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Secondary Traumatic Stress, Burnout and the role of Resilience in New Zealand Counsellors

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Abstract

A survey was conducted with 129 counsellors who were members of various counselling organisations or associations in New Zealand. A quantitative methodology was utilised with questionnaires completed online. Participants were surveyed in relation to the constructs of secondary traumatic stress, burnout, compassion satisfaction, resilience, social support, degree of exposure to trauma and personal history of trauma. The majority of the participants reported age greater than 50 years (n=84), female gender (n=109) and identified as being of New Zealand European/ Pakeha descent (n=105). Statistical analyses were completed to establish the prevalence of secondary traumatic stress, burnout and compassion satisfaction, the relationship between exposure and risk of secondary traumatic stress, the relationship between personal trauma history and risk of secondary traumatic stress and the relationships between burnout, compassion satisfaction, resilience and social support levels with secondary traumatic stress. In addition, the moderating effect of compassion satisfaction was analysed. Results established a prevalence of 21.7% for high risk of secondary traumatic stress, 24.8% for high risk of burnout and 21.7% for high potential for compassion satisfaction in this sample. Results established statistically significant relationships between exposure and secondary traumatic stress, between burnout and secondary traumatic stress and between resilience and secondary traumatic stress. These results are discussed in relation to the secondary exposure to trauma of counsellors working with trauma clients. This research has important theoretical and practical implications for counsellors working with clients who have experienced trauma.

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A brief glimpse into recent world history alerts us to the existence and reality of trauma in the world today. No-one would deny the horrific impact that wars such as the Great World Wars of the 1900s (Sutker, Allain & Winstead, 1993) and the Vietnam War (King, King, Foy, Keane & Fairbank, 1999) have had on individuals, families and communities alike. It was events such as these recent wars which led to the recognition of traumatology as a field of study (Figley, 1988). While some might wish to close their eyes and ignore the truth concerning the extent to which we humans are capable of harming each other, history has produced a timeline of events attesting to this capability. The Holocaust (1933-1945) saw the persecution and murder of approximately 6 million Jewish people and left behind multitudes of people living with the effects of that trauma; people who were children at the time, now adults with post-traumatic stress disorder (Amir & Lev-Weisel, 2003). Likewise, the more recent Rwandan Genocide of 1994 saw up to an estimated one million primarily Tutsi people abused and slaughtered leaving behind countless parentless children devastated and angered by these events (Dyregrov, Gupta, Gjestad & Mukanoheli, 2000). Closer to home and in our collective memory as 'Kiwi's,' are events such as the Aramoana Massacre of 1990 (Boon, Jones & Curnow, 2009) which resulted in the deaths of 13 people again leaving behind devastated and confused family members and communities. The Columbine High School Shootings of 1999 resulted in 15 deaths, more than 20 injuries and thousands of psychologically traumatised individuals (Hawkins, McIntosh, Cohen Silver & Holman, 2004). The September 11, 2001 terrorist attacks against, the World Trade Centre building in New York is a traumatic event imprinted into the memory not only of Americans but of people worldwide and

an event which has resulted in considerable psychological trauma for many involved (Galea, Ahern, Resnik, Kilpatrick, Bucuvalas, Gold & Vlahov, 2002).

It is not only human-caused events such as those described that have potential for traumatic reactions. Natural disasters also have resulted in considerable impact and trauma for those in their pathways. The Indian Ocean Boxing day earthquake and tsunami of 2004 resulted in 35 000 deaths and 500 000 people displaced with lasting psychological effects (Ranasinghe & Levy, 2007). Likewise the Christchurch and Japanese earthquakes and tsunami of 2010 and 2011 resulted in considerable devastation for people present at the time, devastation that many are still trying to come to terms with now in 2014 (Dorahy & Kannis-Dymand, 2012; Proctor & Crowley, 2011).

The events discussed are well known due to the magnitude of their devastation and impact and also to advancements in media reporting. However, the alarming rates of child abuse, family violence and sexual violence (Fanslow, Robinson, Crengle & Perese, 2007; Pereda, Guilera, Forns & Gomez-Benito, 2009; Fanslow & Robinson 2004) in New Zealand attest to the often undetected trauma that is being imposed on persons behind closed doors, often in private, every day in our communities

The ability to inflict trauma upon another is perhaps one of the downfalls of humankind. However, there is hope in that a significant proportion of people dedicate their time and even their lives to helping those affected by trauma. This hope is found in the faces of the nurses who worked with the injured during the wars. It is found in the Peace Keepers who have gone to countries such as those like Rwanda affected by mass genocide. It is found in disaster relief

workers who go to countries affected by natural disasters and do their bit to help people get their lives back on track. It is found in emergency workers who respond to 111 calls and in police officers who respond to fatal callouts.

When the immediate affects, of the trauma have passed and life seems to be moving along, it is often then that many individuals affected by trauma realise that they need some help. Frequently, they turn to professionals such as counsellors, psychotherapists and psychologists for that help. Such professionals are empathetic and compassionate and the client finds a listening ear and much needed support as they work through their respective traumas. Research has been invaluable in assisting the likes of these professionals in understanding the impact of trauma and in providing intervention for their clients. However, in the process of helping individuals affected by trauma, such professionals are themselves secondarily exposed to trauma and this exposure has the potential for significant negative effects. These effects have been labelled vicarious traumatisation (McCann and Pearlman, 1990), compassion fatigue (Figley, 2002) and secondary traumatic stress (Stamm, 2010).

The Study

This study aimed to discover knowledge that would be useful in the mitigation of risk and the promotion of protective factors in counsellors who work with trauma clients. The following questions were focussed on:

- 1) What is the extent of secondary traumatic stress experienced by counsellors in New Zealand who work with people who have experienced trauma?

- 2) Are counsellors with higher proportions of trauma clients on their caseloads more susceptible to secondary traumatic stress?
- 3) Does a personal history of trauma increase the risk of secondary traumatic stress?
- 4) How do burnout, compassion satisfaction, resilience and social support relate to secondary traumatic stress?

This study makes a unique contribution to the field of secondary trauma. No prior studies were found that measured the constructs of secondary traumatic stress, burnout, compassion satisfaction and resilience in a sample of New Zealand counsellors. Therefore, this study provides new knowledge which may be applicable to reducing negative outcomes for counsellors not only in New Zealand but for counsellors exposed to secondary trauma worldwide.

1. Literature Review

This chapter reviews literature relevant to the central elements of this thesis: secondary traumatic stress and compassion fatigue as related to the therapy relationship between professionals and clients who have experienced trauma. It begins with a history of the development of traumatology as a field of study and proceeds towards a clarification of terms. Figley's (2002) Etiological Model of Compassion Fatigue is presented and summarised as it provides a framework for understanding the development and treatment of compassion fatigue. Next, more recent psychological literature is discussed in relation to the prevalence and risk of secondary traumatic stress. Potential protective factors against the development of secondary traumatic stress are discussed. Consideration of the relevant literature highlights the need for further investigation into both risk and protective factors of secondary traumatic stress which leads to the focus of the current study.

Posttraumatic Stress Disorder and Secondary Traumatic Stress

Traumatology in many ways is still in its infancy. Although Figley (1988) noted that evidence of traumatic stress reactions was present in classic writings such as Homer's "The Odyssey" and that circa 1895 Freud and Breuer were involved in recognised responses to highly stressful events. Figley (2002) reported his first involvement in trauma research were in interviewing veterans of the Vietnam War in the 1970s. The reactions of some veterans after exposure to the horrors of war was labelled post-traumatic stress disorder

(PTSD) by the *Diagnostic and Statistical Manual of Mental Disorders* (3rd ed.; *DSM-III*; American Psychological Association [APA], 1980). In 2000, the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-IV-TR*; American Psychological Association [APA], 2000), listed PTSD as an Anxiety Disorder. In 2013 (5th ed.; *DSM-V*; American Psychological Association [APA], 2013), the *Diagnostic and Statistical Manual of Mental Disorders* listed PTSD as a Trauma and Stressor-related disorder. PTSD symptoms have historically been directly connected to persons exposed to the traumatic event. However, similar symptoms have been found in persons not exposed to the event but with knowledge of the trauma or involvement in helping persons who have experienced trauma (Arvay, 2001; Salston & Figley, 2003). This set of symptoms has been labelled “Secondary Traumatic Stress” and if not addressed may lead to “Secondary Traumatic Stress Disorder” (Salston & Figley, 2003). While neither previous nor current versions of the DSM allow for a specific diagnosis of Secondary Traumatic Stress Disorder, they do acknowledge that symptoms of PTSD may be observed in persons not directly exposed to trauma, but persons secondarily exposed for example; family, friends or professionals who work with persons affected by trauma. Figley (1995) suggested that it may be more appropriate to re-label post-traumatic stress disorder as *primary traumatic stress disorder* stating the difference between PTSD and secondary traumatic stress disorder, (STSD) is simply the location of the stressor. In PTSD the person is directly connected to the traumatic event whereas in STSD the person has knowledge of the traumatic event.

Clarification of Terms

There is a growing awareness of and interest in the deleterious effects of trauma work on counsellors and other mental health professionals who work with victims of trauma. Various terms have been used to describe the impact on the counsellor after being exposed to the trauma of others yet early terms tended to ignore such professionals involved in trauma work and focussed instead on the family and friends of trauma victims. Figley (1989, as cited in Arvay & Uhlemann, 1996) initially used the term *secondary victimisation* to describe the impact on families exposed to the trauma of one of their members. In 1995, Figley introduced the term *secondary traumatisation* or *secondary traumatic stress* which results from knowing of the trauma of another and the stress from helping that person. Figley (1995) acknowledged that counsellors and other professionals involved in trauma work were susceptible to the same secondary traumatic stress reactions as were the family and friends of victims. While secondary trauma encompasses a range of people and circumstances the counselling relationship is somewhat unique. In contrast to family and friends of trauma victims, counsellors and other helping professionals typically work with multiple victims and traumas over a significant period of time; frequently spanning the life of their career. In contrast, the exposure of family and friends to secondary trauma may be more limited to person and time. McCann and Pearlman (1990) coined the term *vicarious traumatisation* to describe the cumulative effects upon the counsellor from working with clients who are working through trauma. Identified effects on the counsellor can include feelings of fear and suffering, intrusive thoughts, nightmares and avoidance (Sexton, 1999). These effects result in a transformation within the

counsellor that occurs as a result of the counsellor's engagement with the client and witness to the client's trauma. Arvay (2001) stated that the primary difference between vicarious traumatisation and secondary traumatic stress is theoretical origin and that they both refer to the same phenomenon. She stated that vicarious traumatisation originates from McCann and Pearlman's (1990) constructivist self-development theory, while secondary traumatic stress from the diagnostic criteria of the DSM-IV (*DSM-IV*; American Psychological Association [APA], 1994). In contrast to secondary traumatic stress, McCann and Pearlman (1990) described vicarious traumatisation in terms of disruptions which can occur to the therapist's cognitive schemas about self and world as a result of exposure to a client's trauma. For example, when working with victims of rape, counsellors may find that their schemas related to safety and power are disrupted. According to Salston and Figley (2003), secondary traumatic stress (STS) "parallels" the diagnosis of PTSD with the exception that in STS, the traumatic event is the traumatic experience of the client that becomes shared with the therapist through the process of therapy. Despite different theoretical frameworks, vicarious traumatisation and secondary traumatic stress have much in common. Re-experiencing traumatic events through intrusive thoughts, images and nightmares, avoidance of reminders of trauma, hyper-vigilance and anxiety are all possible effects of therapist's exposure to client trauma that are documented in the literature regarding vicarious traumatisation and secondary traumatic stress (McCann & Pearlman, 1990; Figley, 2002). However, considerable ambiguity continues to exist concerning the use of these terms. Salston and Figley (2003, p. 167) stated that the terms; burnout, compassion fatigue and vicarious traumatisation "are or nearly are synonymous with"

secondary traumatic stress. Figley (2002) further described compassion fatigue as a traumatic stress reaction. Stamm (2010, p.10), proposed that counsellors experiencing compassion fatigue have been “traumatized by work” and that this traumatic stress reaction is either primary or secondary in nature depending on their exposure to trauma. While often used interchangeably, Figley (1995) preferred the terms *compassion stress and compassion fatigue* to secondary traumatic stress stating that inherent in these terms is an acknowledgement of the costs of caring for others experiencing emotional pain. The costs of caring remain inherent in the professional role of counsellors working with clients who have experienced trauma today.

Compassion Fatigue

In discussing the role of the helper (whether a psychotherapist, counsellor, psychologist or others involved in the helping professions) Figley noted the importance of balancing the need to be objective and analytical with the importance of compassion and empathy which he described as the ‘tools of human service.’ (Figley, 2002). Compassion and empathy, he proposed allow the helper to see the world from the client’s perspective and then shape therapy to fit the needs of the client. The etymology of the word compassion, according to the Collins Concise New Zealand Dictionary (HarperCollins, 2012, p.342) came from the Latin, “*com*” and “*pati*” meaning to bear or suffer with. Compassion implies more than empathy. It is involvement in another’s suffering and as such the act of being compassionate carries a cost (Figley, 2002).

Figley (2002) labelled this cost “Compassion fatigue” and acknowledged that it is a natural response from being involved in the trauma of another person.

According to Figley (2002) Secondary Traumatic Stress or Compassion fatigue is a state of tension and preoccupation with the clients who have experienced trauma, involving the re-experiencing of the traumatic events, (through dreams or memory), avoidance of reminders of the trauma or numbing, and persistent psychophysical arousal (for example, anxiety) which may lead to poor concentration and sleep disturbances.

Compassion fatigue results in a reduced capacity or interest in being empathic and as such there are implications for the therapeutic relationship when a counsellor is fatigued. Counsellors have an ethical responsibility to be self-aware of their own potential for compassion fatigue in order to prevent harm to their clients and to maintain professional standards (Everall & Paulson, 2004). However, equally important, trainers, employers and supervisors of counsellors have a role in both assisting counsellors to develop strategies to protect against compassion fatigue and in recognising its occurrence in order to ameliorate its effects. In a qualitative study of counsellors and how they coped with traumatised clients, Hunter and Schofield (2006) acknowledged there is a need to normalise secondary traumatic reactions and also to normalise coping.

It has been recognised that secondary traumatic stress and burnout overlap to a degree, in that both incorporate elements of emotional exhaustion from working with the trauma of others (Adams, Boscarino & Figley, 2006; Salston & Figley, 2003). Adams et al. (2006) proposed that without social support and satisfaction with one’s job, the emotional requirement of

counselling others may leave the counsellor vulnerable to burnout. It is their belief that burnout and secondary traumatic stress, while independent of each other, are both central features of compassion fatigue.

In contrast to compassion fatigue, burnout is “a state of physical, emotional and mental exhaustion caused by long-term involvement in emotionally demanding situations” (Pines & Aronson, 1988, cited in Figley, 2002, p. 1436) whereas compassion fatigue relates specifically to exposure to the trauma of others. Figley (2002) suggested that burnout may require a change in career whereas compassion fatigue when recognised is treatable. Burnout is not specific to working with traumatised people but is related to the work setting such as workload and issues of work responsibility (Deighton, Gurris & Traue, 2007).

Figley’s Etiological Model of Compassion Fatigue

Figley’s (2002) updated model is based on the assumption that empathy and emotional energy provide the basis for effective work with people who have experienced trauma and are necessary for establishing and maintaining a therapeutic alliance, and in delivering effective service. Yet, such an emotional investment can result in compassion fatigue for the therapist. Figley’s model described ten variables that form a causal model for compassion fatigue. His model also provides a means of preparing for, preventing, and treating compassion fatigue. This model is presented in Figure 1 and the ten variables in the model are summarised (Figley, 2002, p.1436-1438).

