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Abstract

Experiencing traumatic events can have a profound impact on human beings, ranging from mild distress to severe symptomology. The mental health professionals that serve traumatized populations are also at risk of exposure in their work. While there are many factors that contribute to negative and positive consequences of clinical work with trauma, the influence of a therapist's own trauma seems to have mixed findings. This study was designed to better understand the role of a therapist's personal trauma on negative and positive associations of clinical work, specifically compassion fatigue and compassion satisfaction. There were no significant correlations found between the experience of personal trauma and compassion fatigue and compassion satisfaction. However, mediation analysis showed that post traumatic growth partially mediates the amount of compassion satisfaction experienced by therapists who are at risk for PTSD. In addition, compassion satisfaction partially mediates the relationship between PTSD and compassion fatigue. These findings have significant implications for training and supervision of therapists working in the field.

THERAPISTS' EXPERIENCES OF TRAUMA, COMPASSION FATIGUE, AND
COMPASSION SATISFACTION: THE ROLE OF POST TRAUMATIC GROWTH

by

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Dissertation

Submitted in partial fulfillment of the requirements for the degree of Doctor of Philosophy in
Marriage and Family Therapy

Syracuse University

May 2019

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This has been such a journey for me. I certainly would not be where I am today without the love and support of my family. Thank you to my parents and grandparents who have always loved and supported me. You taught me to value education and view it as a priority and a source of endless possibility. To my mother who modeled a life of connection, service, and compassion. It is because of you that I believe I grew to understand and be empathic.

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Chapter One: Introduction

Trauma is pervasive. It has become a focus in our world and in our communities. Anyone who watches the news is aware of the violence related to war, crime, and various forms of abuse. Most are also aware of the ways in which being a victim of violence or witnessing traumatic events can have a negative impact on human beings. Many who experience or are exposed to traumatic events have reactions that are logical responses to the experience. Slowly, our mental health system is recognizing the ways in which trauma contributes to client symptomology and behavior.

The increased awareness of the impact of trauma has led to an increase in the need for and use of mental health services. With that has come knowledge of how to assist those who suffer from trauma. From direct response workers to medical professionals and human services workers to mental health practitioners, there are many who are exposed to trauma through their work. Practice and research have also acknowledged the impact of this trauma work on the professionals (Cocker & Joss, 2016; Figley, 2002; Pearlman & MacIan, 1995; Sinclair, Raffin-Bouchal, Venturato, Mijovic-Kondejewski & Smith-MacDonald, 2017). Theorists have defined such concepts as vicarious trauma and compassion fatigue to explain the deleterious effects of exposure to trauma through one's job (Figley, 2002; Huggard, Law & Newcimbe, 2017; McCann & Pearlman, 1990; Newell, Nelson-Gardell, MacNeil, 2016).

To date, much of the research on both the impact of trauma and the impact of working with traumatized people has focused on negative associations. Yet, not every human being experiences symptoms following a traumatic experience. Similarly, not every professional will develop vicarious trauma or compassion fatigue as a result of their work.

There has been evidence of positive effects of working with those who have experienced trauma, such as compassion satisfaction and vicarious resilience (Craig & Sprang, 2010; Engstrom, Hernandez, & Gangsei, 2008; Martin-Cuellar, Atencio, Kelly & Lardier, 2018). Post traumatic growth has been viewed primarily in patients who demonstrated growth after medical trauma (Shakespeare-Finch & Enders, 2008), but it has also been noted in people with other types of trauma (Calhoun & Tedeschi, 2004; Triplett, Tedeschi, Cann, Calhoun, & Reeve, 2012). The concept of vicarious post traumatic growth builds upon the theory of post traumatic growth, although it pertains specifically to therapists who benefit from the growth of their clients. Both terms signal the existence of a positive change after experiencing or being exposed to traumatic events.

This study aimed to better understand the variation in the effect clinical work with trauma has on therapists. Studies have highlighted that personal experiences with trauma have both increased compassion fatigue as well as compassion satisfaction (Baird & Kracen, 2006; McKim & Smith-Adcock, 2014). It is possible then, for personal trauma to have an impact in either direction. Since there seems to be conflicted findings as to the role of personal trauma, it seems possible that another variable influences whether it contributes more to fatigue or satisfaction. This study draws from research on clients and medical patients who experience post traumatic growth as a moderator to whether they experience PTSD (Hallam & Morris, 2014; Powell, Gilson, & Collin, 2012). Post traumatic growth was proposed as a mediator between a therapist's personal experience with trauma and the development of either compassion fatigue or compassion satisfaction.

This study aims to add to previous research about the role of personal trauma in the development of compassion fatigue or compassion satisfaction. It will distinguish between

having experienced trauma and having healed from such events by examining post traumatic growth. The findings may increase awareness in the field of therapists' own trauma and the ways it can be used to benefit both the clinician and the client. It may also inform the training and continued support needs of therapists serving a traumatized population.

This document will be organized into chapters, the first of which is this introduction. The second chapter includes a review of the literature, delineating the concepts in this study, the theoretical underpinnings, and previous studies that addressed the positive and negative impact of working with trauma. Chapter Three focuses on the methodology of the study. The results of the analysis are presented in Chapter Four. Chapter Five discusses the results and clinical and training implications for the field.

