonged exposure, traumatic recollections, other life disruptions) are present. In the present study, strong associations were found between compassion fatigue and amount of secondary exposure to clients' trauma. This

finding lends support for Figley's assertion that the amount of secondary exposure to client's trauma (e.g., prolonged exposure) is a risk factor for the development of compassion fatigue in therapists. Additionally, associations found in the current study between compassion fatigue and overinvolvement, defined as the opposite of engagement, support Figley's claim that disengagement is a protective factor that can ameliorate compassion fatigue.

Associations found between compassion fatigue and perceived control in the workplace are consistent with Maslach and Leiter's (1997) work-climate view of burnout and other negative consequences for therapists. Maslach and Leiter's theory purports that lack of control in the workplace as well as work overload are risk factors for burnout. In the current study, compassion fatigue was found to be related to perceived workplace control. The relationship found in the current study between compassion fatigue and perceived control indicates a conceptual link between compassion fatigue and burnout, with both constructs being related to the workplace factor of perceived control.

Compassion satisfaction was shown in the present study to be strongly associated with perceived control in the workplace and therapists' personal trauma history. In building an integrated model for compassion satisfaction, perceived workplace control is an important contributing factor. It is as yet undetermined whether higher perceived control is caused by having high compassion satisfaction, or vice versa. An unexpected finding in this study was the association between therapists' personal trauma history and compassion satisfaction, with more personal trauma experiences associated with higher levels of compassion satisfaction. According to Cognitive Self-Development Theory, changes in core beliefs about self, others, and the world can lead to a sense of helplessness, lack of control, and disturbance in identity through secondary exposure to client trauma. As these cognitive changes occur, therapists who have already been

through a personal trauma may have previously adopted more resilient core beliefs that allow for integrating the possibility of trauma.

Whereas changes in core beliefs post-trauma may increase resilience and make the development of negative therapist outcomes (e.g., compassion fatigue) less likely, this idea does not fully explain the association between therapists' amount of personal trauma experiences and compassion satisfaction. It is possible that therapists who have been through traumatic experiences and coped effectively are better able to work with traumatized clients and may feel more of a sense of achievement in helping someone else heal from trauma. This ability to turn personal suffering into a sense of meaning and purpose is a core concept in the theory of Posttraumatic Growth (Tedeschi & Calhoun, 1996). Thus, there may be a conceptual link between the constructs of posttraumatic growth and compassion satisfaction as both concepts relate to the ability to turn suffering into a positive outcome. This preliminary conclusion needs further clarification through future research.

Another possible explanation for the finding that more personal trauma experiences related to higher levels of compassion satisfaction is that trauma therapists, who were targeted in the current study, may have been more drawn to therapeutic work with trauma survivors because of their own experiences with trauma. Thus, some trauma therapists may have higher levels of compassion satisfaction because they find their work especially meaningful in light of their own experience overcoming trauma. Future researchers attempting to replicate the finding that more personal trauma experiences is related to higher levels of compassion satisfaction may obtain different results if using a sample of general, not trauma-specific, therapists.

Practical Implications

The present study and associated findings contribute to knowledge and understanding of the importance of workplace factors in influencing both positive and negative psychological

outcomes for therapists. Specifically, the findings of this study underscore the importance of therapists, particularly those working with trauma survivors, having more perceived control over their work environment (e.g., using their own initiative at work, making decisions about the work they do). Perceived control in the workplace was found in this study to be associated with higher levels of compassion satisfaction and lower levels of compassion fatigue. Associations between workplace control and burnout have been demonstrated in previous research (e.g., Rupert & Morgan, 2005). Thus, allowing therapists to have more control over their work activities may be preventative for both burnout and compassion fatigue. Increasing therapists' workplace control may also enhance positive psychological outcomes such as compassion satisfaction. Based on the current study findings, specific recommendations for workplace settings to enhance therapists' sense of control include the following: (1) allowing therapists to be democratically part of decision making; (2) allowing therapists to provide input about their caseloads (e.g., both amount of cases and types of cases).