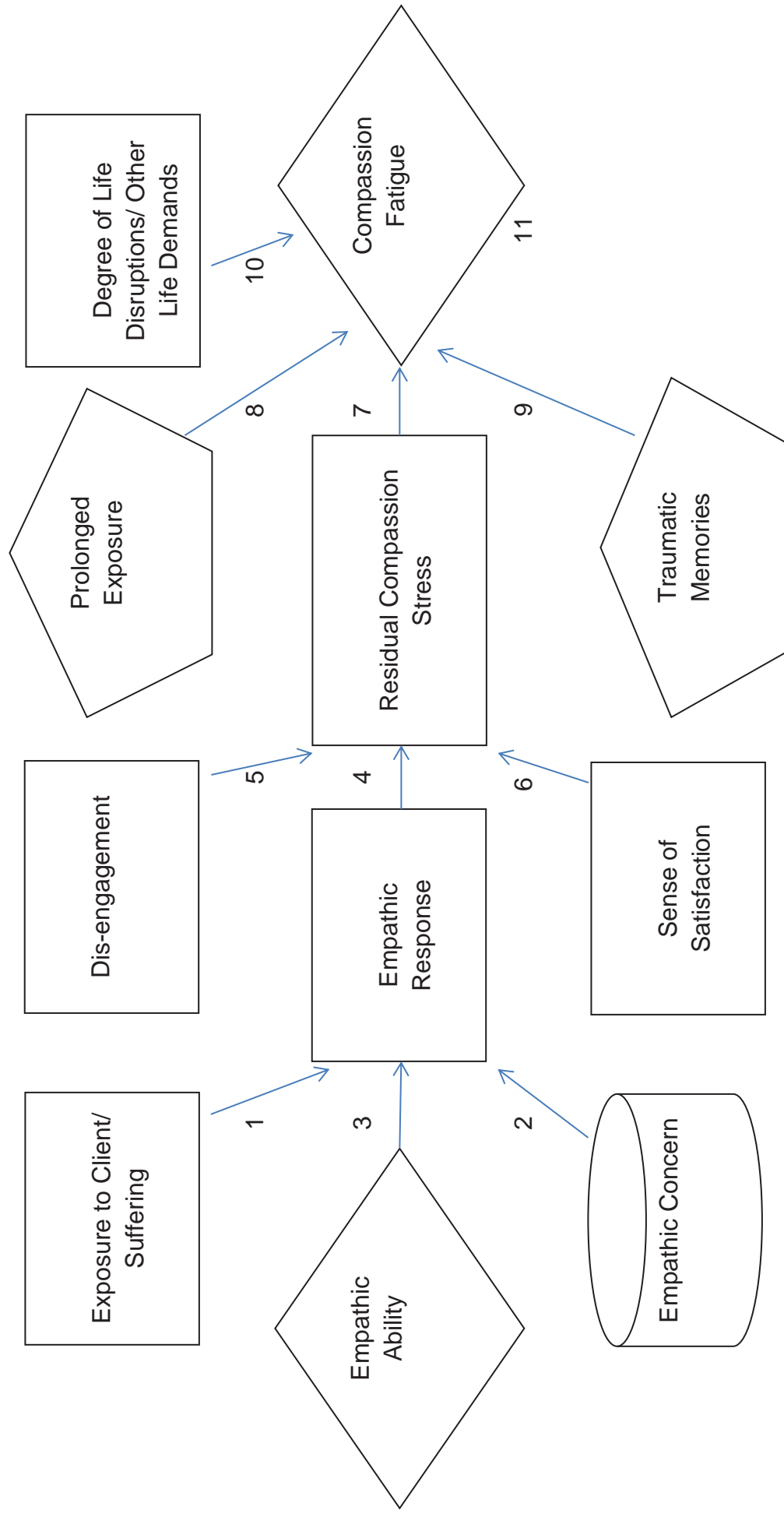


Figure 1. Compassion Stress and Fatigue Model, Figley (2002)

- 1) Exposure to client/ suffering:** This involves the direct contact the counsellor has with the client and assumes the shared experiencing of the client's suffering. Figley (2002) proposed that this is a reason that many counsellors move on from working as counsellors to become supervisors or teachers.
- 2) Empathic Concern:** This refers to the motivation to care for others and is paired with empathic ability. When a counsellor has the ability and motivation to be empathic, he/she can then draw on their skills, training and experience to deliver a service.
- 3) Empathic ability:** Empathy is the ability to recognise the pain of others. An empathic response is necessary to effectively work with people in pain. Without empathy there will be no compassion stress or fatigue.
- 4) Empathic response.** This refers to the extent to which the counsellor uses empathic understanding to reduce the client's suffering. This involves projecting oneself into the perspective of the client and therefore may result in the counsellor experiencing the powerful emotions experienced by the client.
- 5) Disengagement:** This refers to the counsellor's ability to disengage or distance themselves from the suffering of the client outside of sessions. It involves elements of self-care whereby the counsellor recognises that they have their lives apart from the client.

- 6) Sense of Satisfaction:** The degree to which a counsellor is satisfied with their efforts to help a client and has a sense of achievement in their work. This involves recognising where their responsibility ends and the client's begins. Disengagement and sense of satisfaction are coping actions which may reduce the build-up of compassion stress.
- 7) Residual Compassion Stress:** This is the residue of emotional energy from the empathic response and the continual demand to reduce the suffering of the client (Figley, 2002). Compassion stress can have a negative effect on the counsellor. If the counsellor is unable to control it through the described coping actions, it can contribute to compassion fatigue. Three other factors also increase this likelihood; prolonged exposure to suffering, traumatic memories, and degree of life disruption/ other life demands.
- 8) Prolonged exposure:** This involves an on-going sense of responsibility for clients over a significant period of time. Breaks are crucial to allow counsellors respite from being compassionate. Without sufficient breaks, this exposure can contribute to compassion fatigue.
- 9) Traumatic Memories:** Memories from the current client's experiences or from the counsellor's experiences with other clients that the counsellor connects with their own traumatic memories can trigger a traumatic response in the counsellor. This results in an emotional response increasing vulnerability to compassion fatigue.

10) Degree of Life Disruptions/ Other Life Demands: This refers to the unexpected events that may occur in one's personal or professional life, for example: illness or bereavement. Normally these disruptions would result in manageable distress, however, when combined with other aforementioned variables, increases the likelihood of the development of compassion fatigue.

11) Compassion Fatigue: Tension and preoccupation with the clients who have experienced trauma, by A) re-experiencing the traumatic events; B) avoidance/numbing of reminders; C) persistent arousal and the consequent behaviours and emotions from knowing of the trauma of another (Figley, 2002).

Model Implications for Managing Compassion Fatigue

Figley described four implications derived from his model of compassion fatigue which can be used to help counsellors manage and treat compassion fatigue (Figley, 2002, p.1438). These are now summarised: 1) Provide counsellors with an educational overview of compassion fatigue. An overview of Figley's etiological model of compassion fatigue may assist the person in gaining greater understanding of how their symptoms developed and also of what factors may have contributed to and protected against their current state of being. 2) Desensitise the person to the traumatic stressors. Talking about the traumatic event or situation can be beneficial to counsellors with compassion fatigue. While initially likely to provoke some discomfort, the results of desensitisation should decrease or remove the emotional reaction linked to the

traumatic stressor. 3) Thirdly, get the dosage of exposure correct. Exposing the counsellor to the traumatic stressor (event or details that are disturbing them) is a necessary ingredient in desensitisation. However, too much exposure could be overwhelming and too little ineffective. Figley (2002) suggested pairing exposure with relaxation can be particularly effective. 4) Assess and enhance the counsellor's protective factors (Figley, 2002). This includes enhancing their social support system which may involve addressing relationships that are unhelpful as well as increasing supports where it is lacking. Enhancing coping skills is also encouraged.

Strengths and Limitations. One of the strengths inherent in this model is its ability to not only explain and predict the occurrence of compassion fatigue but to prevent, mitigate and treat it. This model could be invaluable in its use in preparing counsellors in training for the reality of the costs of their work, providing them with tools to prepare for and minimise this cost early on in their careers. Sense of satisfaction and disengagement are the only two variables presented within the model which have the potential to prevent or lower compassion stress, however Figley (2002) gave little attention to them when discussing implications for management and treatment, other than to suggest counsellors be provided with an overview of the model. More attention to and discussion of these important variables is warranted. Furthermore, it makes sense that if exposure to the trauma of clients has the potential to be so detrimental that it is important that counsellors learn to disengage from clients out of sessions. Having strategies in place that will assist the counsellor to learn to leave the client's issues in the therapy room is crucial in protecting

against compassion fatigue, yet this is not discussed. Dis-engagement is presented in Figley's (2002) model, however, understated and deserves more attention especially concerning implications for treatment. Figley (2002) advised that dis-engagement involved elements of self-care, yet self-care is not discussed in relation to the treatment and management of compassion fatigue. Furthermore, Figley (2002) described assessing and enhancing counsellor's protective factors as the fourth implication for treatment yet other than social support he does not name these protective factors. If social support is important in the prevention and treatment of compassion fatigue, (such as compassion satisfaction and disengagement are), perhaps it deserves consideration as a variable in the etiological model of compassion fatigue. In addition, Figley's (2002) model does not account for counsellor characteristics or personal resources, (such as resilience) and how such variables might contribute to, or protect against the development of compassion fatigue.

Figley's (2002) implications for treatment have an overemphasis on exposure and desensitisation which is not fully supported by current research on trauma. In their discussion on interventions for trauma, Litz, Gray, Bryant and Adler (2006) acknowledged that while there may be a place for exposure therapy within cognitive based interventions, exposure therapy is not suitable for everyone and has the potential to be damaging. Indeed, if not used with discretion, exposure therapy could subject already vulnerable people to further trauma. Litz et al. (2006) advised that the goal of exposure therapy is to maximise emotional processing of trauma yet many persons who have experienced trauma simply need to share this experience with others. For counsellors who are experiencing compassion fatigue it may be more

appropriate to respond to those who wish to share their experiences and respect those who don't, than to offer exposure and desensitisation therapy as a panacea for all. In support of Figley (2002), Litz et al. (2006) promoted the importance of positive social support stating recovery from trauma is facilitated by its availability. Likewise in their discussion of interventions following exposure to trauma, Bisson, Brayne, Ochberg and Everly (2007) believed social support and practical psychological support to be invaluable. They advocated multiple-session, trauma-focussed cognitive therapy for persons experiencing persistent acute symptoms of traumatic stress whether that stress be due to primary or secondary exposure to trauma. Trauma-focussed cognitive therapy includes elements of exposure therapy in that the trauma is discussed in great detail (encouraging clients to face their fears as opposed to avoiding them) yet it is not as invasive as exposure therapy alone and has a greater focus on challenging and addressing cognitive distortions which have developed as a result of trauma (Bisson et al. 2007). Both Litz et al. (2006) and Bisson et al. (2007) unlike Figley (2002) who has a prescribed treatment for persons experiencing compassion fatigue acknowledged that people cope in different ways and no intervention should be mandated for all.

Figley's (2002) etiological model of compassion fatigue has some support from research (Craig & Sprang, 2010; Jenkins & Baird, 2002; Killian, 2008; Sprang, Clark & Whitt-Woosely, 2007) however not all variables in his model have been tested. For example, while empathy is proposed as a critical precursor to compassion fatigue (Figley 2002) a literature search yielded limited research related to empathy variables as predictors of compassion fatigue. Research concerning the process in which compassion fatigue develops is also

limited. It is unclear whether all variables need to be present in order for compassion fatigue to occur. These are enquiries which could be addressed through longitudinal studies of the development of compassion fatigue in counsellors, however such studies are lacking. It appears that while Figley's (2002) model provides a starting point for understanding compassion fatigue, there is room for development of this model. In their study of compassion fatigue risk in residential treatment childcare workers, Eastwood and Ecklund (2008) found compassion satisfaction appeared to have no direct relationship to risk of compassion fatigue but suggested it may moderate risk for compassion fatigue by more directly having a protective influence upon risk of burnout. Further research is needed to identify how the variables of Figley's (2002) model interact with each other. Eastwood et al. (2008) suggested that while their study provided some support for Figley's (2002) etiological model of compassion fatigue, the model might be improved upon by including burnout risk level as a variable, as burnout can inhibit empathic concern, ability and sense of achievement thereby increasing compassion stress. Likewise, in their study of compassion fatigue in genetic counsellors, Udipi, McCarthy Veatch, Kao and LeRoy (2008) found burnout to be the most significant predictor of compassion fatigue supporting the inclusion of burnout as a variable in Figley's (2002) etiological model of compassion fatigue.

It has been suggested that Figley's (2002) model of compassion fatigue could be improved on by the inclusion of burnout as a risk factor. The current study aims to test the ability of burnout to predict high risk of secondary traumatic stress in a sample of New Zealand counsellors who work with trauma clients.

For the purposes of the current study, the researcher will use the term *Secondary Traumatic Stress* except in situations where the literature specifically refers to *Compassion Fatigue* (as in the preceding section). The Professional Quality of Life Scale (ProQOL; Stamm, 2010) of which this study relies upon, includes a secondary traumatic stress subscale, which in earlier versions of the ProQOL (Stamm, 2002; Stamm 2005), had previously been named the 'compassion fatigue' subscale. Despite the different names of these subscales, their items are nearly identical and as such measure the same construct. Stamm (2010) proposed that burnout and secondary traumatic stress are both elements of compassion fatigue, yet her manual does not provide a means of assessing or screening for compassion fatigue. Due to the absence of a specific compassion fatigue measure in this version of the ProQOL (Stamm, 2010), the current study uses the secondary traumatic stress subscale but acknowledges that for the purposes of comparison with previous research which used earlier versions of the ProQOL (Stamm, 2002; Stamm; 2005), compassion fatigue and secondary traumatic stress are in fact the same construct.

Prevalence of Secondary Traumatic Stress

The prevalence of secondary traumatic stress has been identified in diverse populations of counsellors and others in the helping professions, for example; clergy who counsel church members (Galek, Flannelly, Greene & Kudler, 2011; Hendron, Irving & Taylor, 2012; Holaday, Lackey, Boucher & Glideway, 2001), genetic counsellors (Benoit, McCarthy Veach & LeRoy, 2007;

Udipi, et al. 2008), counsellors of victims of sexual violence (Schauben & Frazier, 1995), solicitors exposed to traumatic material (Vrklevski & Franklin, 2008), police involved in investigating internet child exploitation (Burns, Morley, Bradshaw & Domene, 2008), Employee Assistance Professional counsellors providing work place crisis intervention and disaster management services (Jacobson, 2006), therapists working with sexual offenders (Moulden & Firestone, 2007; Way, VanDeusen, Martin, Applegate & Jandle, 2004) and social workers involved in the September 11 Terrorist Attacks (Boscarino, Figley & Adams, 2004).

In a study, employing the Professional Quality of Life (ProQOL) measure to investigate compassion fatigue among employee assistance professionals (EAP), Jacobson (2006) found 41.2% of her sample presented with low risk, 46.8% with moderate risk and 12% with high risk of compassion fatigue. In a study investigating the prevalence of secondary traumatic stress in counsellors involved with victims of bank robberies, Ortlepp and Friedman (2002) found an overall low risk of compassion fatigue with 79% presenting with low risk, 11% with moderate risk and 10% with high risk. It is noted that in this second study, the counsellors' exposure to the trauma of others was not prolonged but periodic and this may account for the lower levels of high risk of secondary traumatic stress identified. In their study of compassion fatigue in trauma treatment specialists, Craig, et al. (2010) reported only 6% of their sample to be at high risk for compassion fatigue, however acknowledged that the older mean age and experience levels of their participants may account for the lower rates of high risk of compassion fatigue as compared to other studies.

In order to identify counsellors who are more at risk of stress, Arvay and Uhlemann (1996) created a profile of an “impaired counsellor” based on their research of counsellors who worked in the field of trauma. Fourteen percent of their total sample presented with high scores of perceived life stress, traumatic stress and burnout. Counsellors who experienced high stress were more likely to be younger, less experienced and with an education less than a Master’s degree than other counsellors. Furthermore, they were more likely to work in community agencies and to have the perception that their caseloads of trauma clients were too high and intense. Arvay, et al. (1996) noted that such counsellors tended to rely on exercise or time with family and friends as self-care strategies as opposed to engaging in supervision or therapy.

Of the research pertaining to the prevalence of secondary traumatic stress in counsellors, there is little which specifically considers New Zealand counsellors. That which addressed traumatic stress in New Zealand counsellors (Pack, 2004; Evans & Payne, 2008) was qualitative in nature and therefore excluded measures which had the potential to determine the prevalence of which New Zealand counsellors were at risk of secondary traumatic stress. Of the one quantitative study found pertaining to secondary traumatic stress in New Zealand (refer; Hargrave, Scott & McDowall, 2006), the participants were volunteer victim support workers and not trained counsellors. Additionally, the measure used in this study was the Impact of Event Scale (*IES*; Horowitz, Wilner, & Alaverz, 1979) which measures stress from specific events as opposed to that from cumulative exposure. The current study aims to address limitations in existing research by providing an indication of the current

prevalence of secondary traumatic stress in a New Zealand sample of counsellors who work with trauma clients.