Chapter Two: Literature Review

Introduction

This chapter begins with defining the concepts and terms that are used in this study. There is a brief overview of the prevalence of trauma and the need for well trained, trauma informed therapists. This is followed by a summary of systems theory and trauma theory, in which the present study is grounded. The literature review will cover the constructs that have been developed and defined as the negative consequences for therapists who work with traumatized clients. These include compassion fatigue, vicarious trauma, and burnout. Researchers have also addressed some of the positive effects of working with trauma as well. The concepts discussed here include post traumatic growth, vicarious resilience, and compassion satisfaction. The studies reviewed will address the factors that have been found to contribute to either compassion fatigue or compassion satisfaction. The relationship between these conditions will also be examined through the literature. Lastly, the lack of clarity on the role of personal trauma of the therapist will be explored.

Literature exploring these concepts has referred to various professions in the arena of human services (Baird & Kracen, 2006; Cieslak, et.al., 2014; Newell, et al., 2016; Sinclair, et.al., 2017; Zerach, 2013). They have included volunteers at natural disasters, medical and emergency personnel, mental health practitioners with a wide variety of roles, and psychotherapists. In this document the term therapist will be used to include those professionals who provide individual, couple or family therapy to clients. Both the literature and this study refer to therapists in an inclusive fashion. In other words, therapists may be from a variety of disciplines or hold licensure in various professions, such as Social Work, Marriage and Family Therapy, Mental Health Counseling, or Psychology. Some studies included in this review use other terms and

include a wider array of professions. The terms used by the researchers themselves will be used in the description of the study.

Because of the array of terms and concepts that have been used by various theorists and researchers, the definitions of terms to be used in this document by this writer are described in Table 1 .

Table 1.

Term	Definition
Therapist	licensed professional who provides psychotherapy. This includes Marriage and Family Therapists, Clinical Social Workers, Mental Health Counselors, psychologists, and psychiatrists.
Clinician	psychotherapist in the mental health field having direct care of clients
Mental health professionals	those who work directly with clients in the field of mental health. This encompasses professions and roles in mental health beyond therapists, including, but not limited to case managers and residential workers
Trauma	experiences that include adverse life events, including, but not limited to: emotional, physical, and sexual abuse, terrorism, war, sudden loss, natural disasters, school and community violence
Compassion fatigue	condition that effects therapists who work with traumatized clients and is characterized by symptoms similar to post traumatic stress disorder
Vicarious trauma	condition in which therapists working with traumatized clients experience a negative shift in their thoughts, beliefs, sense of safety, and worldview

Burnout	condition effecting helping professionals in which they are physically, emotionally, and physically exhausted after long term exposure to their work
Empathy	understanding and experiencing the emotions of another
Countertransference	emotional reactivity a therapist has to a client's material that is based on the therapists personal experiences related to personal issues and internal conflicts.
Compassion satisfaction	sense of fulfillment derived from helping others in therapy
Vicarious resilience	helping professionals ability to return to a stable place after being exposed to trauma in their work
Post traumatic growth	increased appreciation for life in general, more meaningful relationships, an increased sense of personal strength, changed life priorities, and a richer existential or spiritual life that follows surviving traumatic events
Vicarious post traumatic growth	change in beliefs, view of self and the world that comes as a result of working therapeutically with clients Positive changes that individuals may experience as a result of an intimate, empathic relationship with someone

The increased awareness of the existence of trauma and its' impact on individuals, families, and communities, has highlighted the need for therapists to be more skilled in helping those who have experienced it. This awareness also calls attention to the needs of those who serve a traumatized population. What qualities are necessary for a therapist doing this work? What makes one an effective therapist while working with clients? It seems important in the

training and retention of therapists to fully understand the costs and benefits of helping others heal from trauma. It is also to the benefit of the client, workforce, and society in general if we can promote a positive response to trauma and minimize the deleterious effects.

This awareness and knowledge is important, not just for the trauma specialist, but for anyone providing therapeutic services. The likelihood of therapists encountering clients with trauma is very high. Surveys suggest that as many as 60 percent of adults in the general population were exposed to abuse or significant distress as children (CDC, 2010), and as many as 70 percent of the world population has experienced at least one traumatic event (Kessler, et al., 2017). There is also evidence that many people have actually experienced multiple traumas that could result in symptomology (Kessler, et al, 2017; Kisiel, 2014; Teicher & Samson, 2013). Trauma is even more prevalent in those seeking mental health care, ranging from 30 to 90 percent (Hambrick et al, 2018; Lu, et al., 2013; Mauritz, Goossens, Draijer, & Van Achterberg, 2013). In fact, researchers have found that early childhood trauma in particular may be underlying other issues that present in mental health care (Hambrick, et al., 2018; Teicher & Samson, 2016). Thus, even those therapists who do not intend to specialize in trauma may undoubtedly be exposed to clients who have experienced it.