The practical implications for the finding concerning the importance of perceived control are extensive given the direction that the mental health field is moving with managed care becoming the norm. Specifically, managed care often involves therapists having less of a sense of control over their therapeutic work as they have to answer to third-party payers to justify continued coverage. The findings in this study of the importance of control in both enhancing positive outcomes (e.g., compassion satisfaction) and decreasing negative outcomes (e.g., compassion fatigue) highlight aspects of managed care that may be detrimental to the well-being of therapists and in-turn to clients and the organization as a whole.

The recommendation of allowing therapists to provide input about their caseloads relates to the current research findings concerning therapists' secondary exposure to clients' trauma

material and compassion fatigue. In today's community mental health environments, therapists in a variety of settings are encouraged to have higher and higher caseloads to meet financial demands for the organization and/or practitioner. The present study results highlight the potentially negative outcomes if therapists, especially those working with trauma survivors, have higher amounts of weekly client contact hours. Therapists with higher client caseloads have been shown in previous studies to show increased levels of burnout for therapists (Ackerley et al., 1988; Rupert & Morgan, 2005). Thus, having higher caseloads of trauma clients puts therapists at greater risk for compassion fatigue and burnout. An increased risk for both compassion fatigue and burnout is of concern since the combination of these two conditions has been shown to have the most negative psychological outcomes for therapists (Stamm, 2005).

Although the present study did not find workplace support to be associated with compassion fatigue or compassion satisfaction, this researcher still encourages workplace support to be made a priority. The encouragement of workplace support is consistent with existing recommendations in the literature (Collins & Long, 2003; Skovholt, 2001; Stamm & Pearce, 1995). Future researchers should examine the role of workplace support using alternative measures as there were some weaknesses in the PBI with respect to reliability.

Overinvolvement with clients was associated with increased compassion fatigue and, to a lesser degree, with decreased compassion satisfaction. Therefore, it is recommended that employers provide adequate supervision and consultation for therapists. Another recommendation based on findings in this study is to provide therapists with opportunities for personal counseling to discourage psychological overinvolvement with clients and assist them in developing healthy ways to disengage. In addition to collegial support through supervision and consultation, professional development opportunities and workshops on self-care are

recommended to enhance therapists' professional preparation and ability to take better psychological care of themselves. These opportunities are intended to prevent therapists from becoming overinvolved with clients and developing compassion fatigue. Additional opportunities for paid time-off and vacation days may also enhance therapists' ability to effectively disengage, enhance self-care, and to mitigate negative outcomes.

Overinvolvement with clients should also be discouraged as part of the organization or agency's philosophy and practices. Some workplace settings require therapists to take on too much with respect to involvement with and advocacy for clients, at the potential expense of the therapist, clients, and even the agency itself. Agencies should set the precedent for therapists to be able to disengage and empower clients to be advocates for themselves whenever possible.

Finally, an unexpected finding in this study was that therapists with more personal trauma were associated with higher levels of compassion satisfaction. This finding indicates that therapists who have experienced their own traumatic experiences may find greater purpose and sense of achievement in their work with trauma survivors. As surmised in the previous section, alterations and expansions in therapists' core beliefs that often occur post-trauma may allow them to better defend against negative outcomes and enhance positive outcomes. Although the degree to which therapists effectively processed their personal trauma was not examined in the current study, the development of more resilient core beliefs is one possible explanation. Employers are encouraged to offer personal counseling as well as supervision to help therapists effectively process personal trauma and receive support, which may encourage higher levels of compassion satisfaction. As mentioned previously, it is possible that therapists in this study were specifically drawn to trauma work due to their personal trauma experiences, and they thus may experience their work as more rewarding and satisfying.

Research Implications and Future Directions

A major finding in the current study is the association of therapists' perceived workplace control with both compassion fatigue and compassion satisfaction. Although perceived workplace control has been shown to be associated with burnout in previous studies (Rupert & Morgan, 2005), the present study is the first one known to demonstrate the link between therapists' perceived workplace control and compassion fatigue as well as compassion satisfaction for therapists who work primarily with trauma. Future researchers should attempt to replicate the present findings using different methods of measuring workplace control. The Psychologist's Burnout Inventory (PBI, Ackerley et. al., 1988) is an infrequently used and therefore underdeveloped instrument with somewhat lower reliability. Thus, it is imperative to determine if therapists' perceived workplace control is associated with compassion fatigue and compassion satisfaction when measured in different ways.