Risk Factors for Secondary Traumatic Stress

Proportion of Trauma Clients on Caseload

One risk factor that appears to be supported by the literature is the proportion of trauma clients within a counsellors' caseload. In accordance with Figley's model of compassion fatigue (Figley, 2002), in which the exposure to the suffering of another is necessary in the development of compassion fatigue, it would seem logical that the more exposure a counsellor has, the greater their risk of compassion fatigue. Schauben and Frazier (1995) found in a sample of female counsellors working with survivors of sexual violence that counsellors with higher proportions of trauma clients in their caseloads reported more disrupted beliefs, symptoms of PTSD and self-reported vicarious trauma. Likewise, Sprang, et al. (2007) found that mental health providers with a higher percentage of clients with PTSD on their caseloads predicted higher levels of compassion fatigue and burnout. These results were replicated in Craig, et al. (2010) where a significant relationship was found between percentage of PTSD clients in a caseload and levels of compassion fatigue.

The research reported in this section provide some support for the relationship between proportion of trauma clients on a caseload and increased risk of both primary and traumatic stress in counsellors, thereby supporting the

inclusion of exposure as a variable in Figley's (2002) model of compassion fatigue, however this is by no means conclusive. The current study aims to provide further support for the role of exposure by investigating the relationship between proportion of trauma clients on caseload and risk of secondary traumatic stress in a New Zealand sample of counsellors who work with victims of trauma.

Personal Trauma History

A taskforce convened to address war related stress (specifically the Persian Gulf war) and more generally other traumatic events which may impact communities, advised that traumatic events may "piggyback on" recent stressors and "reawaken" prior traumas (Hobfall et al., 1991, p.849). This supports the contributory role of traumatic memories in Figley's model of compassion fatigue (Figley, 2002). Buchanan, Anderson, Uhlemann and Horwitz (2006) interviewed Canadian Mental Health workers and found moderate rates of personal trauma history, (61% admitted to experiencing emotional or psychological abuse, more than 40% had experienced an accidental disaster and one third child sexual abuse or incest). Their results indicated that current psychological distress was related to past personal trauma history. Likewise, Vrkleviski and Franklin (2008), investigated the impact on solicitors exposed to traumatic material and found that multiple personal trauma history was related to higher scores of distress. In a study of counsellors who worked in the fields of sexual assault and domestic violence, Jenkins, et al. (2002) found 55% of counsellors in their sample reported personal trauma histories involving sexual assault or domestic violence. Counsellors with personal trauma histories scored higher on risk of compassion

fatigue than those without. Adams, Boscarino and Figley (2006) found in a sample of New York city Social Workers following the September 11th World Trade Centre attack, that Social Workers who reported more negative life events had higher levels of psychological distress. Using multiple regression, Killian (2008) found therapist's history of traumatic events to be a factor predicting compassion fatigue in therapists working primarily with children who had been sexually abused. These studies provide support for Figley's model of Compassion Fatigue in that they all attest for the role of Traumatic Memories and Other Life events in contributing towards the development of compassion fatigue.

However, the results of research in regard to the relationship between personal trauma history and secondary traumatic stress are mixed. In contrast, in a study investigating the effects on female counsellors of working with sexual violence victims, Schauben and Frazier (1995) found 70% of the psychologists and 83% of the sexual violence counsellors reported at least one out of five types of previous victimisation. However, current symptomology was not related to a personal history of victimisation. A limitation of this study was that the sample was all female and it only examined the effects of working with sexual violence, suggesting the results may not be generalizable to males and to other trauma types. Likewise, in a study of vicarious trauma in counsellors who worked with sexual abuse survivors and sexual abuse perpetrators, Way et al. (2004) found that overall 75.8% of counsellors had a maltreatment history but that this was not significantly associated with vicarious trauma. In a further study investigating factors which influence both the positive and negative well-being of therapists, Linley and Joseph (2007) found that therapists with a

personal trauma history had greater levels of personal growth than therapists without. There were no significant differences between the two groups on scores of compassion fatigue. This research suggests that personal trauma history may facilitate personal growth. Collins and Long (2003b) proposed that when trauma workers have worked through their own life histories and personal traumas, they may bring to the therapeutic relationship positive coping strategies which can be utilised when working with trauma victims. The authors suggested that it is important to know not only whether trauma workers have a personal trauma history, but whether they have worked through this history. This information is lacking from most research and may have affected the findings of earlier studies that supported the relationship between personal trauma history and compassion fatigue.

Sexton (1999) further advocated the importance of trauma counsellors being aware of and addressing their own personal trauma histories as well as other negative unworked through experiences. He proposed counsellors need to acknowledge that such experiences may interact destructively with client's traumas and therefore it was important to take time out to work through and heal from such experiences. Salston et al. (2003) echoed this concern noting the potential for the unresolved trauma of the therapist to be triggered by the trauma of the client especially when similarities between traumas exist. In such situations, the importance of being able to detach from the client and of the therapist seeking counselling is obvious. The current study aims to contribute to the existing evidence concerning personal trauma history and risk of secondary traumatic stress by testing a sample of New Zealand counsellors who work with victims of trauma.

Protective Factors against Secondary Traumatic Stress

Social Support

Research investigating the potentially protective role of social support against the development of secondary traumatic stress is considerably lacking and inconclusive. Such research is more prevalent in the realm of organisational behaviour and occupational stress than traumatology. Social support has traditionally been divided into two key aspects; emotional social support and instrumental social support. Fenlason and Beehr (1994) described emotional social support as characterised by caring or sympathetic listening to another, whereas instrumental social support is practical involving either the impartation of knowledge and advice or physical assistance. They stated that while emotional and instrumental social support may effectively reduce occupational stress, there is also the potential for such support to increase stress, for example in situations where a supportive other leads the stressed individual to believe a situation to be as bad or worse than previously thought. Similarly, Southwick, Vythilingam and Charney (2005) stated while social support has been linked with reduced stress, in order for it to be effective it must be positive rather than negative. Such findings indicate the importance of more in-depth research into the nature of support and what is required for that support to be effective. Fenlason and Beehr (1994) proposed that content of communication may be a better and more specific measure of the effect of social support on occupational stress.

Of the research pertaining to traumatology, Pietrzak, Johnson, Goldstein, Malley and Southwick (2009) investigated the potential protective role of social support in soldiers returning from Operations Enduring Freedom and Iraqi Freedom against the development of post-traumatic stress and depressive symptoms. They found that veterans with PTSD reported lower levels of post-deployment social support than veterans without PTSD. Increased levels of post-deployment social support were negatively associated with traumatic stress levels and depressive symptoms. Higher post-deployment support was associated with decreased PTSD and depressive symptoms even when controlling for combat exposure.

Of the limited research investigating social support and secondary traumatic stress, Ortlepp and Friedmann (2002) in their investigation of lay trauma counsellors who worked with the victims of bank robberies found social support was related to lower scores of secondary traumatic stress and burnout. In contrast, Hyman (2004) investigated the relationship between perceived social support satisfaction and availability and secondary traumatic stress symptoms in Israeli Police emergency responders finding no significant relationship.

Meyer and Ponton (2006) suggested that while maintaining a healthy wellbeing is dependent on a balance of personal and professional support, professional support is a two-way relationship and counsellors need to be actively involved in both the giving and receiving of support. It may be that in providing support to others, counsellors find an increased sense of satisfaction in their professional roles. In a study of New York Social Workers involved in providing assistance to victims of the September 11th World Trade Centre

Attack, Boscarino et al. (2004) found having effective workplace support was significantly negatively related to secondary traumatic stress. Likewise, Galek, Flannelly, Green and Kudler (2011) discussed the importance of work related social support in enhancing the personal resources necessary to respond to stress thereby reducing burnout. Sexton (1999) also proposed the workplace team as an important social support that has the potential to assist counsellors in working through secondary traumatic stress through the validation of feelings, supportive relationships and demonstrating an understanding of experiences. He suggested that in such a team, trauma can be absorbed and diffused among members.

The research provides clear evidence for the benefits of social support but also notes that in some cases support has the potential to be ineffective in the least and potentially damaging at the worst. Further research is clearly needed in order to determine what is necessary for social support to be effective. In addition, in relation to secondary traumatic stress are certain sources of support more effective than others in protecting against the stresses involved in working with traumatised clients? The current study aims to contribute to the existing limited research concerning social support by investigating its' relationship with secondary traumatic stress.

Resilience

Prior to the emergence of traumatology's own research in relation to resilience, resilience was studied by developmental psychopathologists interested in children growing up in adverse environmental conditions. In 1978,

Garmezy (as cited in Garmezy & Masten, 1986) described 'Project Competence' a Minnesota based research program which identified children vulnerable to developing schizophrenia and other disorders. Competence was seen as a protective factor against the development of psychopathology. Interestingly however, the study found that contrary to expectation, only a minority of children presented with low competence and a large number of children previously labelled as 'vulnerable' due to parental pathology or other environmental disadvantages were very adaptive. "This evidence of a cup more than half full rather than less than half empty," (Garmezy & Masten, 1986, p.512) changed the focus of the research from risk and psychopathology to factors which promote stress-resistance and opened the door to further studies in which the concept of resilience was introduced. A further hallmark study was the Kauai Longitudinal study which commenced in Hawaii in 1955 (Werner, 1993). This study followed the developmental paths of the 698 babies born in 1955 on Kauai Island, with a particular interest in children exposed to perinatal stress, poverty, troubled family environment and parental psychopathology. Approximately one third of the children were designated 'high risk' due to the adverse environmental conditions they were exposed to. However, of this high risk group, one third of the children grew into confident caring adults who appeared to succeed at home, school, work and socially. These children were described as 'resilient,' (Werner, 1993).

Agaibi and Wilson (2005), noted that the study of resilience began to move away from its' traditional roots in developmental psychopathology in 1980 when PTSD was recognised as a diagnostic entry. From this point, interest arose in the role of resilience in trauma survivors who did and did not develop

PTSD. Bonanno and Mancini (2008) suggested that the traditional focus on psychological dysfunction after traumatic events promotes the belief that lasting psychological damage always pursues trauma, however this is not based in evidence. As with the early developmental studies of children in adverse environments where high numbers of vulnerable children went on to succeed in life despite the odds, numbers of persons exposed to potentially traumatic situations who do not go on to develop PTSD are higher than those who do develop PTSD (Bonanno & Mancini, 2008). Bonanno (2005) presented prototypical trajectories of disruption in normal functioning following loss or potential trauma providing evidence for an individual differences model of response to trauma. Four discrete and separable trajectories were described, (refer Bonanno, 2005); however of these, the Resilience Trajectory represented the majority of people (35-55%). These people were reported to experience some mild transient disruptions as a result of their loss or trauma however these disruptions did not interfere with day to day functioning and did not require psychological assistance. In this regard, resilience is not rare but common and a feature of normal coping. Bonanno (2004, p.20) defined resilience as “the ability to maintain a stable equilibrium” and in relation to loss and trauma “pertains to the ability of adults in otherwise normal circumstances who are exposed to an isolated and potentially highly disruptive event, such as the death of a close relation or a violent or life-threatening situation, to maintain relatively stable, healthy levels of psychological and physical functioning.” In defining resilience, as with any other construct there are bound to be differences and disagreements. Bonanno (2012) stated that a common misuse of the word resilience is in reference to it as a trait or personality variable, pointing out that

personality rarely explains more than a small amount of the variance in human behaviour across situations.

Tugade and Fredrickson (2004, p.320) defined psychological resilience as, “effective coping and adaptation although faced with loss, hardship or adversity.” Tugade and Fredrickson (2004) further proposed that positive emotionality is an important element of resilience. Their research suggested that highly resilient individuals tend to experience positive emotions in the midst of stressful situations and that it is these positive emotions and positive appraisals which contribute to their ability to recover from the negative emotional arousal experienced in such situations. Such positive emotionality inherent in resilient individuals suggests possible connections with compassion satisfaction which may warrant further exploration. In a review of depression and stress resilience, Southwick, Vythilingam and Charney (2005) identified various factors related to resilience. Psychosocial factors discussed which contribute to or are associated with resilience include; optimism and high positive emotionality, humour, cognitive flexibility, religion, spirituality and altruism, social support and role models, and an active coping style and exercise, (Southwick et al. 2005). In their study of potential protective factors against the development of traumatic stress and depressive symptoms in soldiers returning from Operations Enduring Freedom and Iraqi Freedom, Pietrzak et al. (2009), found that veterans with PTSD reported lower levels of resilience and that increased levels of resilience were negatively associated with levels of traumatic stress and depressive symptoms. While, the authors did not specifically investigate the mechanisms of resilience, they suggested, similarly to Tugade et al. (2004) that resilience may be protective in that it

improves emotional regulation, decreases fear-related appraisals and promotes positive cognitions about the world thereby increasing one's sense of control, (Pietrzak et al. 2009). Meyer and Ponton (2006, p.200) suggested that "resiliency in counsellors is not an accident. Rather it is the cumulative effect of counsellor's healthy decision making, time management, positive relationships, continuing education, and maintaining a cogent theory of counselling and a spiritual awareness." Grafton, Gillespie and Henderson (2010) likewise believed that resilience can be enhanced through cognitive practices, further education and support. Resilience factors do not operate in isolation but both interact with and influence other factors.

Smith, Dalen, Wiggins, Tooley, Christopher and Bernard (2008, p.194) stated that the word resilience in its most original meaning is, "the ability to bounce back or recover from stress." In testing their Brief Resilience Scale (BRS), Smith et al. (2008) used undergraduate students, cardiac rehabilitation patients and women with fibromyalgia. The authors proposed that the BRS is a reliable means of assessing resilience as the ability to bounce back and recover from stress. In a later article, Smith, Tooley, Christopher and Kay (2010), described resilience not as a stable characteristic but as a personal resource such as social support would be considered. It is therefore more easily modified and through interventions may be developed in persons with limited resilience.

Existing research relates low levels of resilience to increased risk of PTSD and provides some support for the protective role of resilience against the development of PTSD (Pietrzak et al. 2009). Despite, recognition of the value of resilience in counsellors, there is limited research concerning the

relationship between resilience and secondary traumatic stress in counsellors who work with trauma. The current research aims to address this shortage of research by investigating resilience and risk of secondary traumatic stress in a sample of New Zealand counsellors.

Compassion Satisfaction

Research concerning the well-being of therapists has focussed almost exclusively on the negative costs of being empathetic despite the satisfaction and growth therapists may experience as a result of working with traumatised clients. Collins and Long (2003b) acknowledged that the motivation to help is shaped at least in part from the satisfaction derived from helping. Collins and Long (2003a) found, in a small group of trauma workers involved in the 1998 Northern Ireland Omagh bombing response, that compassion satisfaction was a potential protective factor against compassion fatigue and burnout in that workers with high scores of compassion satisfaction were less likely to have high scores of compassion fatigue and burnout. Limiting this research was the small sample size. Linley and Joseph (2007) investigated factors associated with positive and negative well-being among 156 therapists. Positive well-being was measured by personal growth, positive psychological change and compassion satisfaction. Their research found that the best predictor of positive psychological change and compassion satisfaction was the therapeutic bond between therapist and client. Similarly, Ramirez, Graham, Richards, Cull and Gregory (1996) found relationships with patients, their relatives and colleagues along with having professional status had the greatest contribution to job

satisfaction among hospital consultants and that job satisfaction was protective against job stress. Dougherty, Pierce, Panzarella, Ma, Rodin and Zimmermann (2009) surveyed oncology personnel. Similarly, they found that professional satisfaction was strongly negatively correlated with staff stress consistent with previous studies which link satisfaction with patient care and the client-therapist relationship. Taken together, these results suggest that while exposure to trauma clients or patients has been identified as a potential risk, this relationship also has the potential to be a great source of satisfaction which can be protective against stress.

Using multiple regression, Killian (2008) found that the level of social support from friends, family and community was the strongest predictor of compassion satisfaction. This finding warrants further research concerning the relationship between social support and compassion satisfaction. Social support has been highlighted as a protective factor against compassion fatigue Ortlepp et al. (2002) but has rarely been identified as a predictor of compassion satisfaction. Killian (2008) additionally found that working a greater number of hours per week with trauma survivors reduced levels of compassion satisfaction and having a sense of control in the work place increased levels of compassion satisfaction.