The theoretical section will provide a basis for understanding the ways in which this study is rooted in systems, family therapy, and trauma theories. Systems theory provides an understanding of the ways one person may profoundly influence the thoughts and feelings of others (Bateson, 1979; von Bertalanffy, 1968). Family therapy and the concept of empathy provide depth into the understanding of the role therapists play when working with traumatized clients (Satir, Banmen, Gerber, & Gomori, 1991; Bowen, 1993). Interpersonal neurobiology (Schoore, 2002; Siegel, 2012) adds to the understanding of systems and the ways in which one

person can influence the feelings and actual development of another. Lastly, trauma theory (Herman, 1992; van der Kolk, 2014) provides the basis for understanding the impact of traumatic experiences on both clients and therapists as well.

The section on the negative consequences of trauma work will highlight research that identifies the adverse effects of trauma exposure in one's work (Figley, 1995; Killian, 2008; Pearlman & MacJan, 1995; Sprang, Clark & Whitt-Woosley, 2007; Thomas, 2013). The concepts that will be explored in this area include vicarious traumatization (McCann & Pearlman, 1995), burnout (Rossi, et.al, 2012), and finally compassion fatigue (Figley, 1995). Definitions of each construct are included in the chart above. Each of these concepts identify ways in which therapists can develop conditions that impact their functioning, their outlook on the world, and most certainly their clinical work.

As the literature review below shows, there are a myriad of conditions and factors that have been explored around the risk for harm to therapists. Some of these studies have identified factors that could either increase risk or provide protection. Factors include individual characteristics, work environments, and level and type of training and supervision (Baird & Kracen, 2006; Dehlin & Lundh, 2018; Killian, 2008; Thompson, Amatea, & Thompson, 2014). There have been mixed findings around the ways personal experience with trauma may influence both compassion fatigue and compassion satisfaction (Figley, 2002; Hunter, 2012; McKim & Smith-Adcock, 2014; Samios, Abel, & Rodzik, 2013). It seems that most studies link personal trauma with increased risk for negative effects of trauma work (Baird & Kracen, 2006; Figley, 2002; Hensel, Ruiz, Finey & Dewa, 2015). However, some studies have resulted in findings that indicate personal trauma may enhance satisfaction with providing therapy to survivors (Hunter,

2012; McKim & Smith-Adcock, 2014). These discrepancies provide a rationale for the exploration in this study.

This chapter will also discuss the benefits to working with traumatized clients. There is some evidence that suggests therapists, even those working with very traumatized people, can experience growth and deep satisfaction from their work (Arnold, Calhoun, Tedeschi, & Cann, 2005; Hernandez-Wolfe, Killian, Engstrom, & Gangsei, 2015). While the research has not been as robust, there have been studies aimed at identifying the benefits of helping individuals, families, and communities heal from trauma (Hernandez, Gangsei, & Engstrom, 2007; Hunter, 2012; Samios, et.al., 2013; Thompson, Amatea, & Thompson, 2014). The concepts that will be discussed in the literature review include vicarious resilience (Engstrom, et.al, 2008; Pack, 2014), post traumatic growth (Calhoun & Tedeschi, 2004) and vicarious post traumatic growth (Arnold, et.al., 2005), and finally compassion satisfaction (Craig & Sprang, 2010). Each of these are defined in the table above and will be discussed later in this chapter.

Although there is some evidence that personal trauma negatively impacts therapists' work (Baird & Kracen, 2006; Hensel, et al., 2018; Pearlman & MacIlan, 1995), many clinicians may have learned how to overcome adversity in their own lives. There are studies that have shown having a personal trauma history does not necessarily create a negative impact (Leonard, 2008; McKim & Smith-Adcock, 2014). In fact, personal experiences of trauma may actually increase compassion satisfaction (McKim & Smith-Adcock, 2014). It seems that someone who has been through the ordeal and survived, learned to cope and heal, may be better equipped to understand and help others. It may be that having grown from personal traumatic events equates to being an even better trauma therapist. To date, however, there have been only a few studies that confirmed this hypothesis. This question as to whether therapists who have experienced

growth from their own trauma have the potential to be stronger therapists is the focus of this study.

To summarize, research has shown that working with traumatized clients has an impact on the therapist (Engstrom, et.al., 2008; Figley, 2002; McCann & Pearlman, 1990; Sinclair, et al, 2017; Stamm, 2005). There are negative consequences, protective factors, and positive outcomes to working with clients who have been traumatized. The literature reviewed in this chapter outlines individual and contextual factors that may influence these outcomes for therapists.

This present study hopes to inform readers of the ways in which trauma may have an impact on therapists. The literature review will describe the ways our bodies and brains respond to trauma, the ways empathy in a therapeutic relationship poses as a risk for therapists, and the ways in which working with clients who have experienced trauma can also be rewarding. This paper will cite research that examines the factors associated with compassion fatigue as well as compassion satisfaction. It will also highlight the inconsistencies in some of those factors, such as the role of personal experience and whether therapists have grown from those experiences. This study aims to explicate studies where personal experience can have a positive impact on clinical work with traumatized clients. This study will also distinguish between having personal exposure to trauma and having worked through or grown from traumatic experiences. An improved understanding of what factors increase satisfaction will hopefully assist in better preparing trauma therapists, and ultimately improve the services available to those who have been impacted by trauma.

