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EKUNDAYO A. SODEKE–GREGSON MA (Hons)

COMPASSION SATISFACTION, BURNOUT, AND SECONDARY
TRAUMATIC STRESS IN UK THERAPISTS

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Doctor of Clinical Psychology

JULY 2011

SALOMONS
CANTERBURY CHRIST CHURCH UNIVERSITY

DECLARATION FOR MAJOR RESEARCH PROJECT

DECLARATION

This work has not previously been accepted in substance for any degree and is not being concurrently submitted in candidature for any degree.

Signed (candidate) 

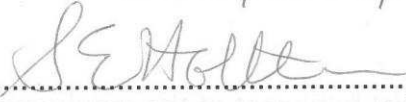
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STATEMENT 1

This thesis is the result of my own investigations, except where otherwise stated. Other sources are acknowledged by footnotes giving explicit references. A bibliography is appended.

Signed (candidate) 

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Signed (supervisor) 

Date 14-7-11

STATEMENT 2

I hereby give consent for my thesis, if accepted, to be available for photocopying and for inter-library loan, and for the title and abstract to be made available to outside organisations.

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Date 14/07/11

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I would like to thank all the therapists who made this research project possible by giving their time to participate in the study.

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Love and thanks to Mum, Tade, Gbenga, & Baba for always being there and teaching me the importance of family. I am also grateful to my father for leading by example and teaching me the importance of hard work.

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COMPASSION SATISFACTION, BURNOUT, AND SECONDARY TRAUMATIC STRESS IN UK THERAPISTS

Summary Page

Section A: Working with adult trauma clients: The impact on therapists

A literature review was conducted to identify the negative and positive impact that working with adult trauma clients has on therapists. Key theoretical concepts and possible causal mechanisms are summarised and the research evidence supporting these concepts are reviewed. The key limitations to the extant literature and future research are discussed.

Section B: Compassion satisfaction, burnout, and secondary traumatic stress in therapists who work with adult trauma clients

Two-hundred and fifty-three therapists working with adult trauma clients completed an online questionnaire which measured levels of compassion satisfaction (CS), burnout, and secondary traumatic stress (STS). Whilst the majority of therapists reported average potential for CS and risk of burnout, 70% had scores which indicated that they were at high risk of STS. Correlations and predictor variables were identified. The results are discussed in relation to the existing literature. Indications are given for future research and implications for clinical settings are highlighted.

Section C: Critical Appraisal

A critical appraisal of the research process is summarised which answers the four set questions. A final personal reflection is also given.

List of Contents

Section A: Working with adult trauma clients: The impact on therapists

	Page No
Abstract	12
Introduction	13
Theoretical Concepts	13
Negative effects of working with trauma clients	13
Compassion Fatigue (CF)	14
Secondary Traumatic Stress (STS)	14
Vicarious Traumatization	15
Burnout	16
Re-conceptualisation of negative effects	16
Positive effects of working with trauma clients	17
Compassion Satisfaction	17
Vicarious Posttraumatic Growth	18
Potential causal mechanisms	18
Countertransference	19
Empathy	20
Emotional contagion	20
Cognitive theories	21
Social learning theory	22
Research evidence	22
PTSD symptoms	22
Cognitive schemas	24
Psychological distress	26
Relational disturbances	27
Limitations to the research	27
Conceptual issues	28
Methodological issues	29

Contextual limitations	29
Future research	30
Conclusions	31
References	33

Section B: Compassion satisfaction, burnout, and secondary traumatic stress in therapists who work with adult trauma clients

	Page No
Abstract	41
Compassion satisfaction (CS)	42
Compassion fatigue (CF)	43
Proposed causal mechanisms	45
Protective and risk factors	45
Research aims	48
Method	48
Participants	48
Design	49
Measures	49
Independent measures	49
Demographic and background information questionnaire	49
Coping Strategies Inventory	50
Dependent measure	51
The Professional Quality of Life questionnaire	51
Piloting of questionnaire	52
Additional assessment	52
Procedure	52
Statistical analyses	53
Results	54
Prevalence of CS, burnout, and STS amongst therapists	54
Data transformation	55

Correlations between CS, burnout, STS, and predictor variables	55
Predictors for CS, burnout, and STS	58
Predictors for CS	58
Predictors for burnout	58
Predictors for STS	59
Acceptability of the online study methodology	60
Discussion	60
Contextual issues	65
Methodological issues	66
Implications for clinical settings	67
Conclusions	68
References	70

Section C: Critical Appraisal

	Page No
1. What research skills have you learned and what research abilities have you developed from undertaking this project and what do you think you need to learn further?	78
2. If you were able to do this project again, what would you do differently and why?	79
3. <u>Clinically</u> , as a consequence of doing this study, would you do anything differently and why?	81
4. If you were to undertake further research in this area what would that research project seek to answer and how would you go about doing it?	82
Final reflection	84
References	85

Section D: Appendices of supporting material

List of Tables

Section B: Compassion satisfaction, burnout, and secondary traumatic stress in therapists who work with adult trauma clients

	Page No
Table 1: Number of therapists at low, average, and high risk of CS, burnout, & STS (N = 253)	54
Table 2: Variables transformed from nominal to dichotomous data	55
Table 3: Correlations between CS, burnout, and STS and independent predictor variables	57
Table 4: Regression model for variables predicting CS (n = 232)	59
Table 5: Regression model for variables predicting Burnout (n = 237)	59
Table 6: Regression model for variables predicting STS (n = 245)	60

Section D: Appendix of Supportive Material

	Page No
Appendix 10: Correlations between independent predictor variables and CS, burnout, and STS	122

List of Appendices

Section A: Working with adult trauma clients: the impact on therapists

Appendix 1: Literature search procedure

Appendix 2: Difference between posttraumatic stress disorder and secondary traumatic stress

Section B: Compassion satisfaction, burnout, and secondary traumatic stress in therapists who work with adult trauma clients

Appendix 3: Permission to use the Coping Strategies Inventory

Appendix 4: Permission to use the Professional Quality of Life Scale

Appendix 5: Online questionnaire (including information for participants, consent form, Coping Strategies Inventory, and Professional Quality of Life Scale)

Appendix 6: Approval letter from Research Ethics Committee

Appendix 7: One example of R&D approval letters¹

Appendix 8: Example of email sent to potential participants

Appendix 9: Consents from psychological professional bodies

Appendix 10: Correlations between independent predictor variables and CS, burnout, and STS

Appendix 11: Example of a histogram showing normality of distribution

Appendix 12: End of study letter to Research Ethics Committee

Appendix 13: Declaration of the end of a study form sent to Research Ethics Committee

Appendix 14: Example of end of study letter for R & D departments

¹ R&D approval was gained from 50 Trusts. However, due to the vast amount of paperwork generated, only one example has been included in the appendices. The remaining 49 letters are available to view on request and will be presented at viva.

Appendix 15: Example of thank you email sent to participants requesting feedback about research results

Appendix 16: Summary of study for Ethic Committee/R&D/participants

Appendix 17: Submission guidelines for Journal of Traumatic Stress

EKUNDAYO A. SODEKE-GREGSON MA (Hons)

MAJOR RESEARCH PROJECT

SECTION A

**WORKING WITH ADULT TRAUMA CLIENTS: THE IMPACT ON
THERAPISTS**

Word Count: 5483 (-3)

A thesis submitted in partial fulfilment of the requirements of
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SALOMONS

CANTERBURY CHRIST CHURCH UNIVERSITY

Abstract

Therapists working with trauma clients are likely to be impacted by engaging in this type of work. However, there are currently competing theoretical concepts used to describe this process and different causal mechanisms are proposed to account for it.

In this review, theoretical and empirical papers describing the possible negative effects of working with trauma clients (compassion fatigue, secondary traumatic stress, vicarious traumatisation, and burnout) and the possible positive effects (compassion satisfaction and vicarious posttraumatic growth) are summarised and discussed. The proposed causal mechanisms for these concepts are then briefly described and reviewed. Finally, current empirical research is presented and reviewed in relation to these concepts.

This review demonstrates that these theoretical concepts appear to overlap and that the terms are often used interchangeably in the literature. Some researchers even argue that the different concepts are actually measuring the same phenomenon. Evidence for the existence of these concepts is inconsistent and there is also an overwhelming bias towards research exploring the negative impact of trauma work. Additionally, the majority of studies have been restricted to the US which calls into question the validity of these concepts in a UK context. The review ends by highlighting ideas for future research.

Key words: compassion fatigue, secondary traumatic stress, vicarious traumatisation, burnout, compassion satisfaction, vicarious posttraumatic growth

Introduction

It is now widely recognised that listening to clients' traumatic stories is likely to impact therapists. Whilst some therapists report feelings of well-being from working with clients with a trauma history, the American Psychiatric Association (APA, 2000) acknowledges that it is possible to become traumatised indirectly by "learning about unexpected or violent death, serious harm, or threat of death or injury experienced" by another person (p. 463).

This review will explore the potential impact that working with trauma clients has on therapists, highlighting both negative and positive effects. The possible causal mechanisms underlying these effects will be evaluated, the current evidence base examined, and areas for future research suggested. For the purpose of this review, only studies on therapists or mental health workers working with adults² suffering from trauma will be considered.

Theoretical concepts

The literature in this area documents a range of relevant theoretical concepts. These concepts can be broadly grouped into positive and negative effects.

Negative effects of working with trauma clients

Research into the well-being of therapists working with trauma clients has tended to focus on the potential negative effects of the work. Many terms have been used to describe these negative effects but the terms most commonly used at present in the literature are compassion fatigue, secondary traumatic stress, and vicarious traumatisation as well as the

² Researchers suggest that there is a distinction in vulnerability between therapists working with adult and child trauma clients (Dyregov & Mitchell, 1992; Figley, 1995; Hopkins, 1998) and this has been supported by empirical research (Brady, Guy, Poelstra, & Brokaw, 1999).

SECTION A: WORKING WITH ADULT TRAUMA CLIENTS

related concept of burnout. It is important to stress that although these concepts are under the umbrella of negative effects, they are not necessarily pathological in nature.

Compassion Fatigue (CF).

Figley describes CF as a “tension and preoccupation with the traumatized patients by re-experiencing the traumatic events, avoidance/numbing of reminders (sic) persistent arousal (e.g. anxiety) associated with the patient. It is a function of bearing witness to the suffering of others” (2002, p. 1435). In order to work effectively with trauma clients, it is necessary to engage empathically to establish an effective therapeutic alliance. However, being compassionate and empathic can be associated with costs for the therapist, namely CF.

CF is believed to arise from prolonged exposure to the trauma of others and symptoms are reported to be similar to those with posttraumatic stress disorder (PTSD). These symptoms can be categorised into three domains: (a) therapists’ re-experiencing their clients’ traumatic event; (b) an avoidance of reminders concerning the trauma; and (c) numbing in response to triggers and persistent arousal (Becvar, 2003). Collins and Long (2003) have found that those suffering from CF are sometimes unable to work with clients effectively and are also challenged in maintaining positive personal and professional relationships.

Secondary Traumatic Stress (STS).

STS is another term that has been used to describe similar processes and has been defined as the “natural, consequent behaviours and emotions resulting from knowledge about a traumatizing event experienced by a significant other. It is the stress resulting from helping or wanting to help a traumatised or suffering person” (Figley, 1999, p. 10). As with CF, STS appears to be part and parcel of working with trauma clients. It is believed to be a natural process which develops suddenly and is an acute reaction characterised by a sense of helplessness, confusion, and isolation from therapists’ support systems (Figley, 1995).

SECTION A: WORKING WITH ADULT TRAUMA CLIENTS

In much the same way as CF, sufferers of STS are believed to experience symptoms nearly identical to those suffering from PTSD but their traumatic event is being exposed to the traumatic event experienced by another person (see Appendix 2 for differences between STS and PTSD). Therefore, a therapist may suffer from STS due to hearing about their client's traumatic event. Chrestman (1999) summarises a list of symptoms which therapists are hypothesized to experience when suffering from STS. These include intrusive imagery related to their client's trauma, avoidant responses, physiological arousal, distressing emotions, addictive/compulsive behaviours, a change in therapists' cognitive schemata, and functional impairment.

Vicarious Traumatization (VT).

McCann and Pearlman (1990) coined the term VT, positing it to be the negative "transformation that occurs within the therapist... as a result of the empathic engagement with client's trauma experiences and their sequelae" (Pearlman & Mac Ian, 1995, p. 558). VT, unlike STS, is believed to be a cumulative process arising from working with several clients over time. Whilst STS focuses on PTSD symptomology delineated by the Diagnostic and Statistical Manual of Mental Disorders (APA, 2000), VT focuses on the disrupted frame of reference which may permanently impact therapists' beliefs about others, their sense of self, world view, and affect tolerance which can affect their personal and professional relationships. Thus, VT is said to affect therapists' beliefs around five psychological needs of safety, trust, esteem, intimacy, and control.

Additionally, therapists may experience disruptions to their sensory systems, whether through intrusive imagery, bodily experiences, or other sensory experiences associated with their clients' trauma. Some therapists are described as experiencing PTSD symptoms, but at a subclinical level. Pearlman and Saakvitne (1995a) assert that VT is unique to trauma work.

SECTION A: WORKING WITH ADULT TRAUMA CLIENTS

As purported by CF and STS, Saakvitne and Pearlman (1996) believe VT to be an occupational hazard which is an inescapable effect of trauma work.

Burnout.

Burnout is another negative effect that has been reported in therapists working with trauma clients. Unlike CF, STS, and VT, burnout is not restricted to those working with trauma clients but is associated with care-giving occupations in general (Maslach, Schaufeli, & Leiter, 2001). Burnout is described as “a state of physical, emotional, and mental exhaustion caused by long term involvement in emotionally demanding situations” (Pines & Aronson, 1998, p. 9). It is most commonly characterised by three dimensions: emotional exhaustion, depersonalisation, and reduced personal accomplishment (Maslach & Jackson, 1981). Emotional exhaustion is defined as the depletion of one’s emotional resources which includes an inability to emotionally engage with client work or personal relationships at work, whilst depersonalisation is understood to encompass a distancing from or dehumanisation of the client. Reduced personal accomplishment is described as a feeling that one’s actions will not make a difference; for example, in helping their client.

Symptoms of burnout are said to include physical, emotional, behavioural, work-related, and interpersonal symptoms (Kahill, 1988). Burnout is believed to be a gradual process which may go unnoticed for a long time (Schaufeli & Enzmann, 1998) and is thought to take longer to recover from than CF, STS, or VT.

Re-conceptualisation of negative effects

From the summaries above, a picture emerges that suggests that these theoretical concepts share much common ground. Attempts to ascertain clear differences between them have generally confirmed overlaps (e.g. Baird & Kracen, 2006). Despite some subtle differences, the lack of conceptual clarity has resulted in these terms often being used

SECTION A: WORKING WITH ADULT TRAUMA CLIENTS

interchangeably in the literature, making it difficult to clearly determine what processes the authors are referring to (Larsen & Stamm, 2008).

Some prominent authors in the field have acknowledged that there may indeed be limited differences between these concepts. For example, Figley (1999) asserts that the terms CF and STS can be used interchangeably as they refer to a similar phenomenon and that the term STS is more user-friendly as it does not hold the negative connotations of CF. He went on to suggest that VT and burnout could both be viewed as latent variables that contribute to CF (Figley, 2002). Adams, Boscarino, and Figley (2006) expanded this argument by proposing that CF is a broader concept still which encompasses VT, STS, and burnout as component clinical features. This proposition has been supported by Stamm who, in her creation of the Professional Quality of Life Scale, maps burnout and STS as subsets of CF.