Lawson and Myers (2011) investigated the relationship between wellness, professional quality of life factors, (compassion satisfaction, compassion fatigue and burnout) and career sustaining behaviours, (CSBs) in professional counsellors. They found a positive correlation between wellness and compassion satisfaction and negative correlations between wellness and compassion fatigue and burnout supporting the relationship between wellness

and compassion satisfaction. A negative correlation was also found for percentage of high-risk clients on caseload and compassion satisfaction suggesting that the more high-risk clients a counsellor has, the less likely they will gain satisfaction from their jobs. The authors suggested that focussing on increasing wellness has the potential to help counsellors enhance and retain high levels of compassion satisfaction while avoiding compassion fatigue and burnout. They suggested that one way of doing this would be to increase counsellor's awareness of career sustaining behaviours as strategies that can enhance wellness and therefore compassion satisfaction. Spending time with partner/family, maintaining a sense of humour and maintaining a work-life balance were among the top identified CSBs, (Lawson et al. 2011).

Alkema, Linton and Davies (2008) investigated the relationship between self-care, compassion fatigue, burnout and compassion satisfaction among hospice care professionals. Similarly, they found that compassion satisfaction was significantly positively correlated with emotional, spiritual and work-life balance components of self-care but not physical, psychological and workplace components. Compassion fatigue was significantly negatively correlated with all aspects of self-care with the exception of physical self-care. Taken together, these results suggest that engagement in self-care may prevent compassion fatigue, however only emotional and spiritual self-care and work-life balance are predictive of increased compassion satisfaction. Yet, the correlational nature of their research mean the causal nature of these relationships cannot be confirmed and the small sample size is a further limitation.

Sprang et al. (2007); Craig & Sprang (2010) found that clinicians with specialised trauma training reported higher levels of compassion satisfaction.

This suggests that enhanced knowledge and training may not only decrease deleterious effects, but increase satisfaction with one's work. Further exploration into the content of such training may yield light on specific aspects of training that prepare and equip therapists for their role. Craig and Sprang (2010) further found years of clinical experience and use of evidence-based practices to be significant predictors of compassion satisfaction.

While there are clearly significant costs to being compassionate in one's role as a professional helper, such as that embodied in the phenomenon of secondary traumatic stress, such reactions on the one hand are normal human responses and may be expected, but on the other hand are not inevitable so long as certain protective factors are put in place. There is hope, in that secondary traumatic stress is treatable and in the fact that despite the circumstances numerous professionals continue to enjoy their roles in working with clients who have experienced trauma and do so displaying great resilience and satisfaction in their jobs.

The research described has discussed factors which may relate to, and or, enhance compassion satisfaction. Support for the potentially protective role of compassion satisfaction against the development of secondary traumatic stress exists, however, much of the research concerning the relationship between compassion satisfaction and secondary traumatic stress has been correlational in nature and therefore causal conclusions cannot be made. The current study aims to add to the existing research by identifying whether compassion satisfaction predicts high risk of secondary traumatic stress, and to further explore the relationship between compassion satisfaction, burnout and secondary traumatic stress.

This chapter presented existing literature relevant to the central components of this thesis. It described the development of the study of traumatology and related constructs of secondary traumatic stress and compassion fatigue. A theoretical model of compassion fatigue was summarised and its strengths and limitations discussed. Studies related to the prevalence of secondary traumatic stress, were further discussed. Literature related to burnout, trauma exposure, personal history of trauma and the potentially protective roles of social support, resilience and compassion satisfaction were presented. Reflection on this literature notes a move in the direction of research on secondary traumatic stress away from a primary focus on risk towards a focus on protective factors against secondary traumatic stress and also a phenomenon labelled posttraumatic positive growth. Further investigation of secondary traumatic stress and of the protective factors against its development in counsellors who work with clients who have experienced trauma is needed as recent research has prompted more questions.

Based on the reviewed literature, it is hypothesised as follows:

Hypothesis One: High levels of compassion satisfaction, secondary traumatic stress and burnout would be present in ten to twenty-five percent of counsellors.

Hypothesis two: Counsellors with increased exposure to traumatic material, as measured by higher proportion of trauma clients on caseloads, would score higher on risk of secondary traumatic stress.

Hypothesis three: Counsellors with a personal trauma history would score higher on risk of secondary traumatic stress than those without.

Hypothesis four: High Secondary Traumatic Stress levels would be predicted by high scores of burnout and low scores of compassion satisfaction, resilience and social support.

Hypothesis five: Compassion satisfaction would moderate the relationship between burnout and secondary traumatic stress.

The methodology used to investigate these constructs in a sample of New Zealand counsellors working with traumatised clients is now presented.

2. Method

Research Design

This study used a quantitative, cross-sectional design to investigate secondary traumatic stress, burnout, compassion satisfaction, resilience and social support amongst a sample of New Zealand counsellors working with clients who have experienced trauma. Parametric data analyses were used to test the hypotheses. Specific statistical procedures are described in the section entitled *Statistical Analysis*. Results of these analyses are presented in the following chapter.

Participants

The participants comprised a sample of 129 counsellors who responded to an advertisement sent to their respective counselling organisations. Counsellors, belonged to at least one of the following organisations; The New Zealand Association of Counsellors, Relationships Aotearoa, The New Zealand Christian Counsellor's Association, Te Whariki Tautoko, The National Association for Grief and Loss NZ, and Addiction Practitioner's Association Aotearoa. Of the 129 participants, 84.5% were female (n=109) and 15.5% were male (n=20). Participants were asked to indicate the age bracket they fit into. A majority of 65.2% of participants reported being older than 50 years of age (n = 84) with only 3.1% indicating age under 35 (n=4). Seventy-six percent of participants reported their current relationship status as 'in a relationship' (n=98) and 24% as 'single' (n=31). The majority of counsellors identified as being New

Zealand European/ Pakeha (n=105; 81.4%), followed by New Zealand Maori (n=6; 4.7%) and Other (n=6; 4.7%). Of those who selected 'Other', the following categories were represented; Jewish (n=1), North American (n=1), Kiwi (n=1) and mixed ethnicity (n=3). One participant did not specify ethnicity (n=1; 0.8%). In regards to highest education, the majority claimed post graduate qualifications, (Masters, PhD or post graduate diplomas), (n=72; 55.8%). Further details are contained within Table 1. Demographics of Sample

An expanded table including years of counselling experience, frequency of professional supervision, personal trauma history and number of social supports is included (refer Appendix A).

Table 1.

Demographics of Sample

Demographic Variable	<i>n</i>	Percent
Gender		
Male	9	15.5
Female	120	84.5
Ethnicity		
NZ Maori	6	4.7
NZ Euro/ Pakeha	105	81.4
Pacific Islander	2	1.6
Other European	4	3.1
American	3	2.3
British	2	1.6
Other	6	4.7
Age		
26-35 years	4	3.1
36-45 years	24	18.6
46-55 years	37	30.3
56-60 years	29	22.5
60 years <	33	25.6
Relationship Status		
Single	31	24.0
In a relationship	98	76.0
Highest Qualification		
Undergrad cert/diploma	16	12.4
Degree Equivalent	12	9.3
Bachelor's degree	29	22.5
Postgraduate	72	55.8

Note: Participants were informed of their right not to answer all questions: Ethnicity, Years counselling experience and Personal trauma history percentages do not sum to 100

Measurement

A self-report anonymous survey was used (refer to Appendix B). In addition to basic demographic questions, therapists were asked about:

Experience

- 1) How many years have you worked as a counsellor?

Professional supervision

- 1) How frequently do you engage in Professional Supervision?
- 2) How effective are these sessions?

Level of Support

- 1) Please select from the following, the supports that you have used in the past 30 days to assist you in coping with the impact of your work with clients.
- 2) If Maori, please select from the following any additional supports you have used in the past 30 days to assist you in coping with the impact of your work with clients.

Trauma

- 1) Please select the types of trauma you have been working with over the past 30 days.
- 2) Taking into consideration your current caseload, what is the proportion of clients who have experienced trauma?
- 3) On average over the past 30 days, how many hours per week would you typically spend with clients who have experienced trauma?
- 4) Have you yourself experienced any of the traumas listed above?

Professional Quality of Life Scale (ProQOL; Stamm, 2010):

This scale is a 30 item self-report test consisting of three subscales used to assess secondary traumatic stress, compassion satisfaction, and burnout. Subscales consist of 10 items each. Example items include; “Because of my helping, I have felt ‘on edge’ about various things” and “I believe I can make a difference through my work.” Items are scored on a 5-point scale from 1 = ‘never’ to 5 = ‘very often’ with a possible range of 10 to 50 per measure. When standardised and converted to a t-score using the Stamm Conversion t-table (Stamm, 2010) this range changes to 19 to 68 for the compassion satisfaction subscale, 28 to 85 for the burnout subscale and 33 to 76 for the secondary traumatic stress subscale. The conversion is not strictly numeric as there are more scores available on a standardised t-score than on the raw score (Stamm, 2010). Stamm (2010) furthermore, advised that calculations using the SPSS scoring scheme have some variance in comparison to the table but that this variance is trivial. Low scores on the secondary traumatic stress measure are indicative of low risk of secondary traumatic stress whereas high scores indicate high risk. Low scores on the compassion satisfaction measure indicate low potential for compassion satisfaction whereas high scores indicate high potential. Low scores on the burnout measure indicate low risk of burnout whereas high scores indicate high risk. Participants were asked to select based on their experiences over the past 30 days. Items 1, 4, 15, 17 and 29 on the burnout subscale are reverse-scored. Psychometric properties for the three subscales have been shown to be reliable in the past (Stamm, 2010). In the

present study, respective Cronbach's alpha coefficients for secondary traumatic stress, compassion satisfaction and burnout were; .80, .85 and .72.

The Brief Resilience Scale (BRS: Smith, Dalen, Wiggins, Tooley, Christopher & Bernard, 2008),

Resilience was measured using the Brief Resilience Scale (BRS: Smith, Dalen, Wiggins, Tooley, Christopher & Bernard, 2008), a 6 item scale used to measure resilience as 'the ability to bounce back from stress'. Items 2, 4, and 6 on the BRS are negatively worded and are reverse-scored. An example of an item is "I usually come through difficult times with little trouble." Items are scored on a 5-point scale from 1 = 'strongly disagree' to 5 = 'strongly agree.' High scores on the BRS indicate high resilience whereas low scores indicate low resilience. Psychometric properties for the BRS have been shown to be reliable (Smith, Tooley, Christopher & Kay, 2010) and were reliable in the current study with Cronbach's alpha at .90.

Procedure

Massey University's Human Ethics approval for the study was granted on 7 August 2012. A trial of the questionnaire was conducted with a group of 8 professional adults who were not counsellors, but had helping professional backgrounds, consisting of one male and seven females, from 28 to 54 years of age. This gave an indication that the average length of time to complete the questionnaire was 12 minutes and confirmed that all items were easily

understood by participants. As a result of participant feedback, some minor amendments were made to the questions around professional supervision.

Participant Selection. Non-probability, purposive sampling (Goodwin, 2008) was used to select the New Zealand Association of Counsellors from the available counselling organisations in New Zealand. This was done to ensure that participants were practising counsellors and that being a national body it was expected that it would result in a representative sample of counsellors in New Zealand as a whole. A letter (refer Appendix C) was sent to the Executive Officer of the New Zealand Association of Counsellors, (NZAC) requesting permission to advertise the study within their organisation. The New Zealand Association of Counsellors is the largest professional body of counsellors in New Zealand with over 700 members. It was hoped that a response rate of approximately one third would occur and result in a sample size of 200 participants. Permission was provided by the NZAC research panel and an agreement reached whereby an advertisement and link to the study (refer Appendix D) would be emailed by the NZAC Administration Officer to all counsellor members. The first email was sent to members mid-September 2012. When only 42 responses had been received by mid-October 2012, a decision was made to send reminder emails to members and to seek Ethics committee approval to forward the survey to specified additional organisations. Approval for the proposed changes was granted by the Ethics Committee on 15 November 2012 and the following organisations were contacted; The Addiction Practitioners Association Aotearoa New Zealand (DAPAAZ), The New Zealand Christian Counsellors Association (NZCCA), Relationships Aotearoa, The National Association of Loss and Grief NZ (NALAG) and Te Whariki Tautoko,

(an organisation for Maori Counsellors). All organisations agreed to email the advert for the study and its' link to their members; however some regions of Relationships Aotearoa decided against participating.

Ethical Considerations. Potential participants were provided with an information sheet (refer Appendix E) prior to completing the survey which provided a brief introduction to the study. It was communicated to them that they were under no obligation to participate but that if they chose to, their participation implied consent. Participants were ensured anonymity. They were told that they could omit any questions they did not want to answer. While no discomfort was anticipated, participants were encouraged to talk with their professional supervisors or colleagues if they experienced any distress in regards to issues the study. Out of appreciation for counsellors' participation, the researcher advised that \$1.00 would be donated to the Women's Refuge for every survey completed.

The online survey programme Qualtrics (www.qualtrics.com, 2012) was used for the online administration of the questionnaire. The questionnaire was hosted on an external Qualtrics server and only a secure browser connection by the School of Psychology's programmer-analyst was required to alter the questions and retrieve data. Use of the Massey University information technology infrastructure required authorisation, and this was approved on 20 August 2012. Data from the server was downloaded via a secure web connection and stored on a local hard drive before being shared with the

researcher. Surveys were anonymised for protection of confidentiality as well as a confidentiality agreement signed by the programmer-analyst.

The Qualtrics survey programme allowed collected data to be exported into the Statistical Package for the Social Sciences (SPSS) version 19, which was used for statistical analysis in this study.

Statistical Analysis. It was decided to proceed with parametric tests for data analysis due to the advantages they have over non-parametric tests in increased sensitivity to significant differences and power to accurately detect significant outcomes (Pallant, 2011). The statistical procedures that were used to analyse the data are briefly outlined below.

Internal Reliability: Cronbach's Alpha

Cronbach's Alpha coefficients were calculated for the Compassion Satisfaction, Compassion Fatigue and Burnout subscales and for the Brief Resilience Scale to determine the internal consistency and reliability of the scales. The internal consistency reliabilities provide the researcher with an indication of the degree to which items that make up the scale are measuring the same attribute (Pallant, 2011).

Correlations:

Pearson's' Product Moment Correlation Coefficients were used to explore the relationships between significant variables. Correlations aim to describe the strength and direction of relation between two variables (Pallant, 2011).

Descriptive Statistics:

Descriptive statistics were used by calculating means, standard deviations, minimum and maximum scores, frequencies and percentages on significant variables. This analysis is useful in providing a description of the data collected.

Independent Samples T-test:

T-tests are used to compare the means between two different groups (Pallant, 2011). T-tests were conducted to investigate whether counsellors with high proportions of trauma clients on their caseloads scored higher on risk of secondary traumatic stress than counsellors with low proportions of trauma clients and to determine whether counsellors' prior trauma history had an impact on secondary traumatic stress scores.

Regression Analyses:

Hypotheses 4 and 5 examined the interrelationship between variables. In order to do this various regression analyses (simultaneous logistic regression, hierarchical multiple regression and moderation analysis) were used.

Results of these analyses are presented in the next chapter.

3. Results

This chapter describes the results of the study in relation to each of the five hypotheses. Data screening and correction methods are discussed first. Types of trauma counsellors reported working with are briefly presented. Each hypothesis is then considered separately, with test procedures and findings reported. Finally, a summary of results is provided.

Data Screening

Data screening and the correction of errors is essential for accurate data analysis (Pallant, 2011). The first method of data screening was the detection of invalid responses. One of the problems with open access internet surveys is the existence of computer programmes, such as Google, which trawl the internet searching for pages. This can result in invalid responding whereby questionnaires appear with entire sections unanswered or consent not selected. Screening detected 51 questionnaires with invalid responses, and these were excluded from the analysis reducing the sample size from 180 to 129. The descriptive statistics function of SPSS was used to screen for any data entry errors (Pallant, 2011). This function identifies values which exceed the minimum or maximum range for each variable. No data entry errors were identified. Missing data were then analysed and corrected and finally the normality of the data assessed. Further detail is provided.

Missing data. In order to reduce the probability of inaccurate analysis, missing data was analysed prior to performing further statistical procedures

(Tabachnick & Fidell, 2001). In human science research, it is rare that a complete data set will be found for every case; however what is important to determine is whether a pattern exists or whether data is missing at random (Pallant, 2011). Missing values may be omitted by participants either in error or by choice. Analysis found one participant omitted their ethnicity, four participants omitted their years of experience, and one participant omitted their personal trauma history. Twenty-three participants (17.8%) omitted one question each in the ProQOL and BRS sections. Further analysis found that 0.5% of the data for the ProQOL measure and 0.4% of the data for the BRS measure were missing. Tabachnick and Fiddell (2001) suggest that if less than 5% of the data are missing at random from a large data set, the effect is minimal and almost any procedure for dealing with missing data will yield similar results. Estimation maximisation was used to replace the missing data in this study due to its perceived reliability. Data missing from participants who omitted ethnicity, years of experience, and personal trauma history were not replaced since it could not be assumed that these values could be approximated by the remainder of the data set.