Theoretical Framework

This study is grounded in systems theory (Bateson, 1979; von Bertalanffy, 1968). The core concepts that organize the theory and are linked to this study are circular causality, structure, boundaries, and relational cycles of interaction (Nichols, 2009). While therapists hope to influence their clients, systems theory establishes the ways in which a client may also have influence over a therapist. Although traumatic experiences may happen to a client, the client's response to that experience will also influence the system. For example, a violent altercation can have a devastating effect on an individual. The individual's affect, thoughts, and behavior can change as a result of that experience. Systems theory suggests that others connected to that individual will also be impacted. When a person becomes afraid or hypervigilant the people and systems they are in relationships with will be affected by their fear and hypervigilance.

Family therapy theory (e.g., Bowen, 1993; Minuchin, 1974; Nichols, 2009; Satir, 1988) provides a basis for understanding the role of the self of the therapist. In family therapy models, therapists enter into the family system in order to join and assist in the change process (Minuchin, 1974; Nichols, 2009; Satir, 1988). Family therapy theory can be used to illustrate the dynamic between the therapist and client and stress the importance of boundaries, engaging with empathy, and being aware of one's own personal experiences that may influence the therapy (Bowen, 1993; Satir, et.al., 1991). When listening to the traumatic stories of clients, it is important for the therapist to be keenly aware of their own boundaries and separate the client story from their own experience. The therapist must also maintain the structure of the session and ensure the space is safe for the client. These concepts lead to the critical importance of the self of the therapist, which will be discussed later in this chapter.

Interpersonal neurobiology (Siegel, 2012) provides a biological component to the ways in which human beings influence one another. This theory articulates how our brains develop

through our relationships. Since our brains are responsible for so many things, such as our feelings, sensations, perceptions, thoughts, and cognitions, it is reasonable to deduce that all of these functions and states are influenced by our relationships (Hambrick, et al., 2018; Schore & Schore, 2014; Siegel, 2012). This is found to be true in intimate relationships, and may also hold true for relationships between therapist and client (Schore, 2002).

Trauma theory provides an understanding of the way in which traumatic events have an influence on the person who experiences them (Herman, 1992). While one person can show emotional, physical, and psychological changes as a result of trauma, trauma can also have a systemic impact. The shifts in one person has influence on the systems and relationships to which that person belongs. This may include the therapeutic system (Zaleski, Johnson & Klein, 2016). Trauma theory is central to understanding the significance of traumatic events on both clients and those who work to help them.

Systems Theory. Systems theory provides a foundation for understanding the way in which a therapist can be impacted by a client (Bateson, 1979; Nichols, 2009; von Bertalanffy, 1968). Basic systems theory posits that one person impacts another in a circular fashion (Bateson, 1979). A client lives and is part of a system that includes family, community, and culture. As the client system enters therapy, the therapist engages with the system as well. The therapeutic system then, can be seen as having an impact on the other systems of the client. Similarly, the therapeutic system can also lead the therapist to be impacted by the client and the systems they represent. The layers of systems the client brings may even be shared by that of the therapist. For example, conditions in the community and geographic area may have the same influence on both the therapist and the client.

Circular causality and understanding the therapeutic relationship as a system can explain the ways a client and his or her behavior or experiences can have an impact on the behavior and experience of the therapist. Circular causality posits that problems do not exist in a simple linear fashion (von Bertalanffy, 1968). There is not an absolute line of cause and effect. Rather, difficulties exist due to relational patterns. Each person and action in a relationship has an impact on the other person. There is a continual loop, wherein the people in the system feed information to each other. This theory, then, can be used to explain the ways in which trauma may influence the client as well as the therapist. While a traumatic event may have occurred in a client's life, their story and the ways in which the therapist is a witness in the relationship, has an impact on the therapist as well. Likewise, the presence of a therapist can have an affect on the client.

Family Therapy Theory and the Role of Self. The field of marriage and family therapy has addressed the role of the self in the therapeutic process (Blow & Sprenkle, 2007; Negash & Sahin, 2011). Several family therapy theories attend to the role of the therapist and focus on the importance of joining with clients in order to better understand the system and also to intervene within it (Minuchin, 1974; Bowen, 1993; Satir, 1988; Nichols, 2009). It is that joining and actually becoming part of the system that opens therapists up to experiences that may transcend the professional role. Being completely present with clients and fully witnessing their pain is likely to leave therapists vulnerable to the intense traumatic events of their clients. The feelings and experiences of clients can trigger the thoughts and feelings of therapists, especially if they have experienced trauma in their own lives. It is critical, then, for therapists to be aware of their own experiences and what they bring into the therapy room. Similarly, therapists must also know when their own issues or struggles are impacting their ability to be present for clients. There is a

keen need to be aware of the self of the therapist, especially when engaging in trauma work (Satir, et.al., 1991). It is important to note here that compassion fatigue is not simply a lack of awareness around the self of the therapist (Negash & Sahin, 2011). Rather, family therapy theory calls attention to the role the self may play.