Positive effects of working with trauma clients

Although currently small, there is a growing body of literature that documents the positive effects of working with trauma which Linley and Joseph (2007) believe parallels the growth of positive psychology. Pearlman (1999) argues that empathically engaging with trauma survivors leaves a person open to a deep and personal transformation which includes “personal growth, a deeper connection with both individuals and the human experience, and a greater awareness of all aspects of life” (p. 51). Stamm (2002) believes that it is not possible to fully understand the negative aspects of doing the work of caring without understanding the ‘positive payments’ that come from helping.

Compassion Satisfaction (CS).

The term CS was coined by Stamm and is “the sense of fulfilment or pleasure that therapists derive from doing their work well” (Larsen & Stamm, 2008, p. 282). It applies to the overall ‘quality of life’ for helping professions and is not limited to those working with

SECTION A: WORKING WITH ADULT TRAUMA CLIENTS

trauma survivors. According to Stamm (2002), CS is made up of three elements: (1) the level of satisfaction a person derives from their job, (2) how well a person feels they are doing in their job; in the case of trauma therapists, this is related to the amount of competency and control the therapist feels they have over the traumatic material they are exposed to, and (3) the level of positive collegiate support a person has where aspects of structural and functional social support are particularly important. Therefore, “the focus of [CS] is on the powerful experiences of emotional engagement, compassionate helping, and the outcomes of that interaction...despite any inherent risks and costs of caring” (Larsen & Stamm, 2008, p. 282).

Vicarious Posttraumatic Growth.

Posttraumatic growth is described as the positive change experienced by an individual due to struggling with a traumatic event. This change is usually reported in three domains: relationships with others, sense of self, and philosophy of life (Calhoun & Tedeschi, 1999). Calhoun and Tedeschi (1999) theorise some ways in which they feel that therapists may also experience posttraumatic growth vicariously through their work with trauma clients. They argue that clients’ stories could inspire us as clinicians (Pearlman & Saakvitne, 1995b); that lessons learnt from trauma clients may become useful in clinicians’ lives when they experience trauma; that working with trauma survivors may produce positive changes in clinicians’ views of the work; that the work may inspire a re-evaluation and shift of priorities in the clinician’s life; that the impact of the work may lead to clinicians strengthening their own ties to their loved ones; and that clinicians may experience an empathetic connection to everyone who is suffering.

Potential causal mechanisms

Not much is written about the possible causal mechanisms underlying these theoretical concepts, and researchers who have explored these have focussed on the

SECTION A: WORKING WITH ADULT TRAUMA CLIENTS

mechanisms for the negative effects. These potential mechanisms are briefly reviewed below and, where possible, links are made to how these may also apply to positive effects.

Countertransference

In the trauma context, countertransference is thought to be the therapists' reactions to the client's transference (Figley, 1999) and exists within the context of each specific therapeutic relationship (Pearlman & Saakvitne, 1995a). It is also understood as therapists seeing themselves in, over-identifying with, or meeting their own needs through their clients (Corey, 1991). In therapy, therapists are negatively impacted because whilst taking in their client's trauma, their unresolved or unconscious conflicts and experiences are also activated. It is believed to be a negative consequence of trauma work and should therefore be prevented or eliminated (Figley, 1999).

Although some researchers have proposed countertransference as a potential causal mechanism (Sabin-Farrell & Turpin, 2003), many only write about countertransference in terms of how it is distinct from other concepts rather than explicating how it may operate (Pearlman, 1999; Neumann & Gamble, 1995). The belief that countertransference is temporary and does not transcend beyond the therapy room (Pearlman, 1999) is used to critique countertransference for not being able to account for the enduring changes in therapists that are hypothesised (McCann & Pearlman, 1990). However, if therapists' unconscious material has been activated, it is unlikely that the emotions that have been stirred up will stop simply because the session has ended. Additionally, there is no explanation for how positive effects of trauma work can be understood and how countertransference can be used as a positive vehicle in trauma work. Although not acknowledged in the literature, individual differences in therapists being impacted by trauma

SECTION A: WORKING WITH ADULT TRAUMA CLIENTS

work may be explained by their different life experiences that may be activated in therapeutic work.

Empathy

Empathy is seen as a crucial ingredient in any helping relationship (Reynolds & Scott, 1999). For therapy to be successful, it is important for therapists to empathically engage with clients. This is achieved by therapists being receptive to clients' stories, by putting themselves in their clients' frame of reference, being able to communicate clients' emotions back to them, and finally, by receiving validation from their client (Patterson, 1974). Four aspects of empathy, namely past affect, present affect, past cognitive, and present cognitive empathy, interact to impact therapists negatively (Pearlman & Saakvitne, 1995b). It is believed that it is through this empathic engagement with trauma material, especially past affect empathy, that therapists are negatively impacted.

The mechanisms through which empathic engagement can positively impact therapists are not discussed in the literature, although it is possible that this may be achieved when a client is able to work through their trauma. Only the cognitive and affective components of empathy are highlighted in the literature, however, as emotions are multifaceted, one can assume that the physical symptoms and behavioural changes hypothesised in therapists can be accounted for by the interconnectedness of these elements. However, it is not clear whether empathic engagement leads to enduring changes in therapists or how individual differences occur.

Emotional contagion

Hatfield, Cacioppo, and Rapson (1992) describe emotional contagion as "the tendency to automatically mimic and synchronise expressions, vocalizations, postures, and movements with those of another person's and, consequently, to converge emotionally" (p.

SECTION A: WORKING WITH ADULT TRAUMA CLIENTS

1). This process is believed to happen at a more unconscious level than empathy. Whilst this can be a useful therapeutic tool, it is believed that if the therapists do not have enough self-awareness, they may experience these emotions as their own which may be detrimental.

It can be presumed that this unconscious process can also account for therapists being positively impacted when clients improve. This mechanism gives some understanding of individual differences as therapists who lack self-awareness may be more vulnerable to being negatively impacted. It also explains the physical symptoms that are hypothesised; however, it is unclear whether this 'mimicry' transcends outside the therapeutic space.

Cognitive theories

Piaget's (1971) theories of assimilation and accommodation can be used to understand the proposed changes in therapists' cognitions. It is believed that our schemas affect how we view and experience the world. When we encounter a new experience, it is filtered through our schemas and is either understood in terms of our pre-existing schemas or our schemas are modified to adequately integrate this new experience. In the case of therapists, elements of clients' trauma stories will either be congruent with their schemas and these will be assimilated or may be at odds with their schemas which may therefore have to change to accommodate this new information.

This theory is able to explain both positive and negative experiences resulting from trauma work. Additionally, as therapists will have different schemas, it provides some understanding of why some therapists may be impacted whilst others are not. It also accounts for the enduring changes hypothesised in some therapists although the behavioural/physical components of these concepts can only be understood as a consequence of changed cognitions.

Social learning theory

Motta (2008) uses Bandura's (1967) social learning theory to explain how secondary traumatic stress may be transmitted through observational learning. The theory posits that it is possible for a person to learn a behaviour by simply observing it in others. Therefore, Motta (2008) hypothesises that therapists can develop PTSD symptoms by observing it in their clients.

Although not discussed by Motta (2008), it stands to reason that therapists can be impacted positively by seeing their once traumatised clients overcome their distressing experiences. However, there is no explanation about why some therapists may be impacted whilst others are not.

Research evidence

The key theoretical concepts that are used to describe the potential positive and negative impact of working with trauma clients, and their proposed causal mechanisms, have been summarised above. It is evident that overlaps exist between these concepts and the theories suggest changes in similar psychological domains. To enable a review of the empirical evidence supporting these concepts, four common domains in which change is theorised to occur have been identified and research evidence in these areas will be presented. It is acknowledged that changes in these domains may occur in therapists not working with trauma clients and indeed, not all therapists working with trauma clients experience changes in all these domains.

PTSD symptoms

The presence of severe PTSD symptoms in therapists is theorised by CF, STS, with subclinical levels expected in VT. Researchers have used a range of self-report scales to measure symptoms common to PTSD including the Impact of Events Scale (Horowitz,

SECTION A: WORKING WITH ADULT TRAUMA CLIENTS

Wilner, & Alvarez, 1979), Trauma Symptom Checklist (Elliot & Briere, 1991), and the Frederick Reaction Index-A (Frederick, 1985).

Kassam-Adams' (1999) study surveyed 100 masters or doctoral level psychotherapists employed in outpatient agencies in the US who were working with clients with sexual trauma. Nearly half of her participants reported 'high' levels of trauma symptomology, such as intrusive imagery and avoidant symptoms, which suggested a need for clinical attention. Severe PTSD symptoms were also reported in 74 mental health workers who worked for a counselling programme following the Oklahoma City Bombing (Wee & Myers, 2002) and Chrestman (1999) found that trauma exposure was associated with increased intrusive imagery, avoidance, sleep disturbance, and dissociation. However, a note of caution is needed because, unlike other researchers, Chrestman's research did not report the number of therapists and their specific work settings.

Milder levels of trauma symptomology have been reported by other researchers (Brady, Guy, Poelstra, & Brokaw, 1999; Follette, Polusny, & Milbeck, 1994). Kadambi and Truscott (2004) found that only 5% of participants in their study, which compared differences in 221 Canadian therapists working with trauma clients, cancer clients, and in general practice, showed elevated levels of traumatic stress.

The literature confirms that some clinicians working with trauma clients experience trauma symptoms similar to their clients, with some experiencing severe symptoms, as hypothesised by CF and STS theories, whilst others report subclinical or low levels of symptoms as theorised by VT. Although it may be that these varied results are due to the use of a range of measures and the research being carried out on different professional groups, at present, there is only mixed support for the occurrence of PTSD symptoms.

Cognitive schemas

The theoretical concepts suggest that working with trauma can result in both positive and negative changes to therapists' cognitive schemas. The Traumatic Stress Institute (TSI) Belief scale (Pearlman & Mac Ian, 1993) was used to measure disrupted cognitive schemata in 188 self-identified US trauma therapists (Pearlman & Mac Ian, 1995). Their results indicated cognitive disruption in the areas of self-trust, self-esteem, self-intimacy, and other-esteem, psychological needs highlighted by VT theories. In contrast, a Dutch study (van Minnen & Keijzers, 2001) using the same scale to compare a group (N = 39) of trauma and non-trauma therapists, found no differences in disrupted cognitive schemas between these groups. Kadambi and Truscott (2004) also found no differences between Canadian therapists who worked with trauma clients, cancer clients, and in general practice.

Research evidence supporting the theorised cumulative effect of VT has also received mixed support. Also using the TSI Belief Scale, Schauben and Frazier (1995) found that 148 female psychologists and sexual violence counsellors working with a higher percentage of sexual violence survivors reported more disruptions in their schemas about themselves and others, and higher levels of self-reported VT. Conversely, Brady et al. (1999) found that therapists did not report significant disruptions of cognitive schemas despite the greater number of sexual abuse survivors they saw, which appears to contradict the supposition for the cumulative negative effect of trauma work. Other studies have used the World Assumption Scale (Janoff-Bulman, 1989) which measures assumptions about the world and self. Both van Minnen and Keijzers (2001) and Chrestman (1999) found no cognitive disruptions in therapists using this measure.

Examples of positive changes resulting from trauma work are reported by Arnold, Calhoun, Tedeschi, and Cann (2005) who interviewed 21 US licensed psychotherapists who regularly worked with trauma clients. Eighteen clinicians felt that their work had "led to

SECTION A: WORKING WITH ADULT TRAUMA CLIENTS

enduring, trait-oriented changes in the self, such as increased levels of sensitivity, compassion, insight, tolerance, and empathy” (Arnold et al., 2005, p. 250). Half also reported an increased awareness of their own good fortune and had a deeper appreciation of the strength and resilience of the human spirit. Positive experiences have also been reported in a group of Australian female therapists who were interviewed about their experiences (Steed & Downing, 1998). These studies provide support for CS and vicarious posttraumatic growth.

Two interesting findings emerged from studies in this area. Firstly, Brady et al. (1999) found that those who worked with more sexual abuse clients reported more spiritual well-being. Secondly, although van Minnen and Keijers (2001) found significantly more trauma therapists subjectively reported negative cognitive changes which they attributed to their therapeutic work, they also reported significantly more positive cognitive changes than non-trauma therapists. These findings add potential new elements to the concepts under investigation. Specifically, they provide empirical evidence that there may be a cumulative positive effect of trauma work and not just a cumulative negative effect, and that it is possible to experience both effects simultaneously. At present, the theoretical concepts do not give an account of how these experiences may co-exist.

In summary, whilst some researchers have reported disruptions to therapists’ cognitive schemata as theorised by VT, others have found no disruptions despite most researchers using the same questionnaire (i.e. TSI belief scale). Additionally, these disruptions may be positive for some therapists. These mixed findings may be, in part, due to therapists reporting difficulties in remembering their cognitive beliefs before starting trauma work (Steed & Downing, 1998).

Psychological distress

Expected psychological distress symptoms include anger, anxiety, depression, low self-esteem, emotional exhaustion, difficulty concentrating, heart palpitations, headaches, body aches, sleep difficulties, changes in eating habits, gastrointestinal distress, increase in addictive behaviours, and withdrawal from others (Figley, 1986; Herman, 1992; Motta, 2008). High levels of psychological distress have been reported in those working in mental health services generally (Meldrum, King, & Spooner, 2002; Kottler, 1993), but there appears to be less research focusing on those working with trauma clients. Some researchers have 'captured' this psychological distress by examining burnout. Kadambi and Truscott (2004) found that around a fifth of their sample of therapists fell within the high range for the emotional exhaustion and depersonalisation subscales on the Maslach Burnout Inventory (Maslach, Jackson, & Leiter, 1996) and more emotional exhaustion has also been reported in sexual assault therapists compared to other counsellors (Johnson & Hunter, 1997).

More common in the literature are low/non-clinical levels of psychological distress (Wee & Myers, 2002; Follette et al., 1994). For example, Kassam-Adams (1999), using the Personal Strain Questionnaire (Osipow & Spokane, 1981) which measures general work-related stress and psychological distress, found that psychotherapists did not differ from the norm when compared with 900 workers in various clinical and non-clinical professions.

There is limited empirical evidence for the hypothesised psychological distress in therapists. This may be due to the wide range of possible psychological symptoms, somatic symptoms, and behaviours that come under the umbrella of psychological distress.

Moreover, the assessment tools that are currently being used may not adequately measure these experiences. It may be that therapists' coping strategies are enabling them to maintain low levels of psychological distress. Indeed, Follette et al.'s (1994) study reported that therapists used significantly more positive coping strategies than law enforcement officers.

Relational disturbances

Exposure to trauma work is theorised to impact on therapists' personal and professional relationships. Chrestman (1999) found that therapists with a higher percentage of trauma clients on their caseload talked less with their family and friends about their work, decreased their children's activities away from home, and attended more professional activities and conferences. Whilst exploring therapists' affective reactions to working with adult survivors of childhood sexual abuse, Knight (1997) reported that statements most commonly reported by therapists included feelings of vulnerability in their personal relationships.