Normality of data. The normality of each of the major scales used in this study was assessed by observing the histograms and normality plots, by considering the magnitude of their skewness and kurtosis values, taking into account the Kolmogorov-Smirnov statistics and considering the 5% trimmed mean. The Compassion satisfaction and BRS distributions were negatively skewed with values of -.143 and -.677 respectively. This is to be expected as approximately 75% of the overall sample presented with moderate to high levels of compassion satisfaction and resilience. A negative kurtosis value of -.123 for

compassion satisfaction would indicate that the distribution was quite flat, however this was not evident in the histogram. A positive kurtosis value of .484 for the BRS indicates the distribution to be quite peaked. This was evident in the histogram. The Secondary trauma and Burnout distributions were positively skewed with values of .151 and .498 respectively. This is to be expected as approximately 75% of the overall sample presented with low to moderate levels of secondary traumatic stress and burnout. A negative kurtosis value of -.542 for the secondary trauma scale indicates that the distribution was quite flat. This was evident also in the histogram. A positive kurtosis value of .635 for the burnout scale indicates that the distribution was quite peaked. This was clearly evident in the histogram. Kolmogorov-Smirnov statistics for all four of the major scales were non-significant with values greater than 0.05, indicating that the distributions for all variables approximated normality.

Outliers. The SPSS outlier labelling procedure identified one outlier for the Compassion Satisfaction variable raw scores, with a low value of 28 given the range of scores being 28 to 50. The 5% trimmed mean statistic removes the top and bottom 5% of cases and calculates a new mean which is compared with the old mean to determine whether extreme scores have a strong influence on the true mean (Pallant, 2011). The difference between the true mean and the 5% trimmed mean was .08 indicating the presence of this outlier had minimal influence on the true mean. The value was therefore retained. No outliers were identified for the Secondary Trauma variable raw scores. Two outliers were identified for the Burnout variable raw scores with high values of 31 and 34 given the range of scores being 11 to 34. The difference between the true mean and the 5% trimmed mean was .09 indicating the presence of

these outliers had minimal influence on the true means. These values were also retained. Four outliers were identified for the BRS variable all with high values of 30 given the range of scores being 8 to 30. The difference between the true mean and the 5% trimmed mean was .12 indicating that the presence of these outliers had minimal influence on the true mean. These values were retained.

Table 2

Tests of Normality for the Major Scales

	Skewness	Kurtosis	Kolmogorov -Smirnov	Mean	5% Trim Mean
CS	-.143	-.123	.076	41.99	42.07
STS	.151	-.542	.077	20.22	20.13
BO	.498	.635	.105	19.84	19.75
BRS	-.677	.484	.167	21.75	21.87

Note: CS = Compassion Satisfaction; STS = Secondary Traumatic Stress; BO = Burnout; BRS = Brief Resilience Scale

Given that the scale distributions approximated normality, it was decided not to transform the data.

Correlation of Measures. The relationships between the primary measures were investigated using Pearson product-moment correlation coefficients. Cohen (1988) established a frequently used guideline for the magnitude of the relationship whereby a correlation coefficient (r) between .10 and .29 indicates a small correlation, between .30 and .49 a medium correlation and between .50 and 1.0 a large correlation. Using Cohen's guidelines, a large positive correlation was identified between the Secondary Trauma Scale and the Burnout Scale indicating that high scores on one measure are related to high scores on the other measure. Large negative correlations existed between the Secondary Trauma Scale and the Brief Resilience Scale and between the Burnout Scale and the Compassion Satisfaction Scale indicating that high scores on one measure are related to low scores on the other measure. Medium negative correlations existed between the Secondary Trauma Scale and the Compassion Satisfaction Scale and between the Burnout Scale and the Brief Resilience Scale indicating that high scores on one measure are moderately related to low scores on the other measure. A medium positive correlation existed between the Compassion Satisfaction Scale and the Brief Resilience Scale indicating that high scores on one measure are moderately related to high scores on the other measure. Some of these relationships are examined more closely during hypothesis testing procedures. Correlations are presented in Table 3.

Table 3

Pearson Product-Moment Correlation for Primary Measure Scales

Measure	1.	2.	3.	4.
1. Sec Trauma	-			
2. Burnout	.57**	-		
3. Comp Sat	-.34**	-.57**	-	
4. BRS	-.53**	-.44**	.30**	-

Note: $N = 129$. BRS = Brief Resilience Scale. ** $p < .01$ (2-tailed)

Types of Trauma. Counsellors were asked to select the types of trauma they had been working with over the past 30 days. Table 4 presents the types of trauma counsellors reported working with. Child Sexual Abuse, Domestic Violence, Death or Injury to a Loved One and Sexual Assault or Rape present the most commonly faced traumas by the counsellors in their therapy work. Counsellors were also given the option of selecting, “Other” and providing examples. Of the 20.1% of counsellors who selected this option the only additional traumas identified by more than one counsellor were abortion ($n=3$; 2.4%) and bullying ($n=3$; 2.4%).

Table 4

Types of trauma worked with over the past 30 days (N=129)

Trauma Type	<i>n</i>	%
Childhood Sexual Abuse	91	70.5
Domestic Violence	90	69.8
Death or Injury to a Loved One	76	58.9
Sexual Assault or Rape	66	51.2
Suicide of a Loved One	37	28.7
Violent Crime	29	22.5
Invasive Medical Procedures	29	22.5
Sexual Harassment	27	20.9
Natural Disasters	22	17.1
Accidents	20	15.5
Torture	12	9.3
Combat or Military Experiences	8	6.2
None	4	3.1
Other	27	20.1

Hypothesis Testing

Hypothesis one: High levels of compassion satisfaction, secondary traumatic stress and burnout would be present in ten to twenty-five percent of counsellors.

This study aimed to identify the prevalence of high risk of compassion satisfaction, secondary traumatic stress and burnout in a sample of New Zealand counsellors. A participant's scores were deemed to be high if they scored above the cut-point of 57 as proposed by the scale developer (Stamm, 2010). To test hypothesis one, a frequency analysis was conducted to determine what percentage of the sample scored within high levels.

Based on the results from the ProQOL (Stamm, 2010), the overall sample reported low to high potential for compassion satisfaction and low to high risk for secondary trauma and burnout. The ProQOL was used in its continuous form, however for the purposes of describing the data, the ProQOL was scored based on theoretical score cut points, set by the scale developer (Stamm, 2010). Stamm published average scores based on data from 1,289 helping professionals around the world. These scores are used as a comparison with the current sample.

The Potential for Compassion Satisfaction, Risk for Secondary Traumatic Stress and Risk for Burnout subscales range from 10 to 50. When converted to a *t*-score, the average is 50 (*SD* 10). About 25% of people score over 57 and about 25% of people score below 43. The cut points are as follows (Stamm, 2010):

- Low Potential/ Risk = 42 or lower
- Moderate Potential/ Risk = 43 to 57
- High Potential/ Risk = 58 and higher

Table 5 presents the proportion of counsellor's scoring in the high, moderate and low levels of the three subscales. Comparably, the current results approximate Stamm (2010) figures with close to 25% of counsellors scoring in the high and low levels of compassion satisfaction, secondary trauma and burnout and close to 50% falling in the moderate levels. Of note, are the higher proportion of counsellors' burnout scores falling in the high levels and the lower proportion of counsellors' burnout scores falling in the low levels compared to compassion satisfaction and secondary trauma.

Table 5

Counsellor's Scores for Potential for Compassion Satisfaction Scale, Risk for Secondary Trauma Scale and Risk of Burnout Scale (N=129)

	Compassion Satisfaction		Secondary Trauma		Burnout	
Level	n	%	n	%	n	%
High	28	21.7	28	21.7	32	24.8
Moderate	69	53.5	67	51.9	70	54.3
Low	32	24.8	34	26.4	27	20.9

Therefore, hypothesis one is confirmed in that 21.7% of the sample reported compassion satisfaction in high levels, 21.7% of the sample reported secondary traumatic stress in the high levels and 24.8% of the sample reported burnout in high levels.

Hypothesis two: Counsellors with increased exposure to traumatic material, as measured by higher proportion of trauma clients on caseloads, would score higher on risk of secondary traumatic stress.

The current study aimed to investigate whether counsellors with higher proportions of traumatised clients on their caseloads scored higher on scores of secondary traumatic stress than counsellors with lower proportions of trauma clients. Table 6 presents these proportions as reported by the counsellors in this study.

Table 6

Proportion of Trauma Clients on Caseload and Group Means on STS

	<i>n</i>	%	Mean STS
Less than 30%	31	24.0	48.70
Greater than 65%	35	27.1	54.03

Note: $p < .033$ (2-tailed); STS = Secondary Trauma Score.

In order to test the hypothesis an independent-samples *t*-test was conducted to compare the secondary traumatic stress scores for counsellors with higher proportions of trauma clients versus counsellors with lower proportions of trauma clients on their caseloads. A significant difference was found in scores for counsellors with greater than 65% of trauma clients on caseload ($M = 54.03$, $SD = 10.88$) and counsellors with less than 30% of trauma clients on caseload ($M = 48.70$, $SD = 8.66$; $t(64) = 2.18$, $p = .033$, two tailed). The magnitude of the differences in the means (mean difference = 5.33, 95% CI: .45 to 10.21) was moderate (eta squared = .07).

Hypothesis two was supported in that counsellors, with high proportions of trauma clients on their caseloads scored significantly higher on secondary traumatic stress than counsellors with low proportions of trauma clients on their caseloads.

Hypothesis three: Counsellors with a personal trauma history would score higher on risk of secondary traumatic stress than those without.

An independent-samples *t*-test was conducted to compare the secondary traumatic stress scores for counsellors with a personal trauma history and counsellors without a personal trauma history. There was no significant difference in scores for counsellors with a personal trauma history, ($M=20.48$, $SD = 4.219$) and counsellors without a personal trauma history, ($M=19.49$, $SD = 3.973$; $t(126) = 1.212$, $p = .228$, two-tailed). The magnitude of the differences in the means, (mean difference = .998, 95% CI -.632 to 2.628) was small, (eta squared = .012)

Hypothesis three was not supported as there was no significant difference in secondary traumatic stress scores for counsellors with and without a personal trauma history.

Hypothesis four: High Secondary Traumatic Stress levels would be predicted by high scores of burnout and low scores of compassion satisfaction, resilience and social support.

Logistic regression analysis. Logistic regression was performed to assess the impact of a number of factors on the likelihood that respondents would report high levels of secondary traumatic stress. The *enter* or *spontaneous* logistic regression method was used to 1) test Figley's (2002) and Stamm's (2010) models of compassion fatigue and secondary trauma, and 2) find the best fit of predictors to account for the variance in secondary traumatic stress. The *enter* method, relies on theory to determine decisions regarding the most relevant variables to enter as predictors (independent variables) and these variables are entered simultaneously. The dependant variable (secondary traumatic stress) was categorised as low versus high.

The model contained four independent variables (burnout, compassion satisfaction, resilience, and social support) which were selected due to their theoretical grounding, and/ or to the strength and direction of their correlations with the dependent variable (refer Table 7).

Table 7.

Pearson Correlation Coefficients between Secondary Traumatic Stress and Variables in Logistic Regression

Measure	Secondary Traumatic Stress
Burnout	.57**
Comp Sat	-.34**
BRS	-.53**
Supports	.20*

Note: BRS = Brief Resilience Scale; * $p < .05$ (2-tailed); ** $p < .01$ (2-tailed).

The full model containing all predictors was statistically significant, χ^2 (4, $N = 62$) = 56.45, $p < .0005$, indicating that the model was able to distinguish between respondents who reported and did not report high levels of secondary traumatic stress. The model as a whole explained between 59.8% (Cox and Snell R square) and 79.9% (Nagelkerke R squared) of the variance in secondary traumatic stress status, and correctly classified 90.3% of cases. As shown in Table 8, only two of the independent variables made a unique statistically significant contribution to the model (burnout and resilience). The strongest significant predictor of reporting high secondary traumatic stress was burnout which recorded an odds ratio of 2.0 indicating that respondents with high levels of burnout were twice as likely, to report high secondary traumatic

stress than those with lower levels of burnout controlling for other factors in the model.

Table 8.

Logistic Regression Predicting Likelihood of Reporting High Secondary Traumatic Stress

	B	S.E	Wald	df	p	Odds Ratio	95% C.I for Odds Ratio	
							Lower	Upper
Burnout	.69	.30	5.3	1	.021*	2.0	1.11	3.6
Compassion	-.20	.15	1.8	1	.178	.82	.61	1.1
Satisfaction								
Resilience	-.47	.18	6.9	1	.009**	.63	.44	.89
Supports	.22	.47	.21	1	.648	1.24	.49	3.14
Constant	4.46	10.56	.18	1	.673	86.71		

Note: * $p < .05$ (2-tailed); ** $p < .01$ (2-tailed).

Resilience recorded an odds ratio of .63 indicating that respondents with low resilience were .63 times more likely to report high secondary traumatic stress than those with higher scores of resilience controlling for other factors in the model.

Hypothesis four was partially supported in that high levels of burnout and low levels of resilience predicted high scores of secondary traumatic stress. However, low scores of compassion satisfaction and social support did not predict high scores of secondary traumatic stress.

Hypothesis five: Compassion satisfaction would moderate the relationship between burnout and secondary traumatic stress.

A moderator is a variable that changes the direction and/or strength of the relationship between a predictor variable and a dependant variable (Baron & Kenny, 1986). It was hypothesised that higher levels of compassion satisfaction would reduce the strength of the relationship between burnout (the independent variable) and secondary traumatic stress (STS) (the dependant variable) where the same level of burnout would be associated with decreasing STS symptoms as the level of compassion satisfaction increased. To test this hypothesis moderation analysis was used. The compassion satisfaction total was used as the moderating variable since it had a strong relationship with burnout as evidenced by correlations previously described in Table 3. The assumptions of normality, linearity and homoscedasticity were met (Tabachnick & Fidell, 2001). Moderation Analysis was performed following the process described by Aiken and West (1991). The independent variable and moderation variable were centralised by subtracting each variable's mean from the observed scores. An interaction term was then generated by multiplying the centralised variables together. Finally, hierarchical multiple regression was used to test the interaction effect between the predictor and potentially moderating variable.

The centralised variable for the main effect of burnout was entered at Step 1, the centralised variable for the main effect of compassion satisfaction was entered at Step 2, and the interaction term was entered at Step 3. Results of the analysis revealed that the interaction term did not explain any significant increase in the variance of secondary traumatic stress, R^2 change = .004, F change (1, 125) = .76, p = .39. Compassion satisfaction did not moderate the relationship between burnout and secondary traumatic stress. The hypothesis was therefore not supported.

Summary of Results.

Hypothesis one was confirmed in that 21-25% of the sample reported high scores of compassion satisfaction, secondary traumatic stress and burnout. Hypothesis two was confirmed in that counsellors, with more than 65% of trauma clients on their caseloads scored significantly higher on secondary traumatic stress than counsellors with less than 30% of trauma clients on their caseloads. Hypothesis three was not supported as there was no significant difference in secondary traumatic stress scores for counsellors with and without a personal trauma history. Hypothesis four was partially supported in that high levels of burnout and low levels of resilience predicted high scores of secondary traumatic stress. However, low scores of compassion satisfaction and social support did not significantly predict, high scores of secondary traumatic stress. Hypothesis five was not supported as compassion satisfaction did not moderate the relationship between burnout and secondary traumatic stress.

The results presented in this chapter have provided clear evidence for each of the hypotheses. Interpretations of these results are discussed in the following chapter.

4. Discussion

The findings of this study suggest that working with the trauma of clients has had a significant negative impact on a proportion of the counsellors in this sample. This is suggested by the fact that just over one fifth of counsellors scored at high risk of secondary traumatic stress and close to a quarter of counsellors scored at high risk of burnout. The absence of high risk of secondary traumatic stress in the majority of the sample may suggest the presence of protective factors such as resilience and compassion satisfaction. Support is provided for the role of exposure to trauma in secondary traumatic stress in that increased exposure to trauma (as measured by proportion of trauma clients on caseload) resulted in higher risk of secondary traumatic stress. Findings in regards to personal trauma history and secondary traumatic stress are discussed. Possible predictors of secondary traumatic stress are presented and the relationships between the constructs explored. This chapter elaborates on these key findings. Each hypothesis will be discussed separately, in order, and the results will be compared to existing literature. Practical implications of this research will be suggested and will be followed by a discussion of the study limitations. Finally future directions for research will be proposed.