Workplace support was not found to be associated with compassion fatigue or compassion satisfaction in the present study. However, the Psychologist's Burnout Inventory had lower reliability for the subscale of Workplace Support, which may have affected the ability of the measure to detect a relationship between workplace support and compassion fatigue and compassion satisfaction. An additional valid and reliable measure needs to be developed to address workplace support. Existing measures were found that measure various forms of social support, however no measures were found that addressed perceived workplace support for therapists except for the Psychologist's Burnout Inventory.

Future researchers should examine individual and workplace factors and compassion fatigue and compassion satisfaction with different samples that are representative of a broader population of trauma therapists. As will be discussed in the Limitations section, the ISTSS and the ATSS members may have been unique with respect to their level of training, investment in

the field, and education level. These differences in the study sample may have differed systematically (i.e., an undetermined confounding variable) as compared to the population of all therapists working with traumatized populations. Future studies should attempt to obtain samples with varying levels of training, which may impact levels of compassion fatigue and compassion satisfaction as well as associated factors.

The primary investigator in the present study attempted to measure specialized training as an individual factor. Because this variable was measured dichotomously, it was not able to be used in analyses due to disproportional nature of the data. Future researchers should include specialized training as a variable and measure it continuously (e.g., asking for the number of hours of specialized training) or perhaps through qualitative inquiry to determine the nature of training.

Additional research needs to be done to further explore the interrelationships between compassion fatigue, compassion satisfaction, and burnout (i.e., subscales on the ProQOL). Previous research has indicated that levels of compassion satisfaction may moderate levels for both compassion fatigue and burnout (Conrad & Kellar-Guenther, 2006). In the present study, the interrelationships among compassion satisfaction, compassion fatigue, and burnout were not examined. However, there was no significant correlation found between compassion fatigue and compassion satisfaction in the present study. Future research is needed to clarify the nature of these relationships.

Future researchers should attempt to replicate the finding that more personal trauma experiences for therapists are associated with higher levels of compassion satisfaction. Additionally, therapists' core beliefs should be examined to test the hypothesis that more resilient core beliefs (i.e., post-trauma core beliefs) enhance compassion satisfaction and protect

against compassion fatigue. Post-traumatic growth should be explored as a mediating factor between personal trauma experiences and compassion satisfaction to clarify the conceptual link among these constructs.

Finally, future researchers should investigate therapists' personal trauma history as it relates to compassion fatigue using different samples of trauma therapists. It is possible that other samples of trauma therapists may have more or less trauma experiences than those in the sample for this study. An association between personal trauma history and compassion fatigue was not found in this study. This relationship has been found in many previous research studies (Kassam-Adams, 1995; Pearlman & MacIain, 1995), although not in all previous studies (Schauben & Frazier, 1995).

The present study was among the first to utilize Figley's (1995) model of compassion fatigue as a conceptual framework. The researcher in the current study found aspects of this model to be significantly related to compassion fatigue, including prolonged exposure to secondary trauma (i.e., amount of secondary exposure and years of clinical experience) and disengagement by measuring overinvolvement, defined as its opposite. Future researchers also should examine other aspects of Figley's (1995) model, including empathy, sense of achievement, traumatic recollections, and amount of life stress. A structural equation modeling method could be used to specify a model of compassion fatigue and to determine the accuracy of the proposed directions of the constructs as articulate by Figley.

Limitations

Several limitations will be discussed in this section that may have compromised the validity and generalizability of the findings of this study. First, reliabilities of the subscales of the Psychologist's Burnout Inventory (PBI) were somewhat low. According to Nunnally (1978), an alpha level of .70 is the accepted standard for instruments in basic research. Reliabilities for

the PBI in the present study are as follows: the Control subscale had an internal correlation of .68, Workplace Support was .55, and Overinvolvement was .64. The Types of Negative Clientele subscale had a sufficiently high internal consistency. Thus, findings related to overinvolvement, workplace support, and control variables may have been compromised because the measures were not sufficiently reliable. These measurement problems may explain why relationships were not found between workplace support and overinvolvement and either of the dependent variables: compassion fatigue nor compassion satisfaction, even though previous researchers detected significant relationships among these variables. A significant relationship was found between both compassion fatigue and compassion satisfaction and perceived control in the workplace. However, the control subscale had marginally low internal consistency (i.e., closer to the accepted standard of .70), compared to lower internal consistencies of the other two subscales. Therefore, this more marginal level of internal consistency lends greater support to the validity of findings related to therapists' perceived workplace control, as compared to findings related to overinvolvement and workplace support.