There appears to be limited use of standardised questionnaires examining this domain. Instead, most reports are anecdotal with indications of both positive and negative disruptions in relationships. For example, Courtois (1988) highlights that exposure to client trauma can lead to either over-identification with, or detachment from clients, both of which can have detrimental effects on the therapeutic relationship. Dutton and Rubenstein (1995) believe that therapists may distance themselves from family, friends, and colleagues as they may feel that they will not be understood. In contrast, Calhoun and Tedeschi (1999) write about the positive impact that the work can have on relationships as "the clinician more fully realizes the degree to which maintaining and nurturing connections to others is important. There is the greater appreciation of loved ones...[and] clinicians may be induced by the client's experience to strengthen their own ties to other persons" (p. 131).

Limitations to the research

The literature discussed here can be considered in the context of a number of limitations, in particular conceptual issues, methodological issues, and contextual limitations.

Conceptual issues

There is limited attention given to the hypothesised causal mechanisms behind these theoretical concepts in the literature. This has meant there is little empirical research aiming to test these proposed mechanisms. Instead, empirical papers have focused on reporting prevalence rates and symptoms in therapists with some reporting correlations between the concepts and predictive factors. Although this research is useful, especially when establishing the concepts' validity in different countries, more research exploring these mechanisms is needed. There is some overlap amongst the mechanisms that have been proposed to date, and these appear inadequate as they do not fully explain which therapists are more or less likely to be impacted positively or negatively.

Evidence for CF, STS, VT, and burnout in trauma therapists is inconsistent and ambiguous and although symptoms of general psychological distress, PTSD, and disrupted cognitions have been found in some studies, most correlations are weak and many scores fall within the subclinical range (Sabin-Farrell & Turpin, 2003; Bride, 2004). Although it is possible to argue that the measures used may not be sensitive enough to detect those therapists who are in distress, another explanation may be that therapists are not struggling at all, or those that are, have already left the field. Indeed, therapists in some samples may struggle more than those in others due to contextual factors (e.g. team dynamics, lack of resources) that these studies do not seem to consider.

Furthermore, Sabin-Farrell and Turpin (2003) report that, at present, “no one questionnaire has been designed to measure the concept of vicarious trauma as a whole” (p. 469) which also applies to the other concepts. This has led to the use of a plethora of measures, with some created for use in specific studies and not used again, making it difficult to directly compare studies. Additionally, the interchangeable use of conceptual terms has led to a lack of clarity, and added to the difficulty in comparing results of studies.

SECTION A: WORKING WITH ADULT TRAUMA CLIENTS

Finally, much of the research has concentrated on looking at the negative consequences of working with trauma which has led to a dearth of research into the positive effects of trauma work.

Methodological issues

Barring a few studies (e.g. Kadambi & Ennis, 2004; van Minnen & Keijsers, 2001), most research has failed to include experimental or comparison groups. This is particularly important as some concepts (i.e. CF, STS, and VT) have been proposed to be unique to those treating trauma clients. Without comparison groups, it is not possible to ascertain whether this is indeed the case, or whether these concepts apply to therapists working with other client presentations.

To date, studies in this field have relied on cross-sectional data which limits our understanding in two ways. Firstly, as there is evidence that therapists' negative reactions may be acute and something they are able to recover from, rather than chronic (Chrestman, 1999), cross-sectional research do not allow for the study of the natural progression of these effects. Secondly, cross-sectional data fails to capture the experiences of those that have left the field as a consequence of their work. It is possible that some studies may fail to pick up extreme distress in therapists as those suffering may be on long-term sick leave or already left the field .

Contextual limitations

The main contextual limitation of the research to date relates to its generalisability to UK therapists. The majority of research has been restricted to the US, with some studies from Australia, Canada, and a handful from Europe. Each of these countries has differing healthcare systems. For example, unlike the UK, at the time of the literature review, the US did not provide a universal healthcare system and 75% of Canada's healthcare services were

SECTION A: WORKING WITH ADULT TRAUMA CLIENTS

privately delivered but publically funded (CBC, 2006). These subtle differences in the delivery of healthcare provision means that the experience of therapists in psychological services may differ from country to country. It is, therefore, difficult to know to what extent these effects are valid in the UK context.

Future research

Several possible future research ideas emerge from this review. As noted throughout, there is conceptual confusion and overlap between these concepts. Although these are relatively new concepts, there is a growing literature base in this area. However research into the causal mechanisms underlying these experiences is needed. Additionally, empirical and theoretical developments should focus on whether these concepts can be clearly delineated or whether they are better understood simply as multifaceted positive and negative experiences. This will then lead the way for better theoretical understanding and greater specificity of different measures, facilitating direct comparisons between research studies in the future.

Research is also needed to ascertain whether these concepts apply to UK therapists many of which work within the National Health Service (NHS). This is particularly important in light of the anticipated increase in the number of therapists treating PTSD in the UK due to the national introduction of Improving Access to Psychological Therapies where PTSD will be treated at primary-care level by Step 3 High Intensity Therapists (NHS, n.d.). Additionally, it may be useful to research the protective and risk factors for UK therapists, which should be drawn from theoretical understanding of the concepts.

Some of the theories propose that these concepts are unique to those engaging in trauma work and this review has been based on those working with adults. Research is therefore needed to ascertain whether these effects are restricted to those therapists who work

SECTION A: WORKING WITH ADULT TRAUMA CLIENTS

with adult trauma clients or whether therapists working with other client groups with different presentations are also vulnerable.

Clinicians have reported finding trauma work rewarding and an honour (Farber & Heifetz, 1981; Saakvitne & Pearlman, 1996). More research is needed to explore the positive effects of working with trauma clients, and the factors associated with these experiences. Additionally, somewhat overlooked in the research is the fact that the majority of clinicians are coping well with their jobs. Their coping strategies should be further explored.

The literature would greatly benefit from longitudinal work. This will make it possible to measure clinicians' levels of CF, burnout, and CS when starting trauma work then over time. The temporal relationship between the development, duration, and course of symptoms could then be better understood. This will also reduce the reliance on therapists to retrospectively recall changes over time. Figley (1999) writes that "to my dismay, I have seen many colleagues and friends abandon clinical work or research with traumatized people because of their inability to deal with the pain of others" (p. 8). Empirical research is needed to substantiate current anecdotal evidence and to quantify the percentage of therapists leaving the specialism owing to these proposed difficulties. In-depth interviews with this population may crystallise our knowledge in this area and add to research into protective and risk factors.

Conclusions

There is growing evidence from other countries that working with trauma clients impacts on therapists both positively and negatively. However, the evidence is inconsistent with conceptual and methodological issues and has mainly been carried out in the US limiting the generalisability of these findings to UK therapists. It is important that the negative effects of the work be acknowledged and measures put in place to address these

SECTION A: WORKING WITH ADULT TRAUMA CLIENTS

effects as they may impact therapists' personal and professional functioning. Positive consequences of working with this client group need further attention as they may act to protect therapists against these negative effects. Acknowledging both the positive and deleterious parts of the work may be crucial in understanding the impact that trauma work has on therapists.

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EKUNDAYO A. SODEKE-GREGSON MA (Hons)

MAJOR RESEARCH PROJECT

SECTION B

**COMPASSION SATISFACTION, BURNOUT, AND SECONDARY
TRAUMATIC STRESS IN UK THERAPISTS WHO WORK WITH
ADULT TRAUMA CLIENTS**

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Doctor of Clinical Psychology

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SALOMONS

CANTERBURY CHRIST CHURCH UNIVERSITY

Abstract

Background: Therapists who work with trauma clients are impacted by this work both positively and negatively. However, most studies have tended to focus on the negative impact of the work, the quantitative evidence has been inconsistent, and the research has primarily been conducted outside the UK.

Method: An online questionnaire was developed which used a standardised measure to assess compassion satisfaction (CS), burnout, and secondary traumatic stress (STS) in 253 UK therapists working with adult trauma clients.

Results: Whilst the majority of therapists scored within the average range for CS and burnout, 70% of scores indicated that they were at high risk of STS. Maturity, time spent engaging in R&D activities, and a higher perceived supportiveness of management and supervision predicted higher potential for CS. Youth and a lower perceived supportiveness of management predicted higher risk of burnout. Higher risk of STS were predicted in therapists engaging in more individual supervision and self-care activities, as well as those who had a personal trauma history.

Discussion: These results are discussed in light of previous research. Of particular note is that exposure to trauma stories did not significantly predict STS scores as suggested by STS theory. Contextual and methodological limitations and ideas for future research are highlighted.

Key words: Compassion satisfaction, burnout, secondary traumatic stress, vicarious traumatisation, compassion fatigue, trauma, Professional Quality of Life scale, online questionnaire

Compassion Satisfaction, Burnout, and Secondary Traumatic Stress in UK Therapists working with Adult Trauma Clients

It is now commonly recognised that engaging in trauma work may impact therapists in different ways. Whilst some therapists report feelings of well-being from working with clients with a trauma history, the American Psychiatric Association (APA, 2000) acknowledges that it is possible to become traumatised indirectly by “learning about unexpected or violent death, serious harm, or threat of death or injury experienced” by another person (2000, p. 463). Two main theoretical concepts have been put forward to describe therapists’ experiences: compassion satisfaction and compassion fatigue.

Compassion satisfaction (CS)

There is a growing body of literature that documents the positive effects of working with trauma. Stamm proposed CS to be “the sense of fulfilment or pleasure that therapists derive from doing their work well” (Larsen & Stamm, 2008, p. 282). CS is made up of three elements: (1) the level of satisfaction a person derives from their job; (2) how well a person feels they are doing in their job, which will be related to the level of competency and control the therapist feels they have over the traumatic material they are exposed to; and (3) the level of positive collegiate support a person has with aspects of structural and functional social support being particularly important (Stamm, 2002). CS is not restricted to those working with trauma clients but concerns those in all ‘helping professions’. High potential for CS have been reported in mental health professionals in the US (Larsen, Stamm & Davis, 2006; Conrad & Kellar-Guenther, 2006), Ireland (Collins & Long, 2003) and amongst interpreters and therapists working at the Treatment Center for Torture Victims in Berlin (Birch, 2001).

SECTION B: CS, BURNOUT, AND STS IN UK THERAPISTS

These positive experiences have also been supported by qualitative research (Arnold, Calhoun, Tedeschi, & Cann, 2005; Steed & Downing, 1998).

Compassion fatigue (CF)

The concept of CF is often used to describe the negative impact of working with trauma clients. It is described as a “tension and preoccupation with the traumatized patients by re-experiencing the traumatic events, avoidance/numbing of reminders (sic) persistent arousal (e.g. anxiety) associated with the patient” (Figley, 2002, p. 1435). Adams, Boscarino, & Figley (2006) propose that CF is a broad concept which encompasses secondary traumatic stress (STS), vicarious traumatization (VT), and burnout as latent clinical features and these terms are often used interchangeably in the literature, despite some nuances. Specifically, STS is defined as the “natural, consequent behaviours and emotions resulting from knowledge about a traumatizing event experienced by a significant other” (Figley, 1999, p. 10). Sufferers are believed to experience symptoms nearly identical to clients suffering from posttraumatic stress disorder (PTSD). Whilst STS is believed to develop suddenly and is an acute reaction (Figley, 1995), CF is overarching and arises through prolonged exposure to clients’ trauma stories.

The cumulative nature of the process arising from working with several clients over time has also been highlighted by VT proponents who posit it to be the negative “transformation that occurs within the therapist...as a result of the empathic engagement with clients’ trauma experiences and their sequelae” (Pearlman & Mac Ian, 1995, p. 558). VT focuses on the disrupted frame of reference which may permanently impact therapists’ beliefs about others, their “sense of self, world view, spirituality, affect tolerance, interpersonal relationships, and imagery system of memory” (Pearlman, 1999, p. 52). Like

SECTION B: CS, BURNOUT, AND STS IN UK THERAPISTS

CF and STS, VT is believed to be an occupational hazard which is an inescapable effect of, and unique to, trauma work.

Burnout, on the other hand, is not specifically limited to those working with trauma clients, but is more a reaction to the demands of one's job and environment. It is "a state of physical, emotional, and mental exhaustion caused by long term involvement in emotionally demanding situations" (Pines & Aronson, 1998, p. 9). Burnout results in physical, emotional, behavioural, work-related, and interpersonal symptoms (Kahill, 1988).

In summary, therapists suffering from CF are hypothesised to experience PTSD symptoms, disruptions to their cognitive schemas, relational difficulties, as well as physical, emotional, or behavioural distress symptoms such as sleep difficulties, anxiety, and social withdrawal. These experiences are believed to affect therapists' personal and professional relationships and also impact on their ability to effectively work with clients (Collins & Long, 2003). To date, research studies provide mixed support for these hypothesised symptoms in therapists working with trauma clients. For example, whilst severe PTSD symptomology has been reported in some therapists (Chrestman, 1999; Kassam-Adams, 1999), milder or subclinical levels have also been observed (Brady, Guy, Poelstra, & Brokaw, 1999; Follette, Polusny, & Milbeck, 1994; Kadambi & Truscott, 2004). Although some studies have documented cognitive disruptions in US therapists (Pearlman & Mac Ian, 1995; Schauben & Frazier, 1995), these have not been replicated by studies in Holland (van Minnen & Keijsers, 2001) and Canada (Kadambi & Truscott, 2004). Whilst Kadambi and Truscott (2004) noted that around a fifth of their Canadian therapists scored high in emotional exhaustion and depersonalisation, only 5% of Craig and Sprang's (2010) US therapists had scores suggesting they were at high risk of burnout. In summary, there is inconsistent empirical support for hypothesised symptoms of CF and it is clear that individual differences occur in the experiences of therapists.

Proposed causal mechanisms

Despite the growing interest in the effects of trauma work, little attention has been given to the potential causal mechanisms underlying these concepts. One proposed mechanism is countertransference, where therapists are believed to be negatively impacted owing to their unresolved or unconscious conflicts and experiences becoming activated whilst engaging with their clients' trauma stories. Other mechanisms hypothesised in the literature are empathic engagement, emotional contagion (Hatfield, Cacioppo, & Rapson, 1992), cognitive theories of assimilation and accommodation (Piaget, 1971), and social learning theory (Bandura, 1967). These mechanisms provide some understanding of the experiences reported by therapists, but do not adequately explain the positive experiences reported and some cannot account for why some therapists are impacted positively, others negatively, and some not at all.

Protective and risk factors

The impact of trauma work appears to vary between individuals which has led researchers to investigate possible protective and risk factors with both therapist and organisational variables being examined. Therapist variables have included age, gender, personal history of trauma, coping strategies, personal therapy, and more work-related variables like exposure to trauma clients, experience, size of caseload, and therapeutic modality used. However, studies have produced inconsistent findings. For example, female therapists have been reported to be at greater risk for developing PTSD symptoms (Kassam-Adams, 1999) and somatic symptoms (Meyers & Cornille, 2002), whereas, men reported higher levels of psychological distress (Wee & Myers, 2002). However, other researchers have not found gender differences in STS (Meldrum, King, & Spooner, 2002) or CF, burnout, and PTSD symptoms (Wee & Myers, 2002). Some studies have reported that therapists with

SECTION B: CS, BURNOUT, AND STS IN UK THERAPISTS

a personal trauma history experienced higher levels of distress (Kassam-Adams, 1995; Pearlman & Mac Ian, 1995) but this finding has not been universally replicated (Schauben & Frazier, 1995).