Hypothesis one: High levels of compassion satisfaction, secondary traumatic stress and burnout would be present in ten to twenty-five percent of counsellors. Establishing the prevalence of compassion satisfaction, secondary traumatic stress and burnout was a key objective of this study. It was deemed important because no research to date has investigated

these issues specifically in a New Zealand sample of counsellors who work with clients who have experienced trauma. Establishing the prevalence of secondary traumatic stress and burnout indicates to a degree how counsellors are coping with their somewhat unique role as counsellors and furthermore highlights the need for resources to not only address this impact but to prepare counsellors in training for the reality of their work and to highlight to employers and supervisors of counsellors important issues involved in supporting their counsellors.

Establishing the prevalence of compassion satisfaction provides a somewhat balancing effect indicating not only the degree to which counsellors are gaining satisfaction from their work but the potential protective role this satisfaction has against the deleterious effects of their work. A range of ten to twenty-five percent was chosen as a testing criterion for this hypothesis in part because of the cut-points established by Stamm (2010) in the Professional Quality of Life Manual, (Stamm proposed that 25% of people score in the low levels, 50% in the moderate levels and 25% in the high levels of compassion satisfaction, secondary traumatic stress and burnout) and in part due to prevalence rates reported in the literature. A review of the literature identified high risk of secondary traumatic stress falling within the range of 6-26% in counsellors exposed to trauma through working with trauma clients, high risk of burnout falling within the range of 5% to 14% and high potential for compassion satisfaction within the range of 17% to 47% (Craig et al. 2010; Eastwood et al. 2008; Jacobson, 2006; Ortlepp et al. 2002). However these studies commenced prior to the publication of the Concise Professional Quality of Life Manual (Stamm, 2010) in which Stamm introduced standardised t-scores in an

effort to make reported prevalence rates more comparable both between studies and within longitudinal studies over time. It was therefore expected that the prevalence rates in the current study would more closely approximate the expected Stamm (2010) rates than previously reported prevalence rates. This outcome was realised with between 20-25% of counsellors scoring at high risk of secondary traumatic stress and burnout and high potential for compassion satisfaction. The prevalence of high risk for burnout and secondary traumatic stress in the current study appears considerably higher than that previously reported (Craig, et al. 2010; Jacobson, 2006; Ortlepp et al. 2002) with the exception of Eastwood, et al. (2008) who reported 26.3% of their sample scored high risk of compassion fatigue. While this difference may be accounted for to some degree by the use of the standardised t-scoring system (Stamm, 2010) in the current study, Stamm noted that it is also important to realise that the ProQOL is not a diagnostic tool, but a screening tool and that the use of cut-points is subject to Type 1 error (there is a greater possibility of including someone who should not be included than excluding someone who should be included). However, cut-points were also used in earlier versions of this test.

Another possible explanation for the higher rates of secondary traumatic stress and burnout in the current study could be due to the differential nature of the counsellors' exposure. For example, as opposed to the current study, Ortlepp et al. (2002) reported only 10% of counsellors scoring high risk of secondary traumatic stress and 7% of counsellors scoring high risk of burnout; results that are contrastingly different to the current study. However, Ortlepp et al. (2002) acknowledged the limited and periodic exposure of their counsellors to trauma whereas in the current study childhood sexual abuse, domestic

violence, death or injury to a loved one, and sexual assault and rape were reported as traumas recently worked with by between 51.2% and 70.5% of the counsellors. These specific traumas assume an ongoing counselling relationship as opposed to brief interventions.

It may be that compared to counsellors in these other studies, the New Zealand counsellors have a more cumulative and higher rate of exposure to trauma resulting in a greater traumatic response. This is supported by the high proportions of trauma clients on counsellors' caseloads in the current study and by New Zealand's high prevalence of traumas such as child abuse. Fanslow, Robinson, Crengle and Perese (2007) found in a sample of 2855 New Zealand women overall prevalence rates of child sexual abuse to be 23.5% in urban women and 28.2% in rural women. Pereda, Guilera, Forns and Gomez-Benito, (2009) identified the prevalence rate for Oceania (of which continent New Zealand is a part) at 23.9% - second highest only to Africa which recorded a prevalence of 34%. In contrast, the continents of America, Asia and Europe recorded prevalence rates of 15.8%, 10.1% and 9.2% respectively supporting the claim that New Zealand has higher rates of child sex abuse and that consequently, New Zealand counsellors are more likely to have higher exposure to trauma such as from working with clients who are dealing with child sex abuse than counsellors in countries where prevalence rates are lower. Prevalence of violence against women in New Zealand however is more comparable with overseas data and provides less support for this claim (Fanslow & Robinson, 2004; Thompson, Bonomi, Anderson, Reid, Dimer, Carrell & Rivara, 2006; Tjaden & Thoennes, 2000; Xu, Zhu, O'Campo, Koenig, Mock & Campbell, 2005; Ellsberg, Jansen, Heise, Watts & Garcia-Moreno,

2008; Krug, Mercy, Dahlberg & Zwi, 2002; Watts & Zimmerman, 2002).

Additional comparisons in prevalence rates between New Zealand and overseas countries for other traumas such as sexual assault, rape and suicide would be worth exploration. Figley's, (2002) etiological model of compassion fatigue demonstrates that exposure to a client's trauma contributes to the development of compassion fatigue and secondary traumatic stress in counsellors. This study may have been the first of its' kind to suggest that New Zealand counsellors have higher exposure to secondary trauma than that reported in the literature. More studies are recommended to establish whether similar results are found.

Sampling method may also offer some explanation for the higher rates of secondary traumatic stress and burnout encountered in this study. It could be that self-selection may have resulted in more counsellors who identify with the experience of secondary traumatic stress choosing to participate, and in counsellors who did not perceive secondary traumatic stress to be an issue in their own practice choosing not to respond. Non-responders may also have introduced variation to the results in additional ways that I cannot infer.

Hypothesis two: Counsellors with increased exposure to traumatic material, as measured by higher proportion of trauma clients on caseloads, would score higher on risk of secondary traumatic stress.

Investigating the impact of proportion of trauma clients on a counsellor's caseload was an important part of this study. While increased workload has been linked to burnout, (Deighton, et al. 2007), increased proportions of trauma

clients on caseload increases the exposure the counsellor has to trauma and could therefore increase the likelihood of secondary traumatic stress. Exposure to client suffering and prolonged exposure are both contributory variables in Figley's (2002) etiological model of compassion fatigue. It was therefore hypothesised that counsellors with high proportions of trauma clients on their caseloads would score higher on risk of secondary traumatic stress than counsellors with low proportions. In the current study, close to a quarter of counsellors reported caseloads with less than 30% trauma clients and close to a quarter reported caseloads with greater than 65% trauma clients. As hypothesised and as predicted by Figley's (2002) etiological model, counsellors with high proportions of trauma clients compared to counsellors with low proportions scored significantly higher on risk of secondary traumatic stress. The effect size indicated a moderate association (Tabachnick, et al. 2001), between the proportion of trauma clients on caseload and high risk of secondary traumatic stress and the probability indicated reliability between these variables. This suggests that in the current study increased exposure to clients' trauma was moderately related to the likelihood of scoring at high risk of secondary traumatic stress and lends some support to the role of exposure in Figley's (2002) model. This would however be better assessed through regression analyses that are more suited to assessing predictability than correlational studies which cannot determine causality Cohen (1988). This did not occur in the current study due to issues with group sizes. Further research with much larger sample sizes is necessary in order to validate the inclusion of exposure as a predictor variable of secondary traumatic stress. While not the aim of the current study, it would also be of interest to investigate Figley's

(2002) second exposure variable; prolonged exposure. The current study provided some insight into the exposure of counsellors to their clients' trauma over the past 30 days. Further research which considers counsellors' prolonged exposure to client trauma and which assesses counsellors' use of regular breaks and holidays would be beneficial in both providing support for prolonged exposure as a variable in Figley's (2002) etiological model and in validating the importance of disengagement as a variable in his model which protects against the development of compassion fatigue and secondary traumatic stress.

Hypothesis three: Counsellors with a personal trauma history would score higher on risk of secondary traumatic stress than those without.

Personal trauma history was of interest in this current study as despite its' inclusion as a variable in Figley's (2002) etiological model of compassion fatigue, the research regarding it has been mixed. The current study found no support for the hypothesis that counsellors with a personal trauma history would score higher on risk of secondary traumatic stress than those without a personal trauma history. Several explanations may account for this insignificant result.

Firstly, it is noted that a high percentage of counsellors in the current study reported a personal trauma history (refer Table 1). It may be that the definition of personal trauma history in the current study was too broad and subjective resulting in potentially confounding results. Counsellors were asked to select the types of trauma they had been working with and then to indicate whether they had ever experienced any of those traumas. This allowed more

commonly experienced events such as accidents, death of a loved one and natural disasters to be included in the category of personal trauma history without determining whether the event was experienced by the counsellor as traumatic and without determining the magnitude of the event. For example, the death of an elderly grandparent while sad may be experienced as less traumatic than the death of a child. Natural disasters also vary in magnitude and whether they are experienced as traumatic. The current results in regards to the effects of personal trauma history on risk of secondary traumatic stress may have been quite different if more stringent criteria were applied to the definition of trauma. For example, a question more in accordance with the criteria of the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; *DSM-V*; American Psychological Association [APA], 2013) for PTSD such as “Have you ever been exposed to actual or threatened death, a serious injury or sexual violation/assault which has resulted in symptoms for more than one months’ duration?” may have limited the number of counsellors reporting a personal trauma history and resulted in more reliable results. Alternatively, it may have been more useful to limit personal trauma history to specific traumas, such as the most reported traumas worked with by counsellors in the current study (child sexual abuse, domestic violence, death or injury to a loved one and sexual assault or rape). The benefit of this is that it would allow further exploration of the role of traumatic memories in Figley’s (2002) etiological model in which Figley proposed that memories from the current client’s experience can connect with the counsellor’s similar traumatic experiences and trigger a reaction.

An alternative explanation for the insignificant result concerning personal trauma history relates to the issue of whether counsellors' had worked through their personal trauma histories or not. The current study (as with previous studies) asked only whether counsellors had experienced previous traumas and not whether they had worked through and resolved them. Collins and Long, (2003b) stated that personal trauma history once worked through can provide counsellors with positive coping strategies. My research may have yielded different results if I had asked this question and compared groups who had worked through their trauma with those who had not. Counsellors who had worked through personal trauma histories may have significantly different secondary traumatic stress scores than both counsellors who had not worked through their traumas and counsellors who did not have personal trauma histories. Linley and Joseph (2007) suggested that personal trauma history had the potential to facilitate personal growth. It could be that counsellors who have worked through their trauma histories not only have lower scores of secondary traumatic stress but higher scores of compassion satisfaction and resilience. Further research exploring the relationship between resolved personal trauma histories and constructs such as secondary traumatic stress, burnout, compassion satisfaction and resilience is warranted.

Hypothesis four: High Secondary Traumatic Stress levels would be predicted by high scores of burnout and low scores of compassion satisfaction, resilience and social support.

Burnout

An important consideration was to ensure that the measures for burnout and secondary traumatic stress did not measure the same constructs as can sometimes be the case when correlations are too large. The large correlation between burnout and secondary traumatic stress in the current study did not present as a concern in regards to the construct validity of either subscale. Internal consistency for the measures as reported by Cronbach's alpha coefficients were satisfactory providing an indication that the items that made up the scales measured the same construct (Pallant, 2011). Stamm (2010) stated that while there is a 34% shared variance between burnout and secondary traumatic stress, the subscales measure different constructs and this shared variance likely explains the distress common to both. Also common to both subscales is negative affect; however, this differs across measures. Unlike the secondary traumatic stress subscale, the burnout subscale addressed exhaustion and unlike the burnout subscale, the secondary traumatic stress subscale addressed fear. The wording of the individual items of both measures was assessed and appears to support Stamm's (2010) claim that different constructs are represented. The only item that raised some ambiguity was item 8 (refer Stamm, 2010); "I am not as productive at work because I am losing sleep over traumatic experiences of a person I help." While this item purports to measure burnout (and reference to reduced productivity supports this), reference to losing sleep and to the traumatic experience of a client is

suggestive of secondary traumatic stress. This exception may have accounted for the slightly lower internal consistency score for burnout as compared to secondary traumatic stress. Despite this exception, other items appeared to be more clearly related to either burnout or secondary trauma, and the researcher was satisfied that the subscales measured what they purposed to measure.

The finding that burnout was the greatest predictor of high risk of secondary traumatic stress in the current study has theoretical and practical importance. Salston and Figley (2003, p. 167) stated that burnout and compassion fatigue “are or nearly are synonymous” with secondary traumatic stress. Yet, the current study supports burnout being a separate construct to secondary traumatic stress and provides support for the inclusion of burnout as a predictor variable in Figley’s (2002) etiological model of compassion fatigue. While Figley’s (2002) model appears to be linear (one phenomenon causes the other leading to compassion fatigue), Stamm (2010) suggested a more reciprocal model with burnout and secondary traumatic stress co-occurring and together resulting in compassion fatigue. The current findings support a linear model, such as Figley’s (2002) model but with burnout a precursor to secondary traumatic stress. It is proposed that counsellors who are burnt out (overworked, tired and exhausted) have less energy to manage compassion stress and consequently are more vulnerable to secondary traumatic stress. As a result of secondary traumatic stress reactions they may then find themselves in a state of compassion fatigue. These are findings supported by Udipi, et al. (2008) who likewise found burnout to be the strongest predictor of compassion fatigue in their study of compassion fatigue in genetic counsellors and by Eastwood, et al. (2008) who found burnout risk level to be the greatest predictor of compassion

fatigue in counsellors who worked at a residential childcare centre. Of note, Udipi et al. (2008) and Eastwood et al. (2008) used earlier versions of the ProQOL (Version 3 and 4, Stamm, 2002; Stamm, 2005) which included a compassion fatigue subscale as opposed to the current study which used version 5 (Stamm, 2010) which replaced the compassion fatigue subscale with a secondary traumatic stress subscale. Despite the differences in names between the subscales, a comparison of the versions yielded minimal changes to the wording of the items and it can be concluded that the items measuring compassion fatigue (Stamm, 2002; Stamm, 2005) as utilised by Udipi et al. (2008) and Eastwood et al. (2008) are nearly identical to the items measuring secondary traumatic stress (Stamm, 2010) in the current study. Therefore, their results in regards to compassion fatigue are comparable with the current study's results concerning secondary traumatic stress. The findings of the current study suggest Figley's (2002) etiological model of compassion fatigue could be improved upon with the inclusion of burnout as a variable. It does not support Stamm's model of compassion fatigue in which burnout and secondary traumatic stress present as two co-occurring elements which contribute to compassion fatigue.

The practical importance of these results, highlight the importance of protecting counsellors against burnout. Burnout is described as a process (Udipi et al. 2008) and therefore early recognition of its development is crucial in terms of both addressing it and reducing the likelihood of predicting secondary traumatic stress reactions. The current study suggests counsellors with high levels of burnout are twice as likely to experience high levels of secondary traumatic stress. If the factors that contribute towards burnout, (for example:

workload; Deighton et al. 2007) are addressed early it would seem logical that the likelihood of high risk of secondary traumatic stress is also reduced. This has important implications for counsellors in terms of self-care as well as for the supervisors and employers of counsellors.

Compassion Satisfaction

The findings in regards to compassion satisfaction in the current study were unexpected. It was expected that low scores of compassion satisfaction would predict high scores of secondary traumatic stress; an expectation supported by the moderate negative correlation between compassion satisfaction and secondary traumatic stress and by the inclusion of compassion satisfaction in Figley's (2002) etiological model of compassion fatigue. This finding replicates that of Udipi et al. (2008) where compassion satisfaction did not significantly predict compassion fatigue in genetic counsellors. One possible explanation for this current result is that compassion satisfaction has its effect on secondary traumatic stress through a third variable. Although, the regression model accounted for a substantial proportion of the variance in secondary traumatic stress, approximately 30% of the variance was not explained suggesting the involvement of other variables. Risk of secondary traumatic stress is related to a combination of predictor variables and compassion satisfaction may moderate or mediate one or more of these variables. These results highlight the need for further investigation concerning the relationship between compassion satisfaction and secondary traumatic stress. Hypothesis five considers the potentially moderating role of compassion satisfaction between burnout and secondary traumatic stress.