A second limitation of this study relates to the generalizability of the sample to the target population. The population to which findings were intended to generalize consisted of all therapists working primarily with traumatized clients in a clinical setting. The sample obtained for this study consisted of therapists (e.g., primarily psychologists, professional counselors, and social workers) who were members of professional organizations aimed at keeping members abreast of research, training, and professional credentialing in the field of trauma. It is possible that the sample obtained for this study differs from the target population in terms of their professional training, interest in the field, and specific professional activities which could have accounted for different responses than a different sample of trauma therapists. Participants in

this sample may have had lower levels of compassion fatigue as compared to other studies (e.g., Conrad & Kellar-Guenther, 2006) due to their high motivation and interest in the field, and therefore may be different from the entire population of trauma therapists. Thus, generalizability of the present findings to all trauma therapists may be somewhat limited.

Third, limitations exist whenever using self-report measures. It is impossible to know the level of accuracy with which participants responded to items on the survey. Social desirability biases may have occurred in the participants' responses. Also, due to the use of internet and e-mail, it is not possible to know for sure if the person who responded to the survey was the person intended from the e-mail list.

A fourth limitation involved the use of a survey methodology and correlational design. Correlational methods of inquiry allow conclusions to be drawn about associations between variables but do not permit conclusions to be drawn about whether changes in one variable cause changes in another. Though the use of multiple regression analyses allows a researcher to draw a stronger conclusion implying causality, causation still cannot be determined because variables are naturally occurring and not experimentally manipulated.

A fifth and final limitation of the present study was the response rate, which implies a potential response bias. A response bias refers to the inability to determine whether those who participated in the survey were systematically different in unknown variables or study variables from those who chose not to participate. In the present study, a response rate of 17% was calculated from the first sample and 11.62% from the second sample. It is possible that those who chose not to respond to the survey had higher levels of compassion fatigue, which may have impacted the findings in this study. Those with high levels of compassion fatigue may have chosen to avoid sharing about their difficulties or were perhaps fearful of being psychologically

triggered by the survey items. Also, thirteen members who partially completed the survey were not included in the data analyses. It is impossible to know if those who did not respond to the survey, or those who partially completed the survey, differed systematically from those who did in any way.

Summary

In summary, this chapter provided a discussion of the results, recommendations, and limitations of the present study. The current study examined the following relationships: (a) workplace variables and compassion fatigue, (b) workplace variables and compassion satisfaction, (c) individual and workplace variables and compassion fatigue, (d) individual and workplace variables and compassion satisfaction. Factors found to be significantly related to compassion fatigue and compassion satisfaction were discussed as well as possible explanations for study variables that were not related. Based on conclusions drawn from this study's findings, future directions for research as well as theoretical and practical implications were discussed. Finally, limitations of the present study were detailed in the conclusion of this chapter.

APPENDIX A
PROFESSIONAL QUALITY OF LIFE SCALE

Compassion Satisfaction and Fatigue Subscales—Revision IV

[Helping] people puts you in direct contact with their lives. As you probably have experienced, your compassion for those you *[help]* has both positive and negative aspects. We would like to ask you questions about your experiences, both positive and negative, as a *[helper]*. Consider each of the following questions about you and your current situation. Select the number that honestly reflects how frequently you experienced these characteristics in the *last 30 days*.

0=Never 1=Rarely 2=A Few Times 3=Somewhat Often 4=Often 5=Very Often

1. I am happy.
- _____ 2. I am preoccupied with more than one person I *[help]*.
- _____ 3. I get satisfaction from being able to *[help]* people.
- _____ 4. I feel connected to others.
- _____ 5. I jump or am startled by unexpected sounds.
- _____ 6. I feel invigorated after working with those I *[help]*.
- _____ 7. I find it difficult to separate my personal life from my life as a *[helper]*.
- _____ 8. I am losing sleep over traumatic experiences of a person I *[help]*.
- _____ 9. I think that I might have been “infected” by the traumatic stress of those I *[help]*.
- _____ 10. I feel trapped by my work as a *[helper]*.
- _____ 11. Because of my *[helping]*, I have felt “on edge” about various things.
- _____ 12. I like my work as a *[helper]*.
- _____ 13. I feel depressed as a result of my work as a *[helper]*.
- _____ 14. I feel as though I am experiencing the trauma of someone I have *[helped]*.
- _____ 15. I have beliefs that sustain me.
- _____ 16. I am pleased with how I am able to keep up with *[helping]* techniques and protocols.