Family therapy theory also provides an understanding of the importance of roles and boundaries within the therapeutic relationship (Bowen, 1993; Minuchin, 1974; Nichols, 2009; Satir, 1988). Therapeutic alliance and boundaries between therapist and client are critical, especially in the area of trauma work. Some level of permeable boundary is necessary for the client(s) to feel connected and cared for by the therapist (Minuchin, 1974; Nichols, 2009). The therapist must also have some ability to have a deep and meaningful connection in order to be helpful. If the boundary is too rigid, it may protect the therapist, but it may also seem as though she is disengaged from the process. If the boundary is diffuse, the therapist may be unable to separate themselves from their client's material (Minuchin, 1974). While a lack of boundaries in a therapeutic relationship may contribute to a therapist developing compassion fatigue, the nature of providing therapy is more likely the risk factor. This will be discussed further in the section on empathy.

Interpersonal Neurobiology. Interpersonal neurobiology also provides a systemic understanding of the ways in which human beings inform one another's development (Schoore, 2002; Siegel, 2012). In his work, Siegel describes mirror neurons, parts of our brain that are directly influenced by another. It has been shown, for example, that when infants look into their caregivers' eyes, parts of their brain light up (neurons fire) at the same time the neurons of the caregiver fire (Siegel, 2012). They are both experiencing something similar in their physical bodies, although they are separate individuals. This interchange assists in the development of

pathways in the brain. In other words, brain structures are altered as a result of the relational exchange. It has also been stated that these neurons play a role in the development of empathy (Pfeifer, Iacoboni, Mazziotta, & Dapretto, 2008). Thus, there is a biological component to how we connect to and are affected by our relationships.

The level of intimacy between people also has influence over the ways in which the experience or feelings of one impacts the other (Schore, 2002; van der Kolk, 2014). For example, the exchange between caregiver and infant described above describes a level of connectedness between the two. That deep connection is what can be attributed to the simultaneous firing of neurons. The depth of a connection causes one person to experience the same physiological reaction as the one to which he is connected (van der Kolk, 2014). This physiological response becomes the foundation for experiencing feelings, regulating emotion, and having connection with other people (Hambrick, et al, 2018; Schore & Schore, 2014; Teicher & Samson, 2016). Hambrick and colleagues (2018) conclude that the interpersonal process and the health of early relationships determine both the way a body may regulate when exposed to trauma, as well as the level of trust that one may have in others.

This theory of interpersonal neurobiology then provides a framework for understanding trauma, relationships, and even therapy. It is possible for a therapist to enter into an intimate healing relationship with a client (Schore & Schore, 2014). In fact, interpersonal neurobiology in trauma treatment focuses on intervening at the right brain level (Schore & Shore, 2014; Zaleski, et al., 2016). To be able to impact deep trauma stored in implicit memory, it is critical for therapists to also engage with that side of themselves. This creates the safety for clients to be seen and held, while also opening the therapist's affect and self. When working with a traumatized client, being open and staying attuned may lead to a deeper level of intimacy for

both the client and therapist (Barrett & Stone Fish, 2014). This, in turn, may increase the level of impact the client's material has on the therapist. In other words, the more a therapist connects to a client on an interpersonal neurobiological level, the more likely they are to be influenced by the client's trauma.

Trauma Theory

Trauma theory explains how adverse events impact individuals as well as the systems to which they belong (Herman, 1992; van der Kolk, 2014). The way in which our bodies respond to trauma is significant in the understanding of how both clients and therapists may respond to traumatic events. At the moment of exposure, the nervous system automatically responds to what is perceived as threatening. The body produces adrenaline, and activates the "flight, fight, or freeze" response (van der Kolk, 2014; Perry, 2009). The hippocampus is suppressed, and the amygdala records experiences as implicit or explicit memory (van der Kolk, 2014). The situation that is perceived as threatening, then, brings about a physiological response that does not allow the cortex to be activated. Therefore, access to cognition, rational thoughts, and problem solving is limited. This automatic response is what is in place when a client is experiencing trauma, which may require the therapist to work at deeper levels. For example, if a client is in a survival mindstate (Barrett & Stone Fish, 2014), he or she cannot access higher level thinking skills often used in psychotherapy. Attempting to develop a therapeutic relationship with someone who is in a survival mindstate takes a tremendous amount of energy. It is not only that hearing traumatic content may be challenging for therapists, what may also be difficult is attempting to stay in a helpful relationship with clients when they are in survival mindstates. The physiological survival response may also be what is activated when a therapist

with their own trauma is exposed to the client's traumatic material and/or difficulty in a challenging relationship.

Complex trauma impacts many clients in a way that may challenge the foundation of the therapeutic relationship. Childhood abuse and neglect lead one to mistrust adults and caregivers (Ford & Courtois, 2009; Hambrick, et al, 2018, Perry, 2009; van der Kolk, 1995). This mistrust requires therapists to work hard to be open and present for clients who have had these experiences. Treatment models call for therapists to be mindful, practice self-awareness, and be empathically attuned in order to most benefit their clients (Barrett & Stone Fish, 2014; Ford & Courtois, 2009). In some cases, the work required to be centered and in touch with one self in order to be connected may also pose a risk for therapists. This approach may very well lead therapists to be more vulnerable to the effects of their client's traumatic material.

The Role of Empathy

While many professionals (e.g., medical, emergency, first responders, etc.) risk symptoms associated with exposure to trauma, there may be something unique about the exposure to traumatic material in a therapeutic setting (Figley, 2002). It is the open and direct interchange between two human beings, the essence of the healing process, which contributes to how a therapist can be affected by the experiences of their clients. The nature of systems and the therapeutic relationship suggests that the client's experience and affect has some influence on the clinician. Being open and connected to clients may make it more likely that therapists will be impacted by their client's lives (Figley, 2002).