Resilience

Resilience is a construct that has received relatively little attention in regards to research concerning secondary traumatic stress and compassion fatigue. Therefore, an important objective of this current study was to identify whether low resilience in counsellors predicted high scores of secondary traumatic stress. A large significant negative correlation between resilience and secondary traumatic stress suggested a relatively strong association between the variables, a finding that was strengthened through logistic regression analysis. Low resilience was a significant predictor of high risk of secondary traumatic stress, a finding that has theoretical and practical implications. The scale used in this current study (Brief Resilience Scale, BRS; Smith et al. 2008) was initially tested on undergraduate students and persons with health complications. In the current study, good reliability and internal consistency was indicated suggesting that the items on the scale measured the same construct. Analysis of the individual items of the BRS (Smith et al. 2008), revealed that all items related to each other and pertained to stress in general as opposed to health related stressors. The researcher was therefore satisfied that this scale would be an appropriate measure of counsellors' resilience to the stress they encountered in their roles as counsellors.

In the current study, low resilience was a significant predictor of secondary traumatic stress. This suggests that resilience may have a place as a variable in models of secondary traumatic stress and compassion fatigue. In the current study, counsellors with low levels of resilience were more likely to report high risk of secondary traumatic stress than counsellors with high levels of resilience. Figley's (2002) etiological model of compassion fatigue contains

variables which contribute towards and protect against the development of compassion fatigue. The inclusion of resilience in this model might be an additional factor which explains (along with compassion satisfaction and disengagement) how counsellors are able to cope with compassion stress thereby preventing the build up towards secondary traumatic stress and compassion fatigue.

These results also have practical implications for counsellors. Research supports the claim that resilience is not a stable trait but can be amended and enhanced through healthy decision making, support and intervention (Grafton et al. 2010; Meyer et al. 2006; Smith et al. 2010). If low levels of resilience predict high risk of secondary traumatic stress in counsellors then it seems logical that targeting resilience in counsellors is of utmost importance. Further benefits would be gained from research which identifies factors related to resilience in counsellors and investigates how resilience can be enhanced in counsellors where resilience is low.

Social Support

The inclusion of social support in the current study was deemed important as there is a considerable lack of research relating social support to secondary traumatic stress. While it has not been included as a variable in models of compassion fatigue, Figley (2002) acknowledged that social support is a potential protective factor against the development of compassion fatigue. The current research did not support the hypothesis that low levels of social support would predict high risk of secondary traumatic stress. Possible explanations for this are considered.

One of the limitations of the current study is its failure to use a validated social support scale and its reliance instead on a measure that calculated total number of social supports. Given this measure's lack of validation, it could be that this measure simply does not effectively measure social support in counsellors who work with trauma clients. Counsellors were asked to select from a list, supports they had used in the past 30 days and then total number of supports were calculated to give an indication of the quantity of support counsellors had. It may be that for some counsellors, there were additional important supports that were not listed and therefore unable to be selected. This may have affected results. In addition, Fenlason et al. (1994) raised the concern that there is also potential for support to reinforce stress, for example in situations where a support person leads the stressed individual to believe their situation to be worse than thought. In the current study, the correlation between social support and secondary traumatic stress was significant, small and positive (not in the direction expected) suggesting that high levels of social support were related to high risk of secondary traumatic stress. While this may be explained by Fenlason's et al. (1994) claim that support can potentially reinforce stress, it is important to note that the size of the correlation between social support and secondary traumatic stress in the current study was quite small indicating only a small association. While the use of a validated support scale may have produced different results, there appears to be a lack of existing measures which address social support in persons whose exposure to trauma is both secondary and cumulative. The Crisis Support Scale (Elklit, Pederson, & Jind, 2001) for example, possesses good psychometric properties but is

designed to measure social support after a crisis and does not address social support in persons with cumulative secondary trauma exposure.

It is clear that further research is required concerning the relationship between social support and secondary traumatic stress. While, social support did not predict secondary traumatic stress in the current study, possible explanations for this have been discussed. Alternatively, it may be that social support has its influence on secondary traumatic stress through relationships with other variables. Elklit et al. (2001) has suggested that social support possibly mediates distress and may even be a predictor of wellbeing in persons exposed to trauma. Whereas, Pietrzak et al. (2009) suggested that social support may work together with resilience to reduce the risk of developing trauma-related psychopathology. In addition, Killian (2008) found social support to be the most significant factor associated with higher scores of compassion satisfaction. Further exploration between social support and other variables related to secondary traumatic stress is needed as the interrelationships may be more complex.

Hypothesis five: Compassion satisfaction would moderate the relationship between burnout and secondary traumatic stress.

Contrary to hypothesis five, compassion satisfaction did not moderate the relationship between burnout and secondary traumatic stress. This means that the effect of burnout on secondary traumatic stress remained constant irrespective of changes in levels of compassion satisfaction and that high compassion satisfaction did not act as a buffer between burnout and secondary

traumatic stress. Previous research has suggested the potentially moderating effect of compassion satisfaction between burnout and secondary traumatic stress (Eastwood et al. 2008) yet no known studies to date have tested this proposed relationship. While the current study did not find support for the hypothesis, the results of one study are by no means conclusive and further research is necessary. The high negative correlation between compassion satisfaction and burnout in the current study is worthy of further investigation. It may be that further regression analyses support compassion satisfaction as a significant predictor of burnout only and not of secondary traumatic stress. Compassion satisfaction may have its influence on risk of secondary traumatic stress through other unknown variables or it may be that another construct with similarities in content to compassion satisfaction is more suited as a predictor of secondary traumatic stress or as a moderator between burnout and secondary traumatic stress. Research by Cohn, Brown, Conway, Fredrickson and Mikels (2009) found that positive emotions but not life satisfaction predicted positive outcomes in a group of university students and that resilience mediated the relationship between positive emotions and life satisfaction. It could be that compassion satisfaction and positive emotionality are related through the shared content of positive affect. Positive emotionality as opposed to compassion satisfaction may have yielded different results in the current study. While the study by Cohn et al. (2009) used university students as opposed to counsellors and did not investigate secondary traumatic stress, it does suggest that the relationship between compassion satisfaction, resilience and outcomes in the current study may be more complex. The medium positive correlation between compassion satisfaction and resilience in the current study suggests

there may be benefits from further investigation of the relationship between these variables in relation to burnout and secondary traumatic stress.

The results of the current study do not provide support for the inclusion of compassion satisfaction in Figley's (2002) etiological model of compassion fatigue nor do they support the potentially moderating effect of compassion satisfaction between burnout and secondary traumatic stress. However, the significant correlations between compassion satisfaction and burnout, secondary traumatic stress and resilience in the current study do indicate important associations between these variables and highlight the importance of further investigation to determine the nature of these relationships. While current results are inconclusive, high levels of compassion satisfaction in the current study are a positive finding as they indicate that the counsellors are experiencing satisfaction in their work.

Practical implications

One of the objectives of this study was to raise awareness around issues of secondary traumatic stress and burnout among counsellors in New Zealand. This study made a practical contribution by making contact with counsellors, through their respective associations and organisations, providing counsellors with an information sheet about potential negative effects of work with trauma clients and inviting counsellors to participate in this study. The information sheet in addition, encouraged counsellors to seek support from professional supervisors or colleagues if the study raised any issues for them. After completing the survey, several counsellors made contact with the researcher

and self-scoring sheets were emailed to them to assist them in scoring their individual risk levels of secondary traumatic stress and burnout and potentials for compassion satisfaction.

Attempts were made to ensure that this sample approximated the population of New Zealand counsellors. Therefore, close to 25% of New Zealand counsellors could be at high risk of burnout and close to 20% at high risk of secondary traumatic stress at a given time. It is recommended that the use of a screening procedure, (such as the ProQOL, Stamm 2010) be implemented regularly by counsellors in New Zealand in order to both raise awareness of issues related to working with trauma and to detect any increase in risk in individual counsellors. Such a screening procedure could be made available by counselling associations and organisations to their members or could be used within professional supervision sessions. Counsellors scoring at high risk of burnout or secondary traumatic stress can then be identified and supported as they work through these issues. Practical Implications of this study's findings are now discussed.

First, this study suggests that New Zealand counsellors compared to counsellors overseas may have a greater exposure to secondary trauma as indicated by the high prevalence rate of high risk of secondary traumatic stress and high proportions of trauma clients on caseloads. Counsellors may benefit from being provided with information around secondary traumatic stress. In addition, counsellors will benefit from exercising discretion when choosing whether to accept additional trauma clients. Consideration should be given to

the existing proportion of trauma clients on their caseload and to the counsellors' current wellbeing and levels of stress. Employers also need to take into consideration these issues before allocating additional trauma clients to counsellors. Disengagement was one of the coping methods described in Figley's (2002) etiological model of compassion fatigue. The importance of counsellors being able to 'dis-engage' from their client's traumatic material is crucial in protecting against the development of secondary traumatic stress. One way in which counsellors can dis-engage, is through the use of regular breaks and holidays. Counsellors can take some responsibility for ensuring this and employers can assist by ensuring that they have leave plans in place for their counsellors and have adequate staffing levels to cover breaks.

Second, while there was no difference in risk of secondary traumatic stress between counsellors with a personal trauma history and those without, the current study did identify that a high proportion of counsellors in the sample had experienced personal trauma. The research relating to personal trauma history and secondary traumatic stress is inconclusive; however recent research suggests the importance of counsellors working through their personal trauma histories (Collins et al. 2003b; Linley et al. 2007). It is recommended that counsellors with personal trauma histories take time to work through these. Personal counselling may be an appropriate option for some counsellors or alternatively, it may be something they can explore in professional supervision sessions.

Third, the relationship between burnout and secondary traumatic stress highlights the importance of protecting counsellors against burnout. Figley (2002) proposed that burnout may require a career change whereas

compassion fatigue or secondary traumatic stress once identified can be treated. It is therefore recommended that employers and professional supervisors regularly screen their counsellors in order to identify risk of burnout and prevent escalation of this risk. Counsellors with high risk of burnout are also at higher risk of secondary traumatic stress, a combination which is not healthy for counsellor or client. In addition, this may indicate that the counsellor is considering resignation or a career change. Identifying and addressing moderate risk of burnout before it escalates to high risk may also assist employers in their retention of counsellors.

Fourth, the relationship between resilience and secondary traumatic stress highlights the need to identify counsellors with low resilience and for interventions and trainings that enhance resilience to be implemented for these counsellors. It is recommended that resilience as a topic be introduced and taught to counsellors in training and that counsellors be encouraged to engage in activities that enhance their own resilience. Supervision and training that addresses issues of secondary traumatic stress and post-traumatic growth in order to improve performance and coping is essential (Lev-Wiesel, Goldblatt, Eisikovits & Admi, 2009).

Study limitations

Several limitations of the current study may affect the generalisability of the findings. These include the cross-sectional design, several forms of bias and the use of a self-report survey.

A cross-sectional design was used for this study where data for each participant was collected at a single point in time and comparisons were made

between subjects. Such designs limit the conclusions that can be made about causality, the direction of relationships between variables and changes over time. In addition, cross-sectional designs are prone to problems of non-equivalent groups (Goodwin, 2007). While, attempts were made to avoid this in the current study, additional comparisons may have been possible between groups had this not been a consideration. Longitudinal studies have advantages and the use of such a design in the current study would have allowed changes in one group to be studied over different periods of time. This may have provided additional information in regards to the trajectories of secondary traumatic stress and burnout and the influence of resilience and compassion satisfaction over time. Longitudinal studies which address secondary traumatic stress in counsellors are recommended.

Two forms of bias were likely in this study, sampling bias and response bias. Although effort was made to ensure that the sample would be representative of the population of counsellors in New Zealand, non-probability sampling was used and is susceptible to sampling bias (Goodwin, 2007). One way in which sampling bias may have been introduced was through this study's exclusive use of an internet survey. While, it was assumed that all counsellors would have access to the internet there may have been a small proportion of counsellors without such access resulting in a biased sample. The online completion of the survey had the advantages of cost efficiency and convenience for participants. However, it relied on participants' motivation and less motivated persons may not have participated therefore introducing potential bias to the sample. Sampling bias may also have been introduced through the problem of self-selection. The current study relied on participants choosing to

participate. Consequently, some counsellors may have selected to participate because the topic either appealed to them or they identified with the experience of secondary traumatic stress. Other counsellors may have chosen not to participate because the topic either did not appeal to them or they did not find it relevant to their own experience. Either way there was the potential that bias may have been introduced. In addition, response bias may have occurred in this study although the use of an internet survey reduced this likelihood due to anonymity between participants and researcher. Response bias can take a variety of forms; for example participants may respond in the way in which they feel is socially desirable (or not desired), they may respond with acquiescence (the tendency to agree with the question) or they may respond in ways which conceal their true response (Furnham, 1986). An example in the current study may be a counsellor who feels that as a professional it would be a weakness to admit to taking work-related issues home and therefore responds that they never find it difficult to separate their personal life from their professional life. The measures used in this study are less vulnerable to acquiescence bias as they include reversed items and participants would be aware that not all items are measured in the same direction. Additionally, the use of the Likert scales for the primary measures balanced favourable and unfavourable statements and forced participants to make item by item decisions (Goodwin, 2007) thereby reducing response bias.

Self-report surveys were the only form of data collection used in this study and are susceptible to the forms of bias previously discussed. In addition, self-report surveys have been criticised in that the questions asked often direct the answers provided (Schwarz, 1999). There are issues with both closed and

open questions in self-report surveys and the current study tried to reduce these issues through use of partially open questions (the inclusion of the option “other” where participants can choose to write their preferred answer). With closed questions, participants are asked to select from a list of possible answers. This list eliminates the possibility that participants will respond with answers that are not available and therefore may result in potentially relevant information not being provided to the researcher. This may have occurred in the current study, for example, the question in regards to personal trauma history did not allow participants to provide additional information regarding the magnitude of their trauma or whether they had worked through it. This was less of an issue for the primary measures as frequency and rating scales were used. While these scales are susceptible to problems too, the current study used version five of the ProQOL (Stamm, 2010) which improved upon earlier versions by addressing such issues. Alexander and Klein, (2009) also highlighted that reliance on self-report measures tends to generate higher prevalence rates of post-trauma conditions than clinical interviews do. While this may have occurred in the current study, Stamm (2010) cautioned that the ProQOL is designed primarily as a screening measure and this needs to be taken into consideration. The results of this study need to be considered within the context of the described limitations. In addition, the response rate (estimated to be less than 30% given the largest counselling organisation reported to have over 700 members) suggests need for further caution in interpreting these results. The small sample sizes for subgroups of participants (for example; male gender, ethnic minorities), was a further limitation of this study. Consequently, this did not allow valid within group comparisons to be

made. This study by no means accounts for the experiences of secondary traumatic stress and other related constructs, of the counsellors who did not participate in this research.

Future directions for research

Five specific directions for future research are recommended. These are the implementation of longitudinal studies, research which compares prevalence of secondary traumatic stress in New Zealand counsellors with that of counsellors from other countries, the validation of a social support measure specific to secondary traumatic stress, investigation of the relationship between resolved personal trauma histories and secondary traumatic stress and the evaluation of interventions designed to reduce burnout and enhance resilience.

A longitudinal study which investigates constructs related to secondary traumatic stress and resilience in this New Zealand population of counsellors is crucial in order to better comprehend the relationships between these constructs. Longitudinal investigation could elicit important information about the trajectories of secondary traumatic stress and burnout. In addition, longitudinal research could inform theory by testing current models overtime and fine tuning these in order to promote understanding of the variables involved in these phenomena. It would also be of interest to investigate Figley's (2002) two exposure variables; exposure to client suffering and prolonged exposure. A longitudinal study could test prolonged exposure in ways that a cross-sectional study could not. In addition, a longitudinal study could provide some insight in regards to the possible benefits of regular breaks and holidays as proposed by the variable "dis-engagement" in Figley's (2002) etiological

model. The use of clinical interviews or corroboration from other sources of information could be incorporated into a longitudinal design and may allow for better clarification of participants' responses. Additionally, the inclusion of qualitative as well as quantitative measures may result in a deeper understanding of secondary traumatic stress and related constructs (Hanson, Creswell, Plano Clark, Petska & Creswell, 2005). The conclusions from such research could provide knowledge applicable both in New Zealand and worldwide to ensure better outcomes for counsellors and other professionals who are exposed to secondary trauma.

Further research is required to determine how the prevalence of secondary traumatic stress in New Zealand counsellors compares with that of counsellors from other countries. The current study suggests that the prevalence of secondary traumatic stress and burnout may be higher for New Zealand counsellors than that reported in the relevant literature. If this is so, it is important to investigate why in order to determine how this might best be addressed. It was proposed that New Zealand counsellors may have a greater exposure to trauma than that of the counsellors reported in research conducted overseas. This is a proposal that is also worthy of further investigation.