A mixed picture has also emerged investigating work-related variables. As exposure to trauma is a pre-requisite for CF, one would expect there to be a relationship between these two variables. This has been confirmed by research which has reported that the percentage of trauma clients on therapists' caseloads was related to PTSD symptoms (Chrestman, 1999; Kassam-Adams, 1999) burnout, and CF (Craig & Sprang, 2010). Surprisingly, others have not found this hypothesised relationship (Deville, Wright, Varker, 2009; Meyers & Cornille, 2002; Schauben & Frazier, 1995) and some have found that those seeing more trauma clients reported less distress (Baird & Jenkins, 2003). Another example is experience, which has either been measured by the number of years therapists have worked in the field or by their qualifications. Those who have worked longer in the field have been reported to be at less risk of being negatively impacted than less experienced therapists (Chrestman, 1999; Neumann & Gamble, 1995; Pearlman & Mac Ian, 1995) and report higher potential for CS (Craig & Sprang, 2010). However, Kassam-Adams (1995) reported that years of clinical experience did not correlate with STS and Baird and Kracen (2003) reported that therapists with more experience reported more emotional exhaustion. A higher qualification, on the other hand, has consistently been found to be protective against CF, burnout, and psychological distress (Baird & Jenkins, 2003; Pearlman & Mac Ian, 1995; Rudolph, Stamm, & Stamm, 1997). A more recent study found evidence-based practice predicted higher potential for CS and lower risk of burnout and STS (Craig & Sprang, 2010).

Examined organisational factors include the provision of supervision, perceived workplace support, provision of trauma-specific training, urban versus rural workplace setting, remuneration, and working for public versus private organisations. Research findings

SECTION B: CS, BURNOUT, AND STS IN UK THERAPISTS

in these areas are also inconclusive. For example, regular supervision or consultation with a supervisor experienced in trauma work is believed to be essential (Pearlman & Saakvitne, 1995) and therapists not receiving supervision have been found to show more cognitive disruptions (Pearlman & Mac Ian, 1995). However, others have found that the amount of supervision received was not related to the experience of traumatic stress or PTSD symptoms (Kassam-Adams, 1999; Meldrum et al., 2002).

Whilst it is possible that these inconsistent findings may be due to the variety of different scales being used to measure therapists' experiences and the research being carried out on differing self-selecting groups, there is, as yet no clear picture of the variables which are associated with, or most likely to predict CF. In fact, a systematic review of the empirical evidence supporting CF, STS, and VT concluded that the quantitative evidence for these concepts was "meagre and inconsistent, relying on small and variable correlations between symptomatic distress and trauma exposure" (Sabin-Farrell & Turpin, 2003, p. 467). Additionally, the majority of research continues to focus on the deleterious effects of trauma work, which has led to a dearth in research on the positive impact, and the factors that might promote positive experiences in therapists.

Much of the published research has been carried out in the US where, until recently, there was no provision of universal healthcare and where supervision requirements for therapists differ from the UK. For example in the state of Minnesota, once a licensed professional counsellor has received 2000 hours of post-doctoral supervised professional practice, they may practice independently and no longer need to be supervised (Minnesota Board of Behavioural Health and Therapy, n.d.). With limited research published in the UK, the question still remains as to whether and to what extent these concepts are contextually valid for UK therapists working with trauma clients.

Research aims

The aims for the present exploratory study were to:

- investigate the reported levels of CS and CF in a national sample of UK therapists working with trauma clients in specialist trauma and secondary-care services (or similar).
- investigate the salient factors that may be associated with CS and CF.
- examine which variables most strongly predict CS and CF.

Method

Participants

Participants were therapists working for the UK National Health Service (NHS) or registered with one or more national professional psychological bodies. Recruitment, which took place between June 2010 and January 2011, actively focused on those therapists working with working-age adults in specialist trauma and secondary-care services (or similar) as it was postulated that these therapists were most likely to be working with clients with severe traumatic histories. However, those therapists working for other services who self-selected into the study were not excluded as long as they worked with adult trauma clients.

Three hundred and forty therapists were recruited. However, 87 questionnaires were excluded from further analysis as therapists either identified themselves as working with children ($n = 4$), older adults ($n = 1$), or dropped out before the end of the questionnaire ($n = 82$). Participants were 253 therapists (182 women, 71 men) with 64.5% aged between 30-49 years. They worked in either specialist trauma services (22.5%), secondary-care services (62.5%), or identified themselves as working in 'other services' (15%) which included specialist/tertiary services, primary care, private practice, and public or voluntary services. The majority of therapists were clinical or counselling psychologists (69.6%), many had a

SECTION B: CS, BURNOUT, AND STS IN UK THERAPISTS

doctoral qualification (39.1%), over half had worked for less than 10 years (56.2%), and over half identified themselves as having a personal history of trauma (59.3%). The predominant therapeutic approach reported was CBT (39.1%), and a large group had had more than a week's trauma-specific training since qualification (47.4%). The majority worked part-time (64%) and had between 1-9 trauma clients on their current caseload (65.2%).

Design

Due to the current state of research in this field, this research was largely exploratory in nature rather than testing specific hypotheses, although certain variables were particularly relevant to examine on the basis of previous research. The design was quantitative in order to capture a large UK sample.

Measures

Independent measures.

Demographic and background information questionnaire. A questionnaire was developed which included questions about participants' personal demographics and background information about their work setting. Questions elicited information about therapists' service setting, age, gender, years of clinical experience, and their highest level of qualification. Core profession options were clinical/counselling psychology, nursing, social work, psychiatry, or other. The number of sessions (1 session equates to 3.75 hours) worked ranged from 0-10. Therapists indicated the number of clients on their caseload as well as the number with whom they were doing trauma-focused work through forced options ranging from 0 clients to 25+ clients. Therapists' predominant therapeutic approach was a forced choice between CBT, EMDR, Psychodynamic, Narrative, Systemic, Integrative, or the option of specifying another modality. The amount of specific trauma training therapists received during their main training course and since qualification was elicited and options varied from

SECTION B: CS, BURNOUT, AND STS IN UK THERAPISTS

half a day to over a week. Therapists were asked to note the number of hours of individual, group, and peer supervision, as well as supervision with an external consultant they received per month. To determine therapists' personal trauma history, they were given a list of traumatic events derived from the Posttraumatic Stress Diagnostic Scale (Foa, 1995) and were asked to respond yes or no to whether they had lived through or witnessed any such event. Organisational support was assessed by asking therapists to rate their perceived level of support afforded to them by their management, administrative staff, peers, and supervision in dealing with their clinical work respectively. Therapists answered these four questions using a 5-point Likert scale which ranged from 'Not at all supported' to 'Very supported'.

Coping Strategies Inventory (CSI; Bober, Regehr, & Zhou, 2006). Therapists' coping strategies were assessed using the CSI which has been validated on 259 therapists and 71 hospital staff who were non-therapists (Bober et al., 2006). The CSI is made up of two parts; beliefs and time. The first covers beliefs therapists have about which coping strategies will reduce levels of secondary stress. An example item is 'time with family' and respondents were asked to rate each item on a 5-point scale (0 = Not at all helpful, 2 = Sometimes helpful, 4 = Always helpful). This CSI-Beliefs scale has three subscales: leisure, self-care, and supervision which have reported internal reliability coefficients of 0.71-0.82. The second, CSI-Time, covers the time therapists spend engaging in these activities. An example item is 'participating in research' and respondents are given a 4-point scale (0 = Not at all, 3 = Frequently) to respond resulting in four subscales: leisure, self-care, supervision, and research & development (R&D), with reported internal reliability coefficients of 0.67-0.80. Permission was received from the author to use the CSI in the present research as part of an online questionnaire (Appendix 3).

Dependent measure.

The Professional Quality of Life Scale, Version 5 (ProQOL; Stamm, 2009). The ProQOL is a 30-item scale which measures the positive and negative effects experienced by those who choose to help others experiencing suffering and trauma. It is made up of three subscales, CS, CF, and burnout. Stamm (2009) describes CS as the “pleasure you derive from being able to do your work well” (p. 12) and an example item is ‘I believe I can make a difference through my work’. CF breaks down into two elements, burnout, and STS. Burnout is described as “feelings of hopelessness and difficulties in dealing with work or in doing your job effectively” whilst STS is “work-related, secondary exposure to people who have experienced extremely or traumatically stressful events” (Stamm, 2009, p. 13). An example burnout item is ‘I feel overwhelmed because my case/workload seems endless’ and a STS item is ‘I avoid certain activities or situations because they remind me of frightening experiences of the clients I help’.

The ProQOL asks respondents to rate how frequently they experience these feelings in relation to their work with clients in the last 30 days. Items are rated on a 6-point scale (0 = Never, 3 = Somewhat, 5 = Very often). The ProQOL was previously standardised on 1187 people from the helping profession. The alpha reliabilities for the scales have good to excellent reliability (CS $\alpha = .88$ [n=1130]; BO $\alpha = .75$ [n=976]; CF is $\alpha = .81$ [n=1135]).

The ProQOL was chosen as it is the most commonly used questionnaire that measures both positive and negative effects of working with those with a trauma history who are suffering (Stamm, 2010). It is not a diagnostic test but merely a guide which raises issues that may need to be addressed regarding each of the three concepts. Permission was received from the author to use the questionnaire in an online format (Appendix 4).

Piloting of questionnaire.

The compiled online questionnaire (Appendix 5) was piloted on sixteen trainee clinical psychologists and two qualified psychologists to assess the workability of the online facility and comprehension of the questions. Based on this pilot, the format of the ProQOL was amended to make it more legible on the computer screen.

Additional assessment.

Previous studies have used an online methodology to assess trauma and PTSD symptoms in the general population following the 9/11 terrorist attacks (Butler et al., 2005; Schlenger et al., 2002; Silver, Holman, McIntosh, Poulin, & Gil-Rivas, 2002). Read, Farrow, Jaanimägi, & Ouimette (2009) examined participants' experience of completing an online assessment to measure trauma and reported a positive reaction to the use of an online survey. To date, no published studies have solely used an online methodology to examine compassion satisfaction, burnout, and secondary traumatic stress in trauma therapists, therefore, an assessment of acceptability of this methodology was conducted as part of this study. Participants were asked two questions: How did you find completing the questionnaire online? and How comfortable did you feel answering these types of questions in an online questionnaire?

Procedure

Ethics approval was gained from the Central London REC 3 Research Ethics Committee (Appendix 6).

Following R&D approval from 50 participating NHS Trusts in England, Scotland, Wales, and Northern Ireland (Appendix 7), the Heads of Psychological Therapies (or equivalent) within the Trusts were contacted. An email was sent from a representative within the Psychology departments to all therapeutic staff that met the inclusion criteria in their

SECTION B: CS, BURNOUT, AND STS IN UK THERAPISTS

Trust asking for volunteers to complete an online questionnaire about the effects that working with clients with a trauma history had on therapists (Appendix 8).

Participants were also recruited from professional bodies including the British Psychological Society (Division of Clinical Psychology and Division of Counselling Psychology), The British Association for Counselling & Psychotherapy, The British Association for Behavioural & Cognitive Psychotherapies, The United Kingdom Council for Psychotherapy, UK Psychological Trauma Society, EMDR Association, Register of Trauma Specialists, and Counselling & Psychotherapy in Scotland through the use of e-bulletins, research notice boards, or by emailing members whose details were publicised on the websites (Appendix 9).

The email received by all potential participants introduced the study and contained a link to the homepage of the online questionnaire which included additional information about the study and consent. Once therapists consented to take part in the study by checking the consent box, they were directed to the anonymous online questionnaire which took approximately 10-15 minutes to complete.

Statistical analyses

A power calculation of required participants was made prior to recruitment. Based on achieving a medium effect size ($R^2 = 0.13$) (as used in other studies e.g. Devilly, et al., 2009), with a statistical power of .8 (as recommended by Cohen, 1988), and considering the inclusion of up to 12 predictor variables into the planned multiple regressions, the researcher aimed to recruit between 120-150 participants. As this was an exploratory study, two-tailed tests were used with a significance value of 0.05. Tests for normality were performed which suggested normal distribution allowing for parametric testing to be carried out.

SECTION B: CS, BURNOUT, AND STS IN UK THERAPISTS

Analyses were conducted using SPSS-17.0 (for Windows 2001). These analyses included: (a) descriptive statistics to summarise demographic information and prevalence of CS, burnout, and STS in therapists; (b) Pearson correlations, or point-biserial for dichotomous variables, to test associations between pairs of variables, (c) multiple regressions to explore predictor variables for CS, burnout, and STS.

Results

Prevalence of CS, burnout, and STS amongst therapists

Participants' scores were calculated and categorised into the cut-offs for low, average, and high levels of CS, burnout, and STS in accordance with Stamm's (2009) guidelines (Table 1). Whilst the majority of the therapists scored within the average range for CS and burnout, 70% of the therapists' scores indicated that they were at high risk of STS with no therapists scoring low on STS.

Table 1

Number of therapists at low, average, and high risk of CS, burnout, & STS (N = 253)

	Compassion Satisfaction	Burnout	Secondary Traumatic Stress
Low	20 (8%)	25 (9.9%)	0 (0%)
Average	135 (53.2%)	163 (64.2%)	76 (30%)
High	98 (38.8%)	65 (25.8%)	177 (70%)

Data transformation

To allow for point-biserial correlations and subsequent multiple regressions to be carried out, it was necessary to transform four variables from nominal data sets to dichotomous data (Table 2).

Table 2

Variables transformed from nominal to dichotomous data

	Nominal variable	Dichotomous variable	Coding
Service setting	• Specialist trauma service	• Specialist trauma service	1
	• Secondary-care service		2
	• Other	• Other	
Highest qualification	• Diploma	• Doctorate/PHD	1
	• Degree		2
	• MA	• Other	
	• MSc		
	• Doctorate		
	• PHD		
Core profession	• Clinical/Counselling Psychology	• Clinical/Counselling Psychology	1
	• Nursing		2
	• Social work	• Other	
	• Psychiatry		
	• Other		
Therapeutic model	• CBT	• NICE-recommended therapy (i.e. CBT & EMDR)	1
	• EMDR		2
	• Psychodynamic		
	• Narrative		
	• Systemic	• Other	
	• Integrative		
	• Other		

Correlations between CS, burnout, STS, and predictor variables

Pearson correlations, and point-biserial correlations, were performed. None of the correlations between the independent variables were above $r = .649$ (Appendix 10).

SECTION B: CS, BURNOUT, AND STS IN UK THERAPISTS

Correlations between the independent predictor variables and CS, burnout, and STS were performed to identify significant correlations (Table 3).