The very nature of therapy requires a therapist to engage with clients, to listen, be present, and experience empathy (Figley, 2002; Hunter, 2012). Carl Rogers defined empathy as

being able “to sense the client's private world as if it were your own” (Rogers, 1992, p 828). Therefore the task of a successful therapist is to essentially experience what the client has experienced. The connection between the client and therapist allows the client to share openly and invite the therapist into his or her world. In doing so, the therapist is able to deeply understand, and even experience the pain, joy, or contentment of the client. Although the experience and feeling originates with the client, the trust in the therapeutic relationship and therapists’ abilities to experience empathy brings them to their own experience of pain, joy, or satisfaction. The ways in which this experience can occur for therapists contributes to their feeling the pain or fear associated with trauma. It is not surprising that some therapists suffer from trauma they are exposed to in the course of their work. As a result, they may be susceptible to some of the very same conditions as clients.

Empathy is considered a necessary trait of a good therapist (Blow & Sprenkle, 2007). However, empathy also entails a process. It includes clients being able to share who they are and what their experiences have been openly. It is a therapist being able to witness and also deeply sense the experience of the other. In that sense, it is a systemic process. What is shared by the client is received by the therapist, and while the therapist is fully present and empathic, she is impacted. Others have also described empathy as a process, rather than a construct or individual characteristic (Singer & Lamm, 2009; Thomas, 2013). It can be rooted in neurobiology and defined as a complex process that is ongoing and involves feedback loops between people.

In his model for compassion fatigue, Figley (2002) differentiated between affective and cognitive empathy. Affective empathy is taking on the emotions of the client, whereas cognitive empathy refers to intellectually understanding the client’s experience. In other words, the

therapist utilizing affective empathy would be likely to feel the same feelings (terror, helplessness, loss), as the client expressing them. It may be that affective empathy and the role of emotion leads to greater emotional resonance, and possibly an increased and intense “direct” experience of trauma.

In her review of the neurobiology of empathy, Thomas (2013) delineates components believed to have an effect on empathy. These include “affective sharing” (Thomas, 2013, p. 367), which is similar to what an infant experiences in connection with an attuned caregiver. In psychotherapy, this would describe how what the client shares causes the therapist to recall shared meaning. The second component Thomas labels “self-other differentiation” (Thomas, 2013, p. 367). This is the therapist’s ability to separate the client’s feelings from his or her own emotional responses. The last component is the “cognitive process” (Thomas, 2013, p. 367). This entails the therapist being able to access higher level cognitive skills in order to process what is being said, assess what it means, make decisions about how to respond, and to enable regulation of emotion. This last component may be a critical part of understanding the interplay between physiological responses to trauma and the role of the therapist.

Some have argued that a lack of boundaries or differentiation can cause empathy to have a negative effect on therapists (Thomas, 2013). In other words, it has been attributed to the therapists’ inability to distinguish clients’ pain from their own. However, neuroscience has found ways to measure empathy (Iacobani, 2008). Such research has made it more clear that there is a difference between empathy and projection of one’s own experience (Gerdes, 2011). I would also argue that the client’s pain has a direct impact on the therapist’s experience of pain, especially if both are accessing processes connected to the right brain (Schoore & Schoore, 2014).

This is not due to a lack of boundaries, but because of the profound nature of the work. According to the DSM – 5, witnessing traumatic events can cause a person to have a traumatic response (American Psychiatric Association, 2013). Why then would having a traumatic response to witnessing traumatic stories of clients be very different? What seems more important is understanding how to minimize the negative impact. In addition, it may also help to better understand the factors that contribute to the ways a therapist may respond.

In conclusion, several theories provide a foundation for this study. Trauma theory is necessary to understand how trauma impacts clients and has implications for therapists as well. Systems theory and family therapy theory highlight the systemic nature and relationship between therapist and client. Lastly, neuroscience and empathy provide some understanding as to how therapists may develop compassion fatigue as a result of their work. The next section will further explain the prevalence and nature of the negative impact of working with trauma.

Negative Impact of Trauma Work on Therapists

Many who commit to the helping professions do so because they want to provide care and support to others. They desire to contribute something positive toward people and their communities. Often, those entering such professions are not fully aware of the risks they may face. Some are even less aware of the ways the stories they will be exposed to may affect them personally as well as professionally (Harr, 2013; Radley & Figley, 2007). Even those who are aware of the heaviness of working with trauma are sometimes surprised by the toll it takes on them. They begin full of hope and energized by the ways they can potentially make a difference. Yet, the intensity of the work and nature of exposure may be detrimental. Some therapists may find they are not as engaged in sessions, that they are physically exhausted and too tired to

complete usual tasks, or they may even suffer from symptoms such as intrusive thoughts and nightmares. Therapists may attribute these things to what is happening within them or maybe even in their personal lives, but they may not recognize that it is their work effecting their physical, spiritual, and psychological self.