- _____ 17. I am the person I always wanted to be.
- _____ 18. My work makes me feel satisfied.
- _____ 19. Because of my work as a *[helper]*, I feel exhausted.
- _____ 20. I have happy thoughts and feelings about those I *[help]* and how I could help them.
- _____ 21. I feel overwhelmed by the amount of work or the size of my case*[work]* load I have to deal with.
- _____ 22. I believe I can make a difference through my work.
- _____ 23. I avoid certain activities or situations because they remind me of frightening experiences of the people I *[help]*.
- _____ 24. I am proud of what I can do to *[help]*.
- _____ 25. As a result of my *[helping]*, I have intrusive, frightening thoughts.
- _____ 26. I feel “bogged down” by the system.
- _____ 27. I have thoughts that I am a “success” as a *[helper]*.
- _____ 28. I can't recall important parts of my work with trauma victims.
- _____ 29. I am a very sensitive person.
- _____ 30. I am happy that I chose to do this work.
- _____

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© B. Hudnall Stamm, 1997-2005. *Professional Quality of Life: Compassion Satisfaction and Fatigue Subscales, R-IV (ProQOL)*. <http://www.isu.edu/~bhstamm>. This test may be freely copied as long as (a) author is credited, (b) no changes are made other than those authorized below, and (c) it is not sold. You may substitute the appropriate target group for *[helper]* if that is not the best term. For example, if you are working with teachers, replace *[helper]* with teacher. Word changes may be made to any word in italicized square brackets to make the measure read more smoothly for a particular target group.

APPENDIX C
STRESSFUL LIFE EXPERIENCES—SHORT FORM

We are interested in learning about your experiences. Below is a list of experiences that some people have found stressful. Please fill in the number that best represents how much of the following statements describe your experiences. If you are not sure of your answer, just give us your best guess.

Describes your Experience (Use in Describe Experiences Column):

0 1 2 3 4 5 6 7 8 9 10

I did not experience A little like my experiences somewhat like my experiences exactly like my experiences

Describe Experience	Life Experience
	I have witnessed or experienced a natural disaster; like a hurricane or earthquake.
	I have witnessed or experienced a human made disaster like a plane crash or industrial disaster.
	I have witnessed or experienced a serious accident or injury.
	I have witnessed or experienced chemical or radiation exposure happening to me, a close friend or a family member.
	I have witnessed or experienced a life threatening illness happening to me, a close friend or a family member.
	I have witnessed or experienced the death of my spouse or child.
	I have witnessed or experienced the death of a close friend or family member (other than my spouse or child).
	I or a close friend or family member has been kidnapped or taken hostage.
	I or a close friend or family member has been the victim of a terrorist attack or torture.
	I have been involved in combat or a war or lived in a war affected area.
	I have seen or handled dead bodies other than at a funeral.
	I have felt responsible for the serious injury or death of another person.
	I have witnessed or been attacked with a weapon other than in combat or family setting.
	As a child/teen I was hit, spanked, choked or pushed hard enough to cause injury.
	As an adult, I was hit, choked or pushed hard enough to cause injury.
	As an adult or child, I have witnessed someone else being choked, hit, spanked, or pushed hard enough to cause injury.
	As a child/teen I was forced to have unwanted sexual contact.
	As an adult I was forced to have unwanted sexual contact.
	As a child or adult I have witnessed someone else being forced to have unwanted sexual contact

	I have witnessed or experienced an extremely stressful event not already mentioned. Please Explain:
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APPENDIX D
DEMOGRAPHIC QUESTIONNAIRE

What is your gender?

- a) Male
- b) Female

What is your ethnicity?