CS was positively correlated with therapists' age ($r = .265, p < .001$), their highest qualification ($r_{pb} = .181, p < .004$), their years of clinical experience ($r = .151, p < .017$), the amount of trauma-specific training they had received since qualification ($r_{pb} = .201, p < .001$), CSI beliefs – leisure ($r = .171, p < .007$), CSI beliefs – supervision ($r = .153, p < .015$), CSI time – self-care ($r = .216, p < .001$), CSI time – supervision ($r = .196, p < .002$), CSI time – R&D ($r = .282, p < .001$), therapists' perceived management support ($r = .214, p < .001$), and therapists' perception of the supportiveness of their supervision ($r = .254, p < .001$). In contrast, burnout was negatively correlated with therapists' age ($r = -.2, p < .001$), their highest qualification ($r_{pb} = -.157, p < .013$), the amount of trauma-specific training they had received since qualification ($r = -.155, p < .015$), CSI beliefs – leisure ($r = -.145, p < .022$), CSI beliefs – supervision ($r = -.189, p < .003$), CSI time – supervision ($r = -.204, p < .001$), therapists' perceived management support ($r = -.328, p < .001$), and therapists' perception of the supportiveness of their supervision ($r = -.249, p < .001$). Additionally, burnout was negatively correlated with CSI time – self-care ($r = -.173, p < .007$), CSI time – R&D ($r = -.192, p < .002$), and perceived peer support ($r = -.155, p < .014$). STS was positively correlated with time spent in individual supervision ($r = .187, p < .003$), CSI time – self-care ($r = .172, p < .007$), and therapists' predominant model ($r_{pb} = .145, p < .022$). Specifically, therapists working with CBT or EMDR scored lower on STS, as did those without a trauma history. STS was negatively correlated with the number of years of clinical experience ($r = -.135, p < .032$) and personal trauma history ($r = -.139, p < .027$). There were no correlations between the number of trauma clients on therapists' caseloads with any of the dependent variables (CS; $r = .119, p < .059$), (Burnout; $r = -.027, p < .674$), (STS; $r = .120, p < .056$).

SECTION B: CS, BURNOUT, AND STS IN UK THERAPISTS

Table 3**Correlations between CS, burnout, and STS and independent predictor variables³**

	Compassion satisfaction	Burnout	Secondary traumatic stress
Service setting	-.024	.008	-.116
Age	.265**	-.200**	-.043
Gender	-.039	.060	.102
Highest qualification	.181**	-.157*	.051
Number of years post qualification	.151*	-.120	-.135*
Core profession	.110	-.095	-.070
Number of sessions	.029	-.035	-.092
Number of clients on caseload	.061	.013	-.054
Number of trauma-focused clients on caseload	.119	-.027	.120
Predominate therapeutic approach	-.042	.027	.145*
Hours of individual supervision per month	.031	-.006	.187**
Hours of group supervision per month	-.029	.006	.035
Hours of peer supervision per month	.027	.034	-.003
Hours of consultant supervision per month	.060	-.039	.123
Days of trauma-specific training during main training course	.011	-.070	.118
Days of trauma-specific training since qualification	.201**	-.155*	-.054
Personal trauma history	-.058	.017	-.139*
CSI Beliefs – leisure	.171**	-.145*	.046
CSI Beliefs – self-care	.123	-.099	.050
CSI Beliefs – supervision	.153*	-.189**	.013
CSI Time – leisure	.048	-.094	-.047
CSI Time – self-care	.216**	-.173**	.172**
CSI Time – supervision	.196**	-.204**	.115
CSI Time – R&D	.282**	-.192**	.063
Perceived support by management	.214**	-.328**	-.111
Perceived support by administrative staff	.102	-.113	.063
Perceived support by peers	.075	-.155*	-.057
Perceived support of supervision	.254**	-.249**	.063
ProQOL – Compassion satisfaction	1	-.697**	-.189**
ProQOL – Burnout		1	.454**
ProQOL – Secondary traumatic stress			1

Note: *p < .05; **p < .01.

³ Please note that the colour red has been used to make it easier to see significant correlations at a glance.

SECTION B: CS, BURNOUT, AND STS IN UK THERAPISTS

CS was negatively correlated with both burnout ($r = -.697, p < .001$) and STS ($r = -.189, p < .003$) whilst burnout was positively correlated with STS ($r = .454, p < .001$).

Predictors for CS, burnout, and STS

Due to the large number of variables and the exploratory nature of the study, it was decided that only those variables that significantly correlated with CS, burnout, and STS would be entered into the multiple regressions. Three multiple regressions were run, one for each of the dependent variables. As this was an exploratory study, the simultaneous method was chosen. It was decided that listwise deletion would be used in these multiple regressions as there were few missing variables. All VIF values were below 10, tolerance statistics were above 0.2, and casewise diagnostics were reviewed and within accepted parameters as recommended by Field (2009).

Predictors for CS.

A significant model emerged: $F(11,220) = 5.825, p < .001$ explaining 22.6% of the variance ($R^2 = .226$) (Table 4). Age, time spent engaging in R&D activities, perceived management support, and perceived supervision support were significant positive predictors of CS. This indicated that older therapists had higher potential for CS. Additionally, the more time therapists spent in R&D activities, (i.e. away from therapeutic work) the higher potential for CS. As therapists' perceived level of support from management and supervision increased, so did their potential for CS.

Predictors for burnout.

A significant model emerged: $F(10,226) = 7.243, p < .001$ which explained 24.3% of the variance ($R^2 = .244$) (Table 5). Perceived management support and age were significant negative predictors of burnout. Being older appeared to be a protective factor against

SECTION B: CS, BURNOUT, AND STS IN UK THERAPISTS

burnout. Additionally, as therapists' perceptions of management support increased, this was related to a decreased risk of burnout.

Table 4**Regression model for variables predicting CS (n = 232)**

	B	SE B	β	t	p
Constant	35.19	3.54			
Age	.80	.34	.21	2.39	.02*
Highest qualification	1.67	1.02	.11	1.64	.10
Years of clinical experience	.38	.44	-.07	-.84	.40
Trauma training post qualification	.14	.25	.04	.57	.58
CSI Beliefs Leisure	1.51	.83	.12	1.82	.07
CSI Beliefs Supervision	-1.15	.89	-.10	-1.30	.19
CSI Time Self-care	1.06	.73	.11	1.46	.15
CSI Time Supervision	-2.9	1.17	-.02	-.25	.80
CSI Time R&D	1.81	8.2	.17	2.21	.03*
Perceived management support	.84	.38	.14	2.22	.03*
Perceived supervision Support	1.31	.56	.17	2.34	.02*

$R^2 = .226$ ($p < .001$). * $p < .05$; ** $p < .01$; *** $p < .001$. Adjusted $R^2 = .187$.

Table 5**Regression model for variables predicting burnout (n = 237)**

	B	SE B	β	t	p
Constant	69.59	3.31			
Age	-.53	.26	-.15	-2.05	.04*
Highest qualification	-1.21	.94	-.08	-1.29	.20
Trauma training post qualification	-.09	.23	-.03	-.39	.70
CSI Beliefs Leisure	-.81	.77	-.07	-1.05	.30
CSI Beliefs Supervision	.82	.83	.07	.99	.32
CSI Time Self-care	-.91	.67	-.10	-1.36	.18
CSI Time Supervision	-.53	1.07	-.04	-.49	.62
CSI Time R&D	-.53	.75	-.05	-.71	.48
Perceived management support	-1.59	.36	-.29	-4.39	.001***
Perceived peer support	-.26	.51	-.04	-.52	.61
Perceived supervision Support	-1.00	.54	-.14	-1.86	.06

$R^2 = .244$ ($p < .001$). * $p < .05$; ** $p < .01$; *** $p < .001$. Adjusted $R^2 = .206$.

Predictors for STS.

A significant model emerged: $F(5,239) = 5.286$, $p < .001$ which accounted for 10.0% of the variance ($R^2 = .100$) (Table 6). Time spent in individual supervision and time spent in

SECTION B: CS, BURNOUT, AND STS IN UK THERAPISTS

self-care were significant positive predictors for STS. Therefore, those therapists who spent more time both in supervision and in self-care activities were at higher risk of STS.

Additionally, those therapists that had experienced a traumatic event themselves were at higher risk of STS.

Table 6

Regression model for variables predicting STS (n = 245)

	B	SE B	β	t	p
Constant	60.01	2.67			
Years of clinical experience	-.63	.36	-.12	-1.75	.08
Therapeutic model	1.55	.92	.10	1.68	.10
Time spent in individual supervision	1.53	.75	.14	2.06	.04*
Personal Trauma history	-2.04	.96	-.14	-2.12	.04*
CSI Time Self-care	1.22	.60	.13	2.03	.04*

$R^2 = .100$ ($p < .001$). * $p < .05$; ** $p < .01$; *** $p < .001$. Adjusted $R^2 = .081$.

Acceptability of the online methodology

The majority of therapists (n = 237) completed the questions about the acceptability of the online methodology. The majority, 52.3% found the online methodology “not difficult/easy” and 17.3% “extremely easy” to complete. Some therapists (26.6%) found the questionnaire “a little difficult” to complete. The overwhelming majority of therapists (84.9%) reported being either “quite comfortable” or “extremely comfortable” in answering these types of questions online.

Discussion

This exploratory study aimed to investigate indicators of the prevalence of both positive and negative experiences associated with working with trauma clients for therapists in the UK. Whilst the majority of therapists reported average potential for CS and average risk of burnout, 70% of therapists had scores that suggested they were at high risk of STS.

SECTION B: CS, BURNOUT, AND STS IN UK THERAPISTS

Higher risks of burnout were associated with higher risks of STS, and they were both associated with a lower potential for CS. Maturity, time spent engaging in R&D activities, and a higher perceived supportiveness of management and their supervision predicted higher potential for CS in therapists. Conversely, youth and a low perceived supportiveness of management were risk factors for burnout. Therapists who spent more time engaged in individual supervision, self-care activities, and had a personal history of trauma reported higher risks of STS.

Past studies have used a range of different outcome measures to study these concepts, making direct comparison of prevalence rates difficult. However, the ProQOL-III (an earlier version of the outcome measure used in the present study) was used by Craig & Sprang (2010) with self-identified trauma specialists in the US. Whereas they found only 5% of their 508 therapists were at high risk of burnout and STS, the present study's findings were drastically different with 25.8% at high risk of burnout and 70% at high risk of STS. For CS, 53.2% of therapists in the present study had an average potential for CS whilst 38.8% had high potential for CS. Whilst lower than Craig & Sprang's (2010) study who reported that 46% of their therapists scored high in CS, this is encouraging as it indicates that a large number of therapists enjoy their work with trauma clients and adds to the growing research evidence suggesting there may be a positive impact of trauma work for therapists.

The proportion of therapists at high risk of burnout and STS was much higher in this study than other studies utilising different measures (Birch, 2001; Kassam-Adams, 1999; Meldrum et al., 2002; Meyers & Cornille, 1999; Wee & Myers, 2002). The reason for the higher level of burnout and STS in UK therapists is not immediately apparent. Whilst the present sample size was smaller than Craig & Sprang's (2010) study, it was comparative with Meldrum et al. (2002) and was larger than those of Wee and Myers (2002) and Kassam-Adams (1999). Participants in the present study were similar to those in Craig & Sprang's

SECTION B: CS, BURNOUT, AND STS IN UK THERAPISTS

(2010) sample although other authors have surveyed mental health professionals who may not actively engage in therapy with clients. Craig and Sprang (2010) surveyed those who identified themselves as having some expertise in trauma treatment, 44.3% of their sample being psychologists and 46.3% from a social work background. In the present study, only 2% of the sample came from a social work background with the majority (69.6%) being either clinical or counselling psychologists.

As with Craig and Sprang (2010), the present study found youth to be a risk factor for burnout. In addition, older therapists reported higher potential for CS. Therapists in the present study were younger than those of Craig and Sprang (2010), so this may account for the lower levels of CS and higher levels of burnout reported in this study. Other researchers have found that years of clinical experience predicted higher potential for CS (Craig & Sprang, 2010), lower levels of cognitive disruptions (Pearlman & Mac Ian, 1995), avoidance, dissociation, anxiety (Chrestman, 1999), and more emotional exhaustion (Baird & Jenkins, 2003). As clinical experience did not significantly predict CS, burnout, or STS in the present research, it appears that maturity and life experience, as opposed to clinical experience per se, was more important in predicting CS and burnout in our sample. It is also likely that these older clinicians have remained in the field as they have found a way of coping with the demands of trauma work.

Interestingly, perceived supportiveness of supervision as opposed to the provision of supervision itself predicted a higher potential for CS which may suggest that the quality of supervision was more important than the quantity. In stark contrast with previous research which found that therapists not receiving regular trauma-focused supervision were more vulnerable to VT (Pearlman & Mac Ian, 1995), the more individual supervision therapists were receiving, the higher their risk of STS. It may be that those therapists who were in distress actively sought out more supervision than those who were coping better, or indeed

SECTION B: CS, BURNOUT, AND STS IN UK THERAPISTS

their managers may have insisted on more supervision for the therapists they perceived as not coping. Although the use of supervision has been recommended to ameliorate the negative effects (Pearlman & Mac Ian, 1995; Pearlman & Saakvitne, 1995; Sexton, 1999), less work has been done to identify the elements that constitute good supervision for trauma work. Through her supervision of those who work with sexual abuse clients, Etherington (2009) suggests that supervision should focus on “the interrelationship between the trauma itself, the person of the counsellor, the helping relationship...and the context in which the work is offered” (p. 183). This seems a good start point; however, more research is needed to further clarify what elements are integral to the supervision of trauma therapists.

Although one might expect that engaging in self-care activities would lead to lower risk of STS as suggested in the literature (Rothschild, 2006), this was not the case in the present study. Similar to supervision, those who spent more time engaging in self-care activities were at higher risk of STS. It is possible that therapists who were struggling more actively engaged in self-care activities in an attempt to alleviate their distress. Further research is needed to explore these supervision and self-care findings.

Higher perceived levels of management support predicted lower risk of burnout and higher potential for CS. These findings support the theoretical underpinnings of CS which proposes positive collegiate support as an integral part of CS and burnout, where personal accomplishments are linked to lack of resources such as poor social support (Schaufeli & Enzmann, 1998). Previous research has also found that therapists, who rated the emotional and technical support afforded to them at work as high, exhibited lower scores of work stress (Kassam-Adams, 1999). Although management support was clearly an important part of therapists’ functioning, the present research did not tease out the aspects of management support that were deemed most helpful. It is also interesting that perceived management support appeared to predict CS and burnout which are not exclusive to trauma therapists,

SECTION B: CS, BURNOUT, AND STS IN UK THERAPISTS

suggesting that perceived management support may be important to therapists in general as opposed to trauma therapists per se. Future research should explore the different elements that make up perceived management support and investigate the different ways in which this can be cultivated in services.

As a coping strategy, time spent in R&D activities was found to positively predict the potential for CS. Perhaps this time spent away from direct client work helps therapists bring a balance to their work life. Indeed Chrestman (1999) found that those therapists who spent more time doing clinical work, as opposed to other activities reported increased avoidance whilst those who spent more time in research activities reported decreased avoidance.

Those with a personal trauma history were shown to be at higher risk of STS in this study. Whilst this was consistent with findings by Pearlman and Mac Ian (1995) and Kassam-Adams (1999), it contradicted findings by Schauben and Frazier (1995). Perhaps therapists' previous experience of trauma made them more vulnerable to the trauma stories of others. Indeed, the proposed causal mechanism of countertransference, could be used to explain this difference.

It is notable that the number of trauma clients on therapists' caseloads did not predict STS as would be predicted by the theories of CF, STS, and VT and which has been reported by researchers (Chrestman, 1999; Kassam-Adams, 1995). Other researchers have also not found this theorised relationship (Deville et al., 2009; Meyers & Cornille, 2002). This calls into question whether it is indeed the exposure to clients' trauma stories that causes trauma therapists' distress, whether it is therapeutic work in general, or other factors. As van Minnen & Keijsers (2000) have found STS symptoms in therapists not working with trauma clients, they have argued that "the negative effects of trauma work, reported in previous studies, may have been overestimated" (p. 197).