In general, the measures used in this study showed evidence of good reliability and validity and their use with the counsellors in this study was assessed as appropriate. The social support measure was an exception and was created due to a lack of validated social support measures specific to secondary traumatic stress. The development and validation of a measure of social support for use with counsellors and other professionals who work with the trauma of others is imperative. This would allow for a better and more

accurate assessment of the potential role of social support in protecting against secondary traumatic stress and burnout.

Further research exploring the relationship between resolved personal trauma histories and secondary traumatic stress is also warranted. Research in relation to personal trauma history and secondary traumatic stress has produced mixed results and is inconclusive. Failure to differentiate between counsellors who have worked through their trauma histories and counsellors who have not worked through their trauma histories may have confounded results. It is therefore essential that future research address this.

Finally, the current study has provided support for the potential roles of burnout and resilience in predicting high risk of secondary traumatic stress. Despite the pervasive nature of burnout and the existence of research on burnout there are limited studies dedicated to addressing burnout and evaluating interventions designed to reduce burnout. Of the existing research, none are known of which relate specifically to counsellors who are exposed to the trauma of others. Halbesleben and Buckley (2004) proposed that one of the issues in developing burnout interventions is the tension between providing specificity to be effective and providing generalisability to be applicable to the range of issues which present in an organisation. Halbesleben, Osburn and Mumford (2003) utilised collaborative action research as a means of reducing burnout in a fire department with good success. They proposed that the key to reducing burnout may not be a specific intervention but the development of programs tailored to the specific needs of the organisation. Collaborative action research with New Zealand counsellors may result in the development of

effective programs which reduce burnout in counsellors exposed to secondary trauma.

While there is limited research related to enhancing resilience in counsellors, programs designed for use with other populations may provide a place to start at. Steinhardt and Dolbier (2008) piloted a program designed to enhance resilience in students (entitled “Transforming Lives through resilience education”) with good success. Benefits may be obtained from testing such programs on counsellors who score low on resilience. Alternatively, collaborative action research with New Zealand counsellors may result in the development of interventions better suited to counsellors who are exposed to secondary trauma.

Conclusion

Working with clients who have experienced trauma can be rewarding but has the potential for deleterious effects. This was found to be true for a proportion of the counsellors in this sample with over one fifth scoring high risk of secondary traumatic stress and close to a quarter scoring high risk of burnout. The prevalence of secondary traumatic stress and burnout in this New Zealand sample was presented and it was suggested that this may be higher than that in the literature. However, the counsellors in this study also showed high levels of resilience and compassion satisfaction. Support was found for the proposal that increased exposure to trauma is associated with higher risk of secondary traumatic stress. Burnout and resilience were also presented as possible predictors of secondary traumatic stress and the implications discussed. Findings in regards to the relationships between personal trauma

history and secondary traumatic stress and between social support and secondary traumatic stress remain inconclusive. Possible reasons for this were discussed.

This study contributes new knowledge to the field of secondary traumatic stress by researching a group of counsellors previously not considered in the literature. It has provided support for the role of burnout in predicting high risk of secondary traumatic stress which until now has had limited research. In addition, this study has introduced resilience as an important variable for consideration. Knowledge gained from this study's findings is applicable to reducing the negative outcomes for counsellors not only in New Zealand but for all counsellors exposed to secondary trauma. This study has discussed the practical implications of this research and highlights future directions for research.

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Appendix A: Table of Results

Table A1.

Demographics of Sample - expanded

Demographic Variable	<i>n</i>	Percent
Gender		
Male	9	15.5
Female	120	84.5
Ethnicity		
NZ Maori	6	4.7
NZ Euro/ Pakeha	105	81.4
Pacific Islander	2	1.6
Other European	4	3.1
American	3	2.3
British	2	1.6
Other	6	4.7
Age		
26-35 years	4	3.1
36-45 years	24	18.6
46-55 years	37	30.3
56-60 years	29	22.5

Table A1.

Demographics of Sample continued

Demographic Variable	<i>n</i>	Percent
60 years <	33	25.6
Relationship Status		
Single	31	24.0
In a relationship	98	76.0
Highest Qualification		
Undergrad cert/diploma	16	12.4
Degree Equivalent	12	9.3
Bachelor's degree	29	22.5
Postgraduate	72	55.8
Counselling Experience		
1-5 years	32	24.8
6-15 years	50	38.8
16-25 years	34	26.4
26-41 years	9	7.2
Freq. of Professional Sup		
Weekly	6	4.7
Fortnightly	42	32.6

Table A1.

Demographics of Sample continued

Demographic Variable	<i>n</i>	Percent
Monthly	77	59.7
3-6 monthly	4	3.1
Personal Trauma History		
Yes	93	72.1
No	35	27.1
Number of Social Supports		
0	3	2.3
1-2	61	47.3
3-4	56	43.4
5-8	9	7

Participants were informed of their right not to answer all questions:

Ethnicity, Years counselling experience and Personal trauma history

percentages do not sum to 100

Appendix B: Survey



MASSEY UNIVERSITY
TE KUNENGA KI PŪREHUROA

Respondent Consent: Your participation in this questionnaire implies consent.

Section 1:

1. What is your gender?

Male

Female

2. How old are you?

20-25 years

26-30 years

31-35 years

36-40 years

41-45 years

46-50 years

51-55 years

55-60 years

Greater than 60 years

3. What best describes your current relationship status?

Single

In a relationship

4. Which ethnic group do you belong to? (If your answer includes more than one ethnic group, please indicate which one you consider to be your primary ethnicity).

New Zealand Maori

New Zealand European/ Pakeha

Pacific Nations

Asian

Other _____

5. What is the highest qualification you have achieved?

Undergraduate (For example: certificate/ diploma, not a degree)

Degree Equivalent (For example: not a degree but recognised as equivalent)

Bachelor's degree (For example: BA, BSc)

Postgraduate (For example: Masters, PhD or postgraduate diploma)

6. How many years have you worked as a counsellor? _____

7. How frequently do you engage in Professional Supervision? (Please mark your best estimate if not sure).

Once a week

Once a fortnight

Once a month

Once every 3-6 months

Once a year

Never

8. How effective are these sessions?

Very effective; I feel empowered after them

I dislike these; I don't find they assist me in coping with my work

I enjoy them but I don't get anything out of them.

9. A) Please select from the following the supports that you have used in the last 30 days to assist you in coping with the impact of your work with clients.

Whanau/ Family: (For example; immediate, extended, whangai)

Friends

Colleagues (For example; peers or managers)

Debriefing meetings (For example; regular or unplanned work meetings)

Church/ Spiritual (For example pastors or spiritual leaders, attendance at meetings)

B) If Maori, please select from the following any additional supports that you have used in the last 30 days to assist you in coping with the impact of your work with clients.

Hapu (For example: Runanga, Kokiri, Marae, Awa, Maunga)

Iwi (For example: Tohunga, Karakia, Whakatauki)

Kaumatua (For example: Koroua, Kuia)

Hauora (For example: Rongoa, Mirimiri)

10. Please select the types of trauma you have been working with in the last 30 days

Childhood sexual abuse

Sexual assault or rape

Sexual harassment

Domestic violence

Violent crime

Natural disasters

Accidents

Invasive medical procedures

Death or injury to a loved one

Torture

Suicide of a loved one

Combat or military experiences

None

Others – please state _____

11. Taking into consideration your current client caseload, what is the proportion of clients who have experienced trauma?

Less than 30%

Between 30 to 65%

Greater than 65%

12. On average over the past 30 days, how many hours per week would you typically spend with clients who have experienced trauma?

Less than 5hrs _____

5 – 9 hrs _____

10- 14 hrs _____

15 – 19 hrs _____

20 – 24 hrs _____

More than 25hrs _____

13. Have you yourself experienced any of the traumas listed in question number 10?

Yes

No

Section 2:

Professional Quality of Life Scale (Stamm, 2010)

When you help people you have direct contact with their lives. As you may have found, your compassion for those you help can affect you in positive and negative ways. Below are some questions about your experiences, both positive and negative, as a helper. Consider each of the following questions about you and your current work situation. Select the number that honestly reflects how frequently you experienced these things in the *last 30 days*.

1=Never 2=Rarely 3=Sometimes 4=Often 5=Very Often

- _____ 1. I am happy.
- _____ 2. I am preoccupied with more than one person I help.
- _____ 3. I get satisfaction from being able to help people.
- _____ 4. I feel connected to others.
- _____ 5. I jump or am startled by unexpected sounds.
- _____ 6. I feel invigorated after working with those I help.
- _____ 7. I find it difficult to separate my personal life from my life as a helper.
- _____ 8. I am not as productive at work because I am losing sleep over traumatic experiences of a person I help.
- _____ 9. I think that I might have been affected by the traumatic stress of those I help.
- _____ 10. I feel trapped by my job as a helper.
- _____ 11. Because of my helping, I have felt "on edge" about various things.
- _____ 12. I like my work as a helper.
- _____ 13. I feel depressed because of the traumatic experiences of the people I help.
- _____ 14. I feel as though I am experiencing the trauma of someone I have helped.

- _____15. I have beliefs that sustain me.
- _____16. I am pleased with how I am able to keep up with helping techniques and protocols.
- _____17. I am the person I always wanted to be.
- _____18. My work makes me feel satisfied.
- _____19. I feel worn out because of my work as a helper.
- _____20. I have happy thoughts and feelings about those I help and how I could help them.
- _____21. I feel overwhelmed because my caseload seems endless.
- _____22. I believe I can make a difference through my work.
- _____23. I avoid certain activities or situations because they remind me of frightening experiences of the people I help.
- _____24. I am proud of what I can do to help.
- _____25. As a result of my helping, I have intrusive, frightening thoughts.
- _____26. I feel "bogged down" by the system.
- _____27. I have thoughts that I am a "success" as a helper.
- _____28. I can't recall important parts of my work with trauma victims.
- _____29. I am a very caring person.
- _____30. I am happy that I chose to do this work.

Brief Resilience Scale (Smith, Dalen, Wiggins, Tooley, Christopher & Bernard, 2008)

Now use the following scale and select one number for each statement to indicate how much you disagree or agree with each of the statements.

1 = Strongly Disagree 2 = Disagree 3 = Neutral 4 = Agree 5 = Strongly Agree

-
- | | |
|---|-----------|
| 1. I tend to bounce back quickly after hard times..... | 1 2 3 4 5 |
| 2. I have a hard time making it through stressful events..... | 1 2 3 4 5 |
| 3. It does not take me long to recover from a stressful event. | 1 2 3 4 5 |
| 4. It is hard for me to snap back when something bad happens... | 1 2 3 4 5 |
| 5. I usually come through difficult times with little trouble | 1 2 3 4 5 |
| 6. I tend to take a long time to get over set-backs in my life..... | 1 2 3 4 5 |
-

If you would like to be provided with a summary of results at the conclusion of this study, please click on the following link and leave your contact details. A summary will be emailed to you.

LINK

If you have experienced some distress or discomfort in completing this survey, I encourage you to talk to your professional supervisor or alternatively to a supportive colleague. Thank you for completing this questionnaire.

Appendix C: Letter requesting access to an institution



MASSEY UNIVERSITY
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Name and title

Organisation

Address

Dear *(insert name)*

My name is Kat Temitope and I am a part-time Masters' degree student within the School of Psychology, Albany campus, Massey University. My research supervisor is Dr Mei Williams and my area of interest is in the impact of secondary traumatic stress on professionals who work with clients who have experienced trauma and in factors which may protect against this.

Using a questionnaire, I plan to investigate whether there are any differences in the occurrence of compassion fatigue and burnout between New Zealand counsellors with higher caseloads of clients who have experienced trauma and counsellors with lower caseloads of clients who have experienced trauma. Secondly, the project will investigate whether resilience and compassion satisfaction modify or mediate the occurrence of compassion fatigue.

I am seeking your permission to invite counsellors who are members of the *(insert organisation)* to participate in this project.

While the *(insert organisation)* will not be named in the publication of findings, it may be able to be identified due to the relatively small number of professional membership bodies for counsellors in New Zealand.

If you require any further information about my planned research then please feel free to contact me using the details listed below.

I look forward to hearing from you.

Yours sincerely,

Kat Temitope

Phone: 07 5700271 / 0277409512

Email: katfishnz@yahoo.com

Appendix D: Advertisement – Invitation to participants

Subject Line: Invitation to Research

Kiaora!

Sometimes the compassion you have for the people you help affects you in both positive and negative ways. Working with people who have experienced trauma can be both challenging and rewarding. Secondary trauma is one of the risks of the job; but we need to be aware of it and we need to learn more about it.

I'd like to invite you to participate in my study where we can help each other to discover what counts towards protecting those in the helping profession from some of the negative impact of their work.

Your experience as a New Zealand counsellor is invaluable.

What's more - for every person who participates I'll donate \$1 to the Women's Refuge.

Please take a moment to click on the following link to my study.

https://qasiasingleuser.asia.qualtrics.com/SE/?SID=SV_4GhY2TcbEWzlsqV

This link will take you first to an information page, where you can learn a little more about my research and then to my questionnaire.

10-15minutes of your time now could benefit you and many others in time to come.

Thank you for taking the time to consider my invitation.

Kat Temitope,

MA student, School of Psychology,

Massey University Committee Approval Statement

This project has been reviewed and approved by the Massey University Human Ethics Committee: Northern, Application 12/054 If you have any concerns about the conduct of this research, please contact Dr , Dianne Gardner, Chair, Massey University Human Ethics Committee: Northern, telephone 09 414 0800 x 41225, email: humanethicsnorth@massey.ac.nz

Appendix E: Information Sheet



MASSEY UNIVERSITY
TE KUNENGA KI PŪREHUROA

Secondary traumatic stress and the role of resilience in New Zealand Counselors

INFORMATION SHEET

Introduction

Kia ora! My name is Katrina Temitope and I am working on my Master's thesis in Psychology.

Research has found that work with clients who experience trauma (for example; sexual abuse, rape and violence) can elicit distressing reactions in therapists, (McCann & Pearlman, 1990). This can be a normal response in the initial stage, but if exposure to working with people with trauma continues over time, it could end up having a negative impact for the therapist. Various terms have been used to describe this impact namely; compassion fatigue, countertransference, secondary traumatic stress and vicarious trauma, (Steed & Bicknall, 2001).

I'm interested in finding out whether there are any differences in the occurrence of compassion fatigue and burnout between New Zealand counsellors with high caseloads of clients who have experienced trauma and those with lower such caseloads. I'd also like to see whether resilience and compassion satisfaction, (the satisfaction you get from helping people) protect against compassion fatigue and burnout.

Your experience as a counsellor in New Zealand would be most valuable to this research. You could help us understand what protects against secondary traumatic stress. I would therefore be very grateful if you would take part in my study.

Participants

I'm also grateful to the _____ who have assisted me by emailing you and other members an invitation and the link to participate in my study.

This survey is anonymous so you can be assured that you won't be identified in any way. Whats more, to show my appreciation for your time and participation, I'm going to donate \$1 to the Women's Refuge for every survey completed.

Project Procedures

If you decide to participate, you'll be asked to complete an online survey. This will take about 10 -15 minutes.

You are under no obligation to accept this invitation.

If you decide to participate, completion of the questionnaire implies consent.

You have the right to decline to answer any particular question.

It is not anticipated that taking part in the study will cause you any discomfort. However, if you do experience some distress, you are encouraged to talk to your professional supervisor or to a supportive colleague.

Data Management

Once the survey has been completed, the data will be analysed. It will then be stored for five years and be available only to myself and my supervisor, Dr Mei Williams. The data will be kept in the locked office of Dr Mei Williams at the Albany campus, Massey University. It will be her responsibility to dispose of it.

A summary of the project findings will be made available to you if you have indicated your interest by providing your contact details on the separate link at the end of the survey.

If you have any questions, please feel free to contact us and thanks for taking the time to read this.

Researcher: Katrina Temitope

Supervisor: Dr Mei Williams

Email: katfishnz@yahoo.com

Email: M.W.Williams@massey.ac.nz

Phone: 0277409512

Phone: 09 414-0800, Ext 41222

Committee Approval Statement

This project has been reviewed and approved by the Massey University Human Ethics Committee: Northern, Application 12/054. If you have any concerns about the conduct of this research, please contact Dr , Dianne Gardner, Chair, Massey University Human Ethics Committee: Northern, telephone 09 414 0800 x 41225, email humanethicsnorth@massey.ac.nz.