- a) Black/African American
- b) White/Caucasian
- c) Latino/Hispanic
- d) Asian/Pacific Islander
- e) Other _____

Which of the following professions best describes your profession?

- a) Professional Counselor
- b) Psychologist
- c) Social Worker
- d) Other _____

Which of the following most accurately describes your **PRIMARY** professional activity?

- a) Counseling/therapy and/or other clinical activities
- b) Case Management
- c) Supervisory/Administrative
- d) Teaching and/or Research activities
- e) Other _____

Which of the following most accurately describes your clinical work environment?

- a) I am the only professional in my work environment
- b) I work with other professionals

Do you consider your clinical work to be **PRIMARILY** with traumatized clients?

- a) Yes
- b) No

How many hours per week are spent working directly with clients who have been traumatized?

How many years have you been doing clinical work including internship and practicum experiences? _____

Have you had any specialized training in working with traumatized populations?

- a) Yes
- b) No

APPENDIX E INFORMED CONSENT

Protocol Title: Trauma Therapists' Quality of Life: Individual and Workplace Factors associated with Compassion Fatigue and Compassion Satisfaction

Purpose of the research study:

The purpose of this study is to examine individual and workplace factors that may be associated with compassion fatigue and compassion satisfaction in mental health professionals working with trauma survivors.

What you will be asked to do in this study:

You will be asked to complete a demographics questionnaire and complete three short surveys.

Time requirement:

The entire survey should take about 15 to 20 minutes.

Risks and Benefits:

A potential risk of participating in this study includes emotional reactivity due to the sensitive nature of some of the questions. Because the topic of the study involves reactions to trauma work, you may find yourself experiencing emotions associated with trauma, particularly if you have a history of traumatic experiences. If you feel that you are experiencing any distress, you may choose to stop completing the survey. If you feel concerned about emotional reactivity due to recent traumatic events you have experienced, you may choose not to complete the survey at this time. Potential benefits include increasing self-awareness about your feelings and thoughts about your work.

Compensation:

There is no compensation for participating in this study.

Confidentiality:

Your identity will be kept confidential to the extent provided by law. Your information will be assigned a code number. Your name will not be used in any report.

Voluntary participation:

Your participation in this study is completely voluntary. There is no penalty for not participating.

Right to withdraw from the study:

You have the right to withdraw from this study at anytime without consequence.

Whom to contact if you have questions about the study:

Lindsay G. Leonard, Ed.S., Doctoral Student, Department of Counselor Education,
(352) 392-0731

Sondra Smith, PhD, Department of Counselor Education, (352) 392-0731 ext. 239

Whom to contact about your rights as a research participant in this study:

UFIRB Office, Box 112250, University of Florida, Gainesville, Fl 32611-2250;
(352) 392-0433

Agreement:

I have read the above and by clicking below I give my consent to participate in the study.

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BIOGRAPHICAL SKETCH

Lindsay Gwyn Leonard was born in 1981 in Madison, Wisconsin. Lindsay is the middle of three children, growing up mostly in Jacksonville and Orlando, Florida. She graduated with honors from Dr. Phillips High School in 1999. Lindsay earned a B.S. in Psychology from the University of Florida in 2003. She then went on to earn an M.Ed. and Ed.S. in Marriage and Family Therapy, also from the University of Florida, Department of Counselor Education.

During her graduate training in Counselor Education, Lindsay worked in a variety of counseling settings. She first worked at the Alachua County Crisis Center serving the local community. Lindsay also worked as an intern at the University of Florida Counseling Center in 2004-2005 and with PACE Center for Girls in 2006-2007. During this clinical training, Lindsay pursued a doctoral degree in Counselor Education at the University of Florida. She decided to specialize in Crisis Intervention and Post-Trauma Counseling, which reflected the majority of her clinical work with the Crisis Center throughout her professional studies.

Beginning in September of 2007, Lindsay joined the clinical team at the University of North Florida's Counseling Center in Jacksonville, Florida. Currently, Lindsay is working as a therapist for college students and as a coordinator for group therapy. After completing the Ph.D. program, Lindsay plans to pursue a teaching position at the University in addition to her ongoing clinical work. Lindsay currently lives with her partner, Shane McKim and their dog Charley. She enjoys painting, kickboxing, running, reading, writing, and spending time with her family.