Contextual issues

The majority of therapists (86%) in the present study worked within the NHS and the structure of psychological provision in the UK differs from that around the world and especially in the US where much of the research in this field has been conducted. It is likely that this may have impacted upon therapists' experiences of their work. The present study was not able to ascertain the contribution that the NHS structure may have had on the reporting of these concepts. Further research should investigate the differences between reported levels of CS, burnout, and STS in therapists working for the NHS and the private or voluntary sector and explore whether different predictors exist in these varied work settings.

It is also important to remember the context of the present study. Data were collected during a challenging period for the NHS where the UK was in recession and the newly formed coalition government had announced changes to the NHS which included "up to £20 billion of efficiency savings by 2014", reduction of "NHS management costs by more than 45% over the next four years", and the restructuring of commissioning with abolishment of Primary Care Trusts to be replaced by GP consortia (Department of Health, 2010, p.5). Anecdotally, this meant that many NHS posts were being cut, under threat, or being re-structured, and less money was available for training. It is, therefore, possible that these extraneous factors may have affected these results, in particular, burnout which is more related to general work stressors.

Notably, primary care services were purposely not recruited to take part in this study. With Improving Access to Psychological Therapies (IAPT) in its infancy, it was impossible to gauge the impact of their inclusion into the study. However, the researcher acknowledges that the introduction of IAPT makes it even more crucial that the positive and negative effects of working with trauma are investigated as PTSD will be treated at primary-care level by Step 3 High Intensity Practitioners (NHS, n.d.).

Methodological issues

The recruitment method chosen made it impossible to ascertain a response rate, and it was not possible to know if those who chose to participate in the study differed from those who chose not to. The findings of this study are therefore made with caution as it is not known how representative this sample is of UK therapists working with trauma clients.

Almost a quarter (24%) of those who started the questionnaire dropped out before the end making their data unusable. Whilst a third of these dropped out immediately after consenting to take part in the questionnaire, the rest dropped out at various points. This high drop-out rate suggests that it may be helpful to re-visit the questionnaire. The fact that respondents dropped out immediately after consenting to take part in the questionnaire may suggest that additional information may be useful on the information sheet to further clarify the research aims, what participation entails, and how long the questionnaire would take to complete. A status bar was included on the questionnaire so that respondents would have an idea of where they were in the process of completing the questionnaire. Perhaps an additional monitor would be helpful (e.g. page 3 out of 10).

As this was an exploratory study, many possible predictor variables were included in the study which meant that multiple correlations were performed, 465 to be exact. With a significance level of .05, this resulted in a probable number of 23 chance findings. Future research should be more focused including fewer predictor variables. This would also mean a shorter questionnaire which may improve the drop-out rates.

This study attempted to access those most likely to work with trauma clients by targeting adult specialist trauma services, secondary care services, as well as those who identified themselves as having a special interest in trauma from professional bodies. It is acknowledged that this sampling procedure excluded a large group of therapists working in child and adolescent teams, older adult services, other specialist services, and primary care.

SECTION B: CS, BURNOUT, AND STS IN UK THERAPISTS

However, future research should consider comparative studies between therapists working with these different client groups as research suggests differences may be present (Braehler, 2006; Dyregov & Mitchell, 1992; Figley, 1995; Hopkins, 1998).

This study was the first to use online methodology to assess rates of CS, burnout, and STS in therapists. The methodology was deemed to be acceptable by the majority of therapists who took part in the study, but there was a relatively high dropout rate after starting. Future research should consider using this methodology as it is more environmentally friendly than paper questionnaires, and results in quicker responses compared to postal surveys (Hoonakker & Carayon, 2009), but a shorter overall questionnaire is advisable.

Implications for clinical settings

Therapists working with trauma clients should be made aware of the possibility of being negatively impacted from working with this client group. Specific risk factors identified in the present research that therapists may want to be aware of include having a personal trauma history and being younger in age. However, they should also be informed that there is the potential for compassion satisfaction and personal growth.

As with all therapeutic work, it is important for therapists to monitor their own well-being, as well as being mindful of the well-being of their colleagues, as being negatively impacted can affect their therapeutic work and professional and personal relationships. Therapists should remain aware of their own possible triggers. It may be helpful for therapists to consider triggers in different domains including the personal, professional, and environmental domains (Yassen, 1995).

Perceived management support was found to be a positive predictor of CS and a negative predictor of burnout. Therefore, management appears to have a role to play in

SECTION B: CS, BURNOUT, AND STS IN UK THERAPISTS

therapists' well-being. This study was not able to identify the specific elements that constitute good management support and this is an area for future research. It is therefore advisable for managers to consult with the therapists in their service that work with trauma clients to determine what support the therapists feel they require from management. Areas that management should consider include organisational culture, workload, work environment, trauma-specific education and training, group support, supervision, resources for self-care (Bell, Kulkarni, & Dalton, 2003), and workplace context. For example, Chrestman (1999) found that lower levels of vicarious trauma were associated with a more diverse caseload.

Supervision is an area that the present research suggests may be advisable for management to review. Services should consider auditing their supervision provision as these results suggest that the perceived supportiveness of supervision, which may be related to the quality of supervision, may be more important to therapists' well-being, specifically therapists' potential for CS, than the quantity of supervision.

Conclusions

This study made a first attempt at exploring the prevalence of CS, burnout, and STS in a sample of UK-wide therapists who worked with adult trauma clients. The findings paint a different picture from those reported by international colleagues with a large number of therapists in the UK seemingly at high risk of STS. However, the majority of therapists' scores suggested average potential for CS and risk of burnout. The study highlighted factors which predicted levels of CS, burnout, and STS in therapists. Of particular note was that exposure to clients' trauma stories, measured by the number of trauma-focused clients on therapists' caseload, was not found to be a predictor of STS as hypothesised in its theory, suggesting that the distress experienced by therapists in this sample may have been due to

SECTION B: CS, BURNOUT, AND STS IN UK THERAPISTS

other factors. Whilst there were contextual and methodological limitations to this research, there is a need for further research to explore and replicate these findings in a representative sample of UK therapists. Attention also needs to be given to finding ways to support therapists who may be in distress.

This was the first large scale study in the UK, and the first to use an online questionnaire, to explore the positive and negative experiences of therapists working with trauma clients. Further research is needed to continue building our knowledge in this area.

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EKUNDAYO A. SODEKE-GREGSON MA (Hons)

MAJOR RESEARCH PROJECT

SECTION C

CRITICAL APPRAISAL

Word Count: 1991 (-1)

(excluding questions)

A thesis submitted in partial fulfilment of the requirements of
Canterbury Christ Church University for the degree of
Doctor of Clinical Psychology

JULY 2011

SALOMONS

CANTERBURY CHRIST CHURCH UNIVERSITY

1. What research skills have you learned and what research abilities have you developed from undertaking this project and what do you think you need to learn further?

Prior to this project, I had limited experience of conducting research with the exception of my undergraduate dissertation and the quality improvement project I undertook in my first year of training. Therefore, I have gained research skills throughout the process of conducting this research starting from the original conception of the research idea to the dissemination of the research results. However, there are three main areas in which I feel I have made most progress.

The first area was in the process of gaining ethical approval. Completing the ethics proposal, going through the Integrated Research Approval System (IRAS) process, and liaising with an ethics committee were new experiences for me, equipping me with a better understanding of the ethical application procedure. Additionally, I gained research and development (R&D) approval from 50 different Trusts across England, Scotland, Wales, and Northern Ireland. This was a lengthy process; I have learnt that preparation, organisation, and time management are key as different Trusts have different requirements, and some Trusts' R&D committees do not convene regularly.

Secondly, my research made use of an online methodology and this is another area where I have learnt new skills. Having researched different options, I decided on using the SurveyMonkey website due to its self-build facilities, different questionnaire templates, and 24-hour support. Building the questionnaire required a steep learning curve but I was able to refer to the site's user manual and contact them via the website for technical support. I felt that this methodology was successful and would consider using it in future research. I also felt that it resulted in quicker responses than if I had used a postal survey, as reported by

Hoonakker and Carayon (2009), which was important due to my tight recruitment window in some Trusts.

Thirdly, before conducting this research, I felt that my understanding of, and confidence with, quantitative methodologies was lacking. I was, therefore, pleased that my research questions were best answered through quantitative research methodology. I found supervision, as well as key texts (e.g. Brace, Kemp, & Sneglar, 2009; Field, 2009), invaluable in supporting my learning process. Through this research, I have reacquainted myself with the use of SPSS and it was my first experience of analysing data and reporting results of multiple regressions. Although I feel that progress has been made, my knowledge, understanding, and confidence of quantitative methodology still needs continued development.

A fellow trainee and I set up a working group for all those trainees who were conducting multiple and logistic regressions. Through this group, I learned the value of peer support, being able to bounce ideas off each other, and the benefits of gaining a new perspective on your research by talking to others. I also took the opportunity to practice presenting my research findings to the group as I felt that this would be a beneficial experience for my viva examination and for presenting my research to other interested parties.

2. If you were able to do this project again, what would you do differently and why?

The area which proved most challenging in the research process was in gaining R&D approval. Trusts were originally supposed to act as Participant Identification Centres (PICs) which meant that their remit would be to identify eligible therapists for the research project. My ethics approval letter stated that “Where the only involvement of the NHS organisation is as a Participant Identification Centre (PIC), management permission for the research is not

SECTION C: CRITICAL APPRAISAL

required but the R&D office should be notified of the study” (Y. Amin, personal communication, June 10, 2010). Whilst some trusts were happy to just be notified of the research project, others required me to go through their full R&D approval procedure. Additionally, I only contacted the Head of Psychological Therapies once I had obtained both ethics and R&D approval. In at least one case, once I had gained R&D approval, the Head of Psychology decided that they did not want to take part in the project. Although in the end I was able to gain R&D approval from 50 Trusts, it was a time-consuming and stressful process. In retrospect, my best option would have been to apply for ethics approval at the same time as contacting Trust representatives to gauge their interest. The Trust representative and I could have then jointly applied for R&D approval whilst awaiting ethics approval, although final approval would have remained pending. This would have meant that the Trust representative would have had a vested interest in the project and would have been more likely to promote it within their Trust. Although it would not necessarily have reduced the number of different Trusts I needed to contact due to a desire to get a national sample, this may have saved time as approvals would have been sought simultaneously.

I would also consider handling the recruitment process differently. I had originally planned to ask Trusts to supply the work email addresses of their therapists so I could send them the invitation email directly which would have allowed me to calculate a response rate. However, on speaking to R&D departments and some Heads of Psychological Therapies, it became clear that the favoured option was for them to forward the invitation email themselves for data protection reasons. Despite this, I could have asked the Trusts to inform me of how many therapists were included in their mail-out to allow me to gauge a response rate. Unfortunately, I would still not have been able to report an accurate response rate for

SECTION C: CRITICAL APPRAISAL

those professional bodies that advertised my research on their research notice boards or by e-bulletins.

I found supervision to be very supportive and invaluable throughout this process and some of the debates I had with my supervisors were crucial in steering the direction of my research. However, as I was keen to take notes during these sessions, I felt that I was not always as fully engaged in conversations as I would have liked and I sometimes felt that I wanted to review certain discussions afterwards. I feel that my learning would have been enhanced if I had taped and reviewed each supervision session. This would have also helped in my preparation for my viva examination and in preparing to present my research to other parties as it would have allowed me to listen to how I presented my procedure, data collection, and results to my supervisors.

3. Clinically, as a consequence of doing this study, would you do anything differently and why?

I became interested in this field following some teaching about working with clients experiencing posttraumatic stress disorder and reflecting on how engaging in this type of work may affect me. Although self-care was something that I had considered before, this teaching crystallised its importance for me. My research finding that 70% of the therapists were at high risk of developing secondary traumatic stress (STS) and 26% at high risk of burnout confirms my original concerns about therapeutic work of this nature. However, despite their being a risk of being negatively impacted by therapeutic work with trauma clients, this study has given me hope that there is also the possibility of being positively impacted.

Over and above working with trauma clients, this research has made me reflect on my clinical practice in general and the impact that any therapeutic work may have on me,

especially since exposure to client trauma did not predict risk of STS or burnout. I think that it will be important for me to take time to reflect on my own personal triggers and have an idea of the coping strategies that I find helpful. I know that I find supervision helpful in supporting my therapeutic work and although not investigated in the present research, personal therapy has also been an effective coping strategy for me. Indeed, Linley and Joseph (2007) found that therapists who were actively receiving personal therapy or who had received therapy in the past reported more personal growth, more positive changes, and less burnout. My research has also made me more aware of looking out for compassion satisfaction (CS), burnout, and STS in my colleagues or those I supervise in the future.

4. If you were to undertake further research in this area what would that research project seek to answer and how would you go about doing it?

The theories of compassion fatigue (CF), STS, and vicarious traumatisation (VT) assert that these experiences are unique to trauma work and their development is therefore dependent on exposure to clients' trauma stories. However, in the present study of UK therapists working with trauma clients, the number of trauma-focused clients on therapists' caseloads did not predict STS as theory would suggest. Similar findings have also been reported in Australian (Deville, Wright, & Varker, 2009), Canadian (Kadambi & Truscott, 2004), and Dutch therapists (van Minnen & Keijser, 2001). This calls into question whether it is indeed exposure to clients' trauma stories that causes trauma therapists' distress or whether it is a function of therapeutic work in general.

To be able to explore this further in the UK context, I would use a quantitative comparison study to answer the following: (1) are CF, STS, and VT present in UK non-trauma therapists?; (2) do levels of CF, STS, and VT in trauma and non-trauma therapists

SECTION C: CRITICAL APPRAISAL

differ?; and (3) what factors most strongly predict CF, STS, and VT in trauma therapists compared to non-trauma therapists?

I would seek to recruit a group of trauma and non-trauma therapists to participate in the research taking care to ensure that the two groups are comparable in terms of gender, age, and clinical experience. Measures that specifically target the different elements/symptoms the theories describe would be chosen. These may include The Traumatic Stress Belief Scale – Revision M (Pearlman, 1996) which measures disrupted cognitive schema in the five areas of psychological needs which are hypothesised to be sensitive to trauma and The Secondary Traumatic Stress Scale (Bride, Robinson, Yegidis, & Figley, 2004) which measures intrusion, avoidance, and arousal symptoms in therapists due to indirect exposure to clients' trauma stories. As well as general demographic information (e.g. age, gender, years of clinical experience, qualification, personal trauma history, and coping styles) other background information such as therapists' work setting, supervision provision, their caseload composition, and the amount of time spent in other activities (e.g. audit, R&D) will also be gathered. It is hoped that this research will contribute to our understanding of whether CF, STS, and VT are indeed unique to trauma therapists or whether we are simply measuring phenomena present in all therapists regardless of whether they work with trauma clients.

In addition, whilst not unique to trauma therapists, I would also be interested in comparing levels of CS between this group of trauma and non-trauma therapists. To date, those few studies, which are highlighted above, whom have compared different groups of therapists have tended to explore the negative impact of therapeutic work. Although they did not enquire about CS, van Minnen and Keijser (2001) interviewed their participants about both positive and negative cognitive changes. Their findings suggested that there were differences between trauma and non-trauma therapists in this domain so I would be interested

SECTION C: CRITICAL APPRAISAL

examining whether there are differences in potential for CS between trauma and non-trauma therapists. As yet, there is no assessment tool that solely measures CS so the Professional Quality of Life scale (Stamm, 2010) which measures CS, burnout, and STS, will be utilised.