Wilson and Lindy (1994) have labeled some of the ways in which trauma work can alter the experience and performance of a therapist. For example, empathic withdrawal refers to the therapist who is physically present in session but not available emotionally or cognitively to the client. Therapists who consistently think of their clients outside of session and feel overwhelmed with the responsibility of helping them may suffer from empathic enmeshment (Wilson & Lindy, 1994). Wilson and Lindy (1994) use empathic disequilibrium to describe therapists who are so moved by clients' stories that they remain feeling helpless and are rendered ineffective in their work. Each of these conditions have obvious implications for the therapist personally and professionally.

Research has measured the ways providers have been impacted by the traumatic material to which they are exposed (Figley, 1995; Figley, 2002; McCann & Pearlman, 1990; Stamm, 2010). Several terms have been coined with regard to trauma affecting helping professionals. These include compassion fatigue (previously termed secondary traumatic stress), vicarious trauma, and burnout. While some may use them interchangeably, there are notable differences between them. The way in which vicarious trauma or burnout develops, for example, is different. One tends to develop over time whereas the other may develop suddenly. In addition, the domains of impact on the therapist vary. Compassion fatigue impacts psychological and emotional functioning, whereas vicarious trauma has a greater hold on cognitive structures and personal values.

Prevalence

It has been estimated that anywhere from ten to 50 percent of those working with traumatized clients may suffer from compassion fatigue or vicarious trauma (Huggard, et al, 2017; Lawson, 2007; Tehrani, 2007). In his study, Lawson (2007) took a sample of members from the American Counselors Association. Demographics indicated a wide range of caseloads as well as a range of exposure to traumatic material, with average caseloads being 28 clients a week and those with trauma being about 36%. Only 11% of the 500 participants were deemed at high risk for compassion fatigue, as measured by the Professional Quality of Life (ProQOL) scale (Stamm, 2005). However, other studies suggest as many as 90% of therapists experience negative effects of working with trauma (Arnold, et al, 2005). In their qualitative study using naturalistic interviews with 21 licensed psychotherapists, Arnold, et.al., (2005) found that 19 of the participants, or 90%, experienced intrusive thoughts and images based on their client's trauma. It was estimated that 45% of their clinical work was trauma related. Another 71% described having negative emotional responses to their client's traumatic stories, including sadness, anger, shock, anxiety, helplessness, fear, and frustration. Such feelings and experiences are included in the criteria for compassion fatigue.

Some evidence suggests that therapists who work primarily with traumatized clients may be at even greater risk of developing compassion fatigue. In one study in the UK, researchers surveyed 253 therapists who worked primarily with traumatized adults (Sodeke-Gregson, et al., 2013). The ProQOL (Stamm, 2009) was used to determine both the prevalence of compassion fatigue as well as the predictive variables. Findings showed that 70% of therapists scored in the high range for secondary traumatic stress. This indicates that their risk for having symptoms of compassion fatigue was increased.

The studies cited above had findings that demonstrated a wide range of the prevalence of compassion fatigue. Perhaps the variance is related to the methodology. For example, one study used quantitative methods while the other was qualitative. The last study took place in another country, which may also speak to differences in the findings. Such variance, however, makes it apparent that a clear count of those suffering from working with traumatized clients may be useful.

The next section will include more in depth descriptions of the negative impact of trauma work on therapists. The concepts to be highlighted again are vicarious trauma, burnout, and compassion fatigue. The differences between these will be explored, as will the ways they have been found to coexist.

Vicarious Trauma

Vicarious trauma (VT) has been described as the alteration of a therapist's beliefs, cognitions and sense of safety in the world (McCann & Pearlman, 1990). This is based in constructivist theory, which states that our beliefs about the world are created by the ways we make meaning from the events in life. McCann and Pearlman (1990) noted that the effects of vicarious trauma could last long after the therapeutic interaction with a client. The other areas of a therapist's life that may be impacted include "safety, trust, esteem, intimacy, and control" (Baird & Kracen, 2006, p. 182). Therefore, the ways in which a therapist feels safe, views human beings, and engages in the world may be permanently altered because of their exposure to client's stories.

It seems that therapists would naturally alter their understanding of the world because of their experiences. In many ways, this new understanding is how we might grow and change in positive, more enlightened ways. However, vicarious trauma has debilitating effects, making

therapists disengage not only from their work, but their personal lives as well (McCann & Pearlman, 1990). Since there are costs associated with developing vicarious trauma, researchers have attempted to define some of the risk factors. In their study of 188 trauma therapists, Pearlman and MacIain (1995) found that those therapists who were new to the work suffered the most. They also discovered that those with a personal history of trauma were more likely to have symptoms of vicarious trauma. Much like clients who experience trauma first hand, all therapists do not have the same reaction to being exposed to trauma in their work. There has been an interest in identifying qualities and contextual factors that help to minimize the development of vicarious trauma. Pearlman and MacIain (1995) suggest specialized training, support, and supervision may serve as protective factors.

Burnout

Burnout is the result of work related stress and exhaustion that accumulates over time (Morse, Salyers, Rollens, Monroe-DeVita, & Pfahler, 2012; Paris & Hoge, 2010). It was originally viewed as a way to assess the negative impact of stressful work experiences in the human services field (Maslach, 1976). Burnout is a phenomenon that has been studied primarily in order to prevent turnover in the workplace. However, it has also been measured in those providing psychotherapy services (Rosenberg & Pace, 2006).