The online methodology was well received in the present study so this methodology could be utilised once again.

Final reflection

At first, I found it difficult to write this critical appraisal as I felt quite distant and detached from my research. I wondered whether this was a reflection of the research methodology in that recruitment was done remotely, questionnaires were anonymous, and I had not met any participants. Coincidentally, on a weekend away in Scotland two weeks before the submission deadline, I got talking to a clinical psychologist who disclosed that she took part in my research and had found it interesting and worthwhile. This experience gave me a new appreciation and pride for my research and its impact. It also confirmed that part of my satisfaction with any research process comes from meeting (potential) participants and I hope to make it an integral part of any future research I conduct.

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EKUNDAYO A. SODEKE-GREGSON MA (Hons)

MAJOR RESEARCH PROJECT

SECTION D

APPENDIX OF SUPPORTING MATERIAL

A thesis submitted in partial fulfilment of the requirements of
Canterbury Christ Church University for the degree of
Doctor of Clinical Psychology

JULY 2011

SALOMONS

CANTERBURY CHRIST CHURCH UNIVERSITY

Appendix 1 – Literature search procedure

To find relevant papers, empirical studies, books, and book chapters, a literature search was performed using the following databases: PsychINFO, Ovid MEDLINE, all EBM Review databases, and British Nursing Index and Archive and Journals@Ovid. Combinations of the following search terms were used: trauma\$, therapist, clinician, psychotherapist, psychologist, posttraumatic stress disorder, PTSD, effects, consequences, and impact were used to elicit relevant articles. Once key concepts, terms, and authors were identified through abstracts, articles, and references, further searches were made to gather additional books and articles. These articles and book chapters were then limited to those concerning therapists and mental health workers working with an adult population with a traumatic history. Studies focusing on those working with child or older adult populations were excluded.

**Appendix 2 – Differences between posttraumatic stress disorder and secondary
traumatic stress**

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Figley, C. R. (2002). Traumatic symptoms of primary and secondary traumatic stress disorder symptoms. In C. R. Figley (Ed.), *Treating compassion fatigue* (pp. 4-5). New York: Brunner/Routledge.

Appendix 3 – Permission to use the Coping Strategies Inventory

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Appendix 4 – Permission to use the Professional Quality of Life Scale

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Appendix 5 – Online questionnaire (including information for participants, consent form, Coping Strategies Inventory, and Professional Quality of Life Scale)

SECTION D: APPENDIX OF SUPPORTING MATERIAL

EXPOSURE TO CLIENT TRAUMA: THE EFFECTS ON THERAPISTS WORKING IN SPECIALIST TRAUMA & SECONDARY-CARE SERVICES (pilot)

Thank you for your interest in this research study. Below is further information about the study and what your participation in the study will entail.

Why have I been contacted and what is the purpose of the study?

This study aims to look at the impact that client trauma has on qualified therapists who work psychologically with clients in specialist trauma and secondary-care services. You have been contacted because you are a qualified member of staff who works in either a specialist trauma or secondary-care service.

What will my participation entail?

You will be requested to complete a series of questions which should take around 10-15 minutes to complete. The questionnaire will need to be completed in one go as it is not possible to save and return to it at a later date. If you would like to take part, please complete the questionnaire before 31st December 2010.

Do I have to take part?

No, you are under no obligation to take part.

Confidentiality & Anonymity

The survey is completely anonymous and confidential. No identifying information will be requested. All data will be securely stored and password protected.

Can I withdraw from the study after I have started to complete the questionnaire?

Yes, you can withdraw from the study at anytime by pressing the 'Exit' link at the top of the page. At the end of the questionnaire, you will be asked to press the 'Submit questionnaire' button. Once you have pressed this button, your data will be sent for analysis.

What if I become distressed through completing the questionnaire?

We hope you do not become distressed through completing this questionnaire, but acknowledge that it is a possibility due to the subject matter. Because of this possibility you may of course decide not to take part. Or you may wish to discuss it with someone else, such as a trusted colleague, friend or family member before deciding whether or not to take part. Some level of distress or emotional response is probably normal when working with trauma. However, if distress or high level of stress is ongoing, then you may want to consider speaking to your supervisor, manager, appropriate professional body, a support agency, or your own GP. If you are concerned for your own or a colleague's mental health, there is further information about sources of support for mental health issues at work at www.shift.org.uk.

What will happen to the results?

The results from this study will be written up as a fulfilment for a Doctorate in Clinical Psychology. It will also be written up for publication and presented at a conference.

Will I be able to see the results of the study?

Yes. If you would like feedback on the overall results, these will be available from 15th July 2011 – 30th September 2011. Please contact me on eas20@canterbury.ac.uk to register your interest in receiving feedback and a summary of the results will be sent to you once they have been compiled. A summary of the overall results will also be sent to service heads in all participating services, however, service heads will not know whether any therapists from their service participated in the study or not.

Unfortunately, no individual feedback will be available as responses are anonymous.

SECTION D: APPENDIX OF SUPPORTING MATERIAL

Who should I contact if I need any further information or want to make comments about the study?

You can contact Ayo Sodeke-Gregson, Clinical Psychologist in Training (eas20@canterbury.ac.uk), Dr Sue Holttum (sue.holttum@canterbury.ac.uk) or Dr Jo Billings (Jo.Billings@swlstg-tr.nhs.uk).

If you wish to make a complaint about any aspect of this research study, please contact:

Dr Paul Camic
Research Director
Department of Applied Psychology
Canterbury Christ Church University
Broomhill Road
Tunbridge Wells
Kent
TN3 0TG

*** Please indicate, by ticking the boxes, if you would like to participate in this study:**

- I have read and understood the information provided and consent to participate in the study
- I do not wish to participate in this study

SECTION D: APPENDIX OF SUPPORTING MATERIAL

*** Please indicate what type of service you work in:**

Specialist trauma service

Secondary-care service

Other (please specify)

*** Age:**

25-29 years

30-34 years

35-39 years

40-44 years

45-49 years

50-54 years

55-59 years

60-64 years

*** Gender:**

Male

Female

*** Please indicate the highest qualification you have in psychology/psychotherapy:**

Diploma

Degree

MA

MSc

Doctorate

PHD

Other (please specify)

*** Please indicate your number of years post-qualification:**

0-4 years

5-9 years

10-14 years

15-19 years

20+ years

*** Please indicate your core profession:**

Clinical/Counselling Psychology

Nursing

Social work

Psychiatry

Other (please specify)

*** How many sessions a week do you work in your specialist trauma service/secondary-care service?**

- 0 sessions
- 1 session
- 2 sessions
- 3 sessions
- 4 sessions
- 5 sessions
- 6 sessions
- 7 sessions
- 8 sessions
- 9 sessions
- 10 sessions

*** How many clients do you currently have on your caseload in this service?**

- 0 clients
- 1-4 clients
- 5-9 clients
- 10-14 clients
- 15-19 clients
- 20-24 clients
- 25+ clients

*** How many clients have you seen in the last month whom you are currently doing trauma-focused work with?**

- 0 clients
- 1-4 clients
- 5-9 clients
- 10-14 clients
- 15-19 clients
- 20-24 clients
- 25+ clients

*** What is your predominate therapeutic approach when working with trauma clients:**

- CBT
- EMDR
- Psychodynamic
- Narrative
- Systemic
- Integrative

Other (please specify)

SECTION D: APPENDIX OF SUPPORTING MATERIAL

*** On average, how many hours of supervision do you receive in your service per month?**

	0-2	3-4	5-6	7-8	9-10	11+
Individual supervision	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Group supervision	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Peer supervision	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Supervision with an external consultant	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Please add any clarification information as desired:

*** Approximately, how much specific trauma training did you receive whilst on your main training course?**

- Half a day
- One day
- Two days
- Three days
- Four days
- Five days
- More than a week

Please add any clarification information as desired:

*** Approximately, how much specific trauma training have you received since completing your main training course?**

- Half a day
- One day
- Two days
- Three days
- Four days
- Five days
- More than a week

Please add any clarification information as desired:

*** Many people have lived through or witnessed a very stressful and traumatic event at some point in their lives. Below is a list of traumatic events. Please indicate if any of the events have happened to you or if you have witnessed them.**

Serious accident

Natural disaster

Military combat or war zone

Imprisonment

Torture

Life-threatening illness

Non-sexual assault

Sexual assault

Sexual contact when you were younger than 18 with someone who was 5 or more years older than you

Yes, I've experienced one or more of these events

No, I have not experienced any of the above events

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Bober, T. & Regeher, C. (2006). Coping Strategies Inventory: Beliefs

“This has been removed from the electronic copy”

Bober, T. & Regeher, C. (2006). Coping Strategies Inventory: Time

*** How supported do you feel by your management?**

- Not at all supported
- Somewhat not supported
- Supported
- Somewhat supported
- Very supported

*** How supported do you feel by your administrative staff?**

- Not at all supported
- Somewhat not supported
- Supported
- Somewhat supported
- Very supported

*** How supported do you feel by your peers?**

- Not at all supported
- Somewhat not supported
- Supported
- Somewhat supported
- Very supported

*** How supportive do you feel your supervision is in dealing with your clinical work?**

- Not at all supportive
- Somewhat not supportive
- Supportive
- Somewhat supportive
- Very supportive

“This has been removed from the electronic copy”

B. Hudnall, Stamm (2009). Professional Quality of Life: Compassion Satisfaction and Fatigue Version 5

How did you find completing the questionnaire online? (optional)

- Extremely difficult
- Moderately difficult
- A little difficult
- Not difficult, easy
- Extremely easy

How comfortable did you feel answering these types of questions in an online questionnaire? (optional)

- Not at all comfortable
- A little comfortable
- Moderately comfortable
- Quite comfortable
- Extremely comfortable

SECTION D: APPENDIX OF SUPPORTING MATERIAL

Please indicate which Trust you work in. (optional)

- 2gether NHS Foundation Trust
- 5 Boroughs Partnership NHS Trust
- Avon and Wiltshire Mental Health Partnership NHS Trust
- Barnet, Enfield and Haringey Mental Health NHS Trust
- Barnsley PCT
- Bedfordshire and Luton Mental Health and Social Care Partnership NHS Trust
- Belfast Health and Social Care Trust
- Berkshire Healthcare NHS Foundation Trust
- Birmingham and Solihull Mental Health NHS Foundation Trust
- Bradford District Care Trust
- Bro Morgannwg NHS Trust
- Calderstones Partnership NHS Foundation Trust
- Cambridgeshire and Peterborough NHS Foundation Trust
- Camden and Islington Mental Health and Social Care Trust
- Cardiff and Vale NHS Trust
- Central and North West London NHS Foundation Trust
- Cheshire and Wirral Partnership NHS Foundation Trust
- Cornwall Partnership NHS Trust
- Coventry and Warwickshire Partnership NHS Trust
- Coventry Teaching PCT
- Cumbria Partnership NHS Foundation Trust
- Cumbria Teaching PCT
- Derbyshire Mental Health Services NHS Trust
- Devon Partnership NHS Trust
- Dorset Healthcare NHS Foundation Trust
- Dorset PCT
- Dudley and Walsall Mental Health Partnership NHS Trust
- East London NHS Foundation Trust
- Greater Manchester West Mental Health NHS Foundation Trust
- Hampshire Partnership NHS Foundation Trust
- Herefordshire PCT
- Hertfordshire Partnership NHS Foundation Trust
- Humber NHS Foundation Trust

SECTION D: APPENDIX OF SUPPORTING MATERIAL

- Isle Of Wight NHS PCT
- Kent and Medway NHS and Social Care Partnership Trust
- Lancashire Care NHS Foundation Trust
- Leeds Partnerships NHS Foundation Trust
- Leicestershire Partnership NHS Trust
- Lincolnshire Partnership NHS Foundation Trust
- Manchester Mental Health and Social Care Trust
- Mersey Care NHS Trust
- Milton Keynes PCT
- NHS Ayrshire and Arran
- NHS Borders
- NHS Dumfries and Galloway
- NHS Fife
- NHS Forth Valley
- NHS Grampian
- NHS Greater Glasgow & Clyde - Clyde Division
- NHS Greater Glasgow & Clyde - North Glasgow University Hosp Division
- NHS Greater Glasgow & Clyde - Primary Care Division
- NHS Greater Glasgow & Clyde - South Glasgow University Hosp Division
- NHS Greater Glasgow & Clyde - Yorkhill Division
- NHS Highland
- NHS Lanarkshire - Acute Services Division
- NHS Lanarkshire Primary Care Division
- NHS Lothian - Lothian Primary Care NHS Trust
- NHS Lothian - Lothian University Hospitals Division
- NHS Lothian - West Lothian Healthcare NHS Trust
- NHS National Services Scotland
- NHS Orkney
- NHS Shetland
- NHS Tayside - Tayside Primary Care NHS Trust
- NHS Tayside - Tayside University Hospitals NHS Trust
- NHS Western Isles
- Norfolk and Waveney Mental Health NHS Foundation Trust
- Norfolk PCT
-

SECTION D: APPENDIX OF SUPPORTING MATERIAL

- North East London NHS Foundation Trust
- North Essex Partnership NHS Foundation Trust
- North Glamorgan NHS Trust
- North Lancashire Teaching PCT
- North Staffordshire Combined Healthcare NHS Trust
- North West Wales NHS Trust
- North Yorkshire and York PCT
- Northamptonshire Healthcare NHS Foundation Trust
- Northern Health and Social Care Trust
- Northumberland, Tyne and Wear NHS Foundation Trust
- Nottinghamshire Healthcare NHS Trust
- Oxfordshire and Buckinghamshire Mental Health NHS Foundation Trust
- Oxfordshire Learning Disability NHS Trust
- Oxleas NHS Foundation Trust
- Pembrokeshire and Derwen NHS Trust
- Pennine Care NHS Foundation Trust
- Plymouth Teaching PCT
- Portsmouth City Teaching PCT
- Powys Health Care NHS Trust
- Rotherham, Doncaster and South Humber Mental Health NHS Foundation Trust
- Sandwell Mental Health NHS and Social Care Trust
- Sheffield Care Trust
- Shropshire County PCT
- Somerset Partnership NHS Foundation Trust
- South Eastern Health and Social Care Trust
- South Essex Partnership University NHS Foundation Trust
- South London and Maudsley NHS Foundation Trust
- South Staffordshire and Shropshire Healthcare NHS Foundation Trust
- South West London and St George's Mental Health NHS Trust
- South West Yorkshire Partnership NHS Foundation Trust
- Southern Health and Social Care Trust
- Suffolk Mental Health Partnership NHS Trust
- Surrey and Borders Partnership NHS Foundation Trust
- Sussex Partnership NHS Foundation Trust
-

SECTION D: APPENDIX OF SUPPORTING MATERIAL

- Tavistock and Portman NHS Foundation Trust
- Tees, Esk and Wear Valleys NHS Foundation Trust
- Welsh Ambulance Services NHS Trust
- West London Mental Health NHS Trust
- Western Health and Social Care Trust
- Wolverhampton City PCT
- Worcestershire Mental Health Partnership NHS Trust

Other (please specify)

Thank you for your time.

Please feel free to write down any comments you have about the subject matter or filling out the questionnaire.

Thank you for taking part.

Appendix 6: Approval letter from Research Ethics Committee

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Appendix 7 – One example of R&D approval letters⁴

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⁴ R&D approval was gained from 50 Trusts. However, due to the vast amount of paperwork generated, only one example has been included in the appendices. The remaining 49 letters are available to view on request and will be presented at viva.

Appendix 8 – Example of email sent to potential participants

Dear Therapist,

EXPOSURE TO CLIENT TRAUMA: THE EFFECTS ON THERAPISTS WORKING IN SPECIALIST TRAUMA AND SECONDARY-CARE SERVICES

I am a trainee clinical psychologist on the Salomon's training course. My doctoral research explores the effects that being exposed to clients' trauma stories has on therapists who work in secondary-care and specialist trauma services.

I would, therefore, like to recruit therapists working in adult secondary-care and specialist trauma services. Participation takes the form of completing a 10-15 minute online questionnaire which is anonymous and confidential. The research has been approved by a university peer-review panel and has gained NHS ethics approval. It has been approved by the [REDACTED] R&D department.

If you would like to take part in the study, please click on the hyperlink below for more information and to access the questionnaire.

<http://www.surveymonkey.com/s/GXHSMTX>

Many thanks in advance for your time.

Ayo Sodeke-Gregson, Trainee Clinical Psychologist.

Email: cas20@canterbury.ac.uk

Appendix 9 – Consents from psychological professional bodies**British Psychological Society – Division of Clinical Psychology**

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British Psychological Society – Division of Counselling Psychology

“This has been removed from the electronic copy”

British Association for Behavioural & Cognitive Psychotherapies

“This has been removed from the electronic copy”

Counselling & Psychotherapy in Scotland

“This has been removed from the electronic copy”

UK Psychological Trauma Society

“This has been removed from the electronic copy”

United Kingdom Council for Psychotherapy

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British Association for Counselling Psychotherapy, EMDR Association, and Register of Trauma Specialists

The BACP gave verbal consent for me to contact those therapists who published their contact details on the website who specified they worked with posttraumatic stress. Specifically, those therapists who responded ‘No’ to the Exclude from canvassing” option available were contacted.

All therapists on the EMDR Association website and the Register of Trauma Specialists were contacted as long as they supplied an email address allowing people to email them.

SECTION D: APPENDIX OF SUPPORTING MATERIAL

Appendix 10 - Correlations between independent predictor variables and CS, burnout, and STS⁵

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
1.	1	.035	-.063	-.059	.043	-.009	.096	.198**	-.151*	.055	.002	-.094	-.009	-.159*	.036	-.243**	-.054	-.042	-.061	-.143*	-.026	-.010	-.149*	-.315**	-.117	-.169**	-.077	-.098	-.024	.008	-.116
2.		1	-.056	.383**	.649**	.262**	-.258**	-.106	.081	.030	-.194**	-.067	.051	.062	.134*	.297**	-.279**	-.030	.023	.043	.026	.200**	.013	.114	-.087	-.066	-.125*	.073	.265**	-.200**	-.043
3.			1	-.125*	-.056	-.078	-.140*	-.138*	.027	.125*	.026	.012	-.023	-.069	.053	-.028	-.038	.108	.183**	.199**	-.073	.090	.011	.016	-.063	-.134*	.076	.046	-.039	.060	.102
4.				1	.240**	.468**	-.111	-.097	.081	-.026	-.075	.004	-.015	.010	.172**	.060	-.121	-.060	.029	.039	-.014	.110	.005	-.007	.002	-.107	-.048	.052	.181**	-.157*	.051
5.					1	.204**	-.256**	-.071	.022	-.098	-.342**	-.066	.050	-.060	.125*	.271**	-.164**	.008	-.012	-.002	.128*	.060	-.069	.158*	-.139*	-.006	-.128*	.006	.151*	-.120*	-.135*
6.						1	-.049	.009	.129*	-.025	-.228**	-.027	-.066	-.125*	.142*	.076	-.065	-.011	.055	-.046	.086	-.088	-.030	-.053	-.010	.004	-.036	-.052	.110	-.095	-.070
7.							1	.556**	.250**	.058	.095	.036	.081	.036	.048	.113	.129*	.077	.039	.009	.035	-.037	.095	.058	.080	.027	.087	.052	.029	-.035	-.092
8.								1	.323**	-.059	.069	-.040	-.008	-.030	-.006	.045	.074	.174**	.018	.045	.082	-.015	.019	.080	.016	.114	.121	.083	.061	.013	-.054
9.									1	.105	.011	-.059	.139*	.113	.191**	.294**	-.084	.106	.028	.113	.056	.159*	.141*	.303**	-.005	.009	.072	.068	.119	-.027	.120
10.										1	.076	-.014	.048	.021	.045	-.069	-.064	.018	-.005	.017	-.037	.064	.013	-.037	.031	.076	.130*	.026	-.042	.027	.145*
11.											1	.018	-.089	.054	-.011	-.074	.053	.019	.108	.105	-.015	.115	.192**	-.058	.125*	.048	.100	.184**	.031	-.006	.187**
12.												1	.106	.241**	-.130*	.020	.085	.001	-.013	.061	-.017	.022	.168**	.035	.097	.082	.133*	.096	-.029	.006	.035
13.													1	.306**	-.001	.012	.073	.098	.020	.013	.010	-.002	-.007*	.010	.050	.081	.185**	.012	.027	.034	-.003
14.														1	.048	.046	.076	.022	-.034	.049	-.061	.112	.155*	.151*	.059	.079	.037	.115	.060	-.039	.123
15.															1	.120	-.081	.057	.054	-.014	.048	.123	.045	.066	-.008	.021	-.052	.002	.011	-.070	.118
16.																1	-.053	.032	.004	.011	.069	.071	.145*	.365**	.016	.054	-.016	.062	.201**	-.155*	-.054
17.																	1	.071	.060	.076	.055	-.202**	.020	-.098	.019	.187**	.195**	-.020	-.058	.017	-.139*
18.																		1	.251**	.302**	.458**	.084	.161*	.102	.174**	.182**	.268**	.272**	.171**	-.145*	.046
19.																			1	.472**	.237**	.354**	.250**	.114	.174**	.050	.147*	.182**	.123	-.099	.050
20.																				1	.196**	.282**	.465**	.212**	.271**	.074	.349**	.385**	.153*	-.189**	.013
21.																					1	.097	.106	.103	.011	.162*	.039	.103	.048	-.094	-.047
22.																						1	.511**	.397**	.144*	-.002	.087	.188**	.216**	-.173**	.172**
23.																							1	.496**	.306**	.162**	.248**	.482**	.196**	-.204**	.115
24.																								1	.150*	.156*	.057	.266**	.282**	-.192**	.063
25.																									1	.385**	.443**	.313**	.214**	-.328**	-.111
26.																										1	.403**	.234**	.102	-.113	.063
27.																											1	.469**	.075	-.155*	-.057
28.																												1	.254**	-.249**	.063
29.																													1	-.697**	-.189**
30.																														1	.454**
31.																															1

Note: 1 = service setting; 2 = age; 3 = gender; 4 = highest qualification; 5 = number of years of clinical experience; 6 = core profession; 7 = number of sessions; 8 = number of clients on caseload; 9 = number of trauma-focused clients on caseload; 10 = predominate therapeutic approach; 11 = hours of individual supervision per month; 12 = hours of group supervision per month; 13 = hours of peer supervision per months; 14 = hours of consultant supervision per month; 15 = days of trauma-specific training during main training course; 16 = days of trauma-specific training since qualification; 17 = personal trauma history; 18 = CSI beliefs – leisure; 19 = CSI beliefs – self-care; 20 = CSI beliefs – supervision; 21 = CSI time – leisure; 22 = CSI time – self-care; 23 = CSI time – supervision; 24 = CSI time – R&D; 25 = perceived support by management; 26 = perceived support by administrative staff; 27 = perceived support by peers; 28 = perceived support of supervision; 29 = ProQOL – compassion satisfaction; 30 = ProQOL – burnout; 31 = ProQOL – secondary traumatic stress.

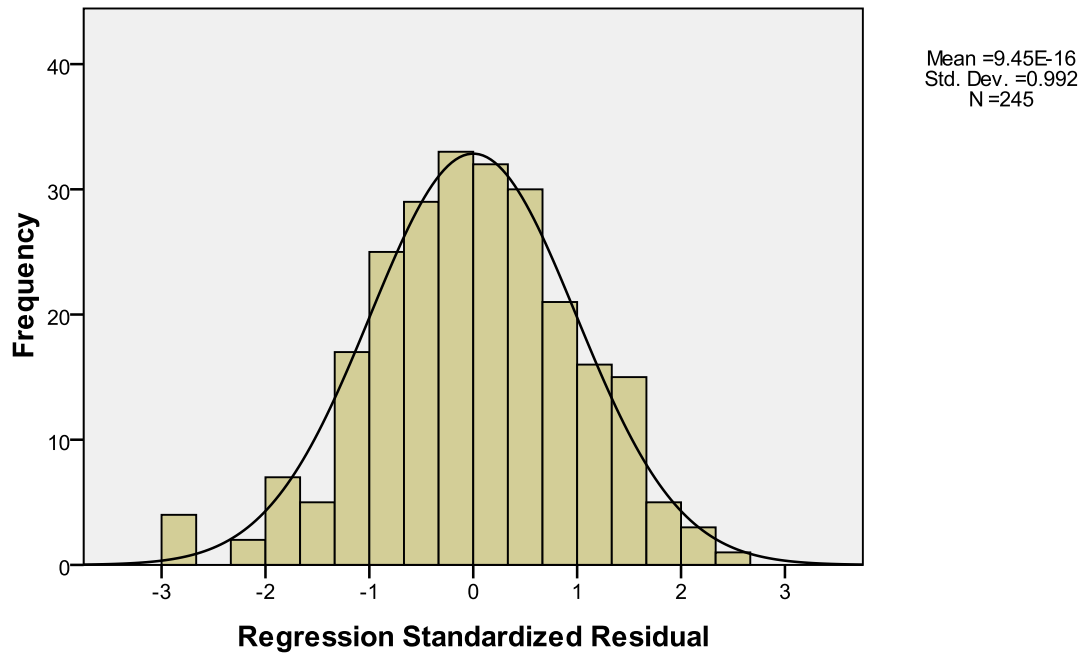
*p < .05; **p < .01.

⁵ Please note that the colour red has been used to make it easier to see significant correlations at a glance.

Appendix 11 – Example of a histogram showing normality of distribution

Histogram

Dependent Variable: ProQOL 30 Days- Compassion Satisfaction Scale



Appendix 12 – End of study letter to Research Ethics Committee

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Appendix 13 – Declaration of the end of a study form sent to Research Ethics Committee

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Appendix 14 – Example of end of study letter for R&D departments

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**Appendix 15 – Example of thank you email sent to participants requesting feedback
about research results**

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Appendix 16 – Summary of study for Ethic Committee/R&D/participants

E.A. Sodeke-Gregson

Main REC reference no: 10/H0716/21

COMPASSION SATISFACTION, BURNOUT, AND SECONDARY TRAUMATIC STRESS IN UK THERAPISTS WHO WORK WITH ADULT TRAUMA CLIENTS

Therapists who work with trauma clients are impacted both positively and negatively by this work. The three theoretical concepts under examination were:

- Compassion satisfaction (CS) - “the sense of fulfilment or pleasure that therapists derive from doing their work well” (Larsen & Stamm, 2008, p.282) and is made up of (1) the satisfaction a person derives from doing their job; (2) how well they feel they perform in their job; and (3) the level of positive collegiate support a person feels they receive
- Burnout - “a state of physical, emotional, and mental exhaustion caused by long term involvement in emotionally demanding situations” (Pines & Aronson, 1998, p. 9) which results in physical, emotional, behavioural, work-related, and interpersonal symptoms (Kahill, 1988)
- Secondary traumatic stress (STS) - the “natural, consequent behaviours and emotions resulting from *knowledge about* a traumatizing event experienced by a significant other. It is the stress resulting from *helping or wanting to help* a traumatised or suffering person” (Figley, 1999, p.10). It is said to be unique to trauma work and sufferers are believed to experience symptoms nearly identical to clients suffering from posttraumatic stress disorder (PTSD).

Aims

1. To investigate the reported levels of CS, burnout, and STS in a national sample of UK therapists working with adult trauma clients in specialist trauma and secondary-care services (or similar service)
2. To investigate the salient factors that may be associated with CS, burnout, and STS
3. To investigate which variables most strongly predicted CS, burnout, and STS

Method

- An online questionnaire was developed which asked demographic and background information and used the Professional Quality of Life scale, *Version 5* (Stamm, 2009) to measure CS, burnout, and STS.
- Therapists, who worked with adult clients with a trauma history, were recruited from 50 NHS Trusts across England, Wales, Scotland, & Northern Ireland or who were registered with the BPS, BACP, BABCP, UKCP, UK Psychological Trauma Therapists, EMDR Association, Register of Trauma Specialists, or Counselling & Psychotherapy in Scotland.
- There were 253 participating therapists (182 women, 71 men) of whom 64.5% were aged between 30-49 years. They worked in either specialist trauma services (22.5%), secondary care services (or equivalent) (62.5%), or identified themselves as working in ‘other services’ (15%) which included specialist/tertiary services, primary care, private practice, and public or voluntary services.

Results

Number of therapists at low, average, and high risk of CS, burnout, & STS (N=253)

	Compassion Satisfaction	Burnout	Secondary Traumatic Stress
Low	20 (8%)	25 (9.9%)	0 (0%)
Average	135 (53.2%)	163 (64.4%)	76 (30%)
High	98 (38.8%)	65 (25.7%)	177 (70%)

SECTION D: APPENDIX OF SUPPORTING MATERIAL

- CS was negatively correlated with both burnout and STS
- Burnout and STS were significantly correlated

Compassion satisfaction:

- Being older predicted higher levels of CS
- Increased time spent in R&D activities predicted higher levels of CS
- Higher levels of perceived supportiveness of management and perceived supportiveness of supervision predicted higher levels of CS

Burnout:

- Being older predicted lower risk of burnout
- Higher levels of perceived supportiveness of management predicted lower risk of burnout

Secondary Traumatic Stress:

- Increased hours of individual supervision predicted higher risk of STS
- Increased time spent engaging in self-care activities predicted higher risk STS
- Having a trauma history predicted higher risk of STS

Key discussion points

- Although 70% of therapists were at high risk of STS and 25% were at high risk of burnout, positively, 92% reported average to high CS
- As perceived supportiveness of supervision rather than hours spent in supervision predicted higher levels of CS, it appears that quality of supervision may be more important than the quantity.
- Those engaging in more individual supervision and self-care activities reported higher levels of STS. Perhaps therapists who were having difficulties actively sought out more supervision and engaged in more self-care activities to help alleviate their distress.
- Higher levels of perceived supportiveness of management predicted higher levels of CS and lower levels of burnout highlighting the important role that management can play in therapists' sense of fulfilment with and functioning at work
- Exposure to client trauma, measured by the number of trauma clients on therapists' caseload, did not predict STS as STS theory would suggest. This calls into question whether it is indeed exposure to clients' trauma stories that causes distress in therapists working with trauma clients.

If you have any questions, or would like additional information, please contact me at the address below:

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July 2011

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Appendix 17 - Submission guidelines for the Journal of Traumatic Stress

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