Burnout is characterized as an overwhelming sense of exhaustion. Workers suffering from burnout are often detached from their jobs, tend to feel ineffective, and are likely to be less productive (Maslach, 2003). Measures of burnout look at three areas: emotional exhaustion, depersonalization, and a reduced sense of accomplishment (Paris & Hoge, 2009; Morse, et.al. 2012). In their meta-analysis of studies of burnout in mental health, Paris & Hodge (2009) noted the following as contributing factors to exhaustion: long hours, loss of control over work

environment, and demands of the workplace. Depersonalization was found to be connected to “negative client behaviors”, not feeling valued as a profession or an employee, and not having collegial supports. Accomplishment was associated with the number of hours providing therapy as well as salary. The researchers were clear, however, that these correlates should be considered as “potential”, as the original studies were either not clear on variables or were methodologically weak.

Burnout can occur in any profession, as it is most related to dissatisfaction in the work environment. It tends to be associated with fatigue and stress related to specific job tasks, such as paperwork and long work hours (Paris & Hoge, 2010). Burnout is a result of being immersed in distressing work environments over a period of time. It does not appear to be directly linked to clinical work or the type of material clients bring into session. Although burnout is not specific to those working in mental health, it does affect therapists in the same way as other professions. As some of the studies reviewed later in the chapter will show, burnout can accompany other factors, such as compassion fatigue.

Compassion Fatigue

Originally identified as secondary traumatic stress (Figley, 1995), compassion fatigue is now labeled a condition specifically affecting those working with traumatized clients. In his article, Figley states the “meaning of compassion is to bear suffering” (Figley, 2002, p.1434). Compassion fatigue, then, is what may arise when therapists continually bear the suffering of their clients.

In his theoretical model for compassion fatigue, Figley (2002) includes several factors in its development. The constructs most related to the individual helper include empathic ability, empathic response, and residual compassion stress. Whether these lead to the development of

compassion fatigue depends on outside influences. The figure below provides a visual for the model (Figley, 2002, p. 1437.)

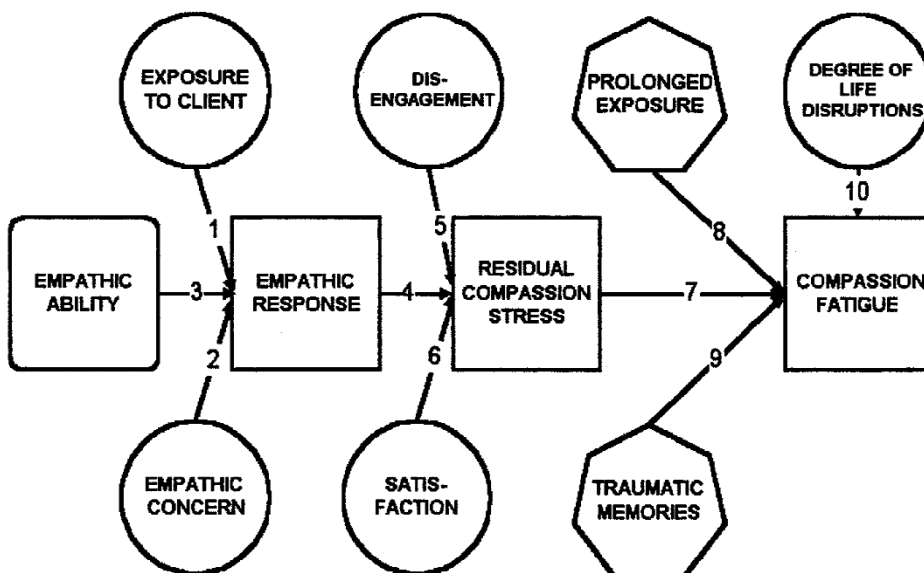


Figure 1. Compassion Stress and Fatigue Model (Figley, 1995, 1997).

Figley hypothesizes that the client story (or exposure) combines with the therapist's ability and empathic concern, which may elicit an empathic response. At the next stage, the amount of disengagement or satisfaction that the therapist experiences may contribute to residual compassion stress. In the last stage, prolonged exposure to traumatic material as well as personal traumatic memories may determine whether compassion fatigue develops. The last personal factor that has influence in the model is the degree to which the therapist experiences other disruptions in life. Other disruptions include life events such as illness, job loss, and financial strain.

Figley's model of compassion fatigue takes both personal characteristics and external factors into account. An individual therapist either intuitively has or develops empathic ability. As discussed in the theoretical section, empathy is critical both in therapy work as well as

understanding the ways client material can impact a therapist. Moving through the model, one can see that there is an interplay between the individual therapist's responses to client material and outside factors, such as the amount of exposure and other negative life events. The culmination of these factors may lead to compassion fatigue.

The manifestation of compassion fatigue includes therapists developing symptoms because of their exposure to the clients' stories. Such symptoms are very similar to PTSD, and include distressing feelings, thoughts, or images, and a decrease in functioning (Bride, Radey, & Figley, 2007). Those suffering from compassion fatigue may have difficulty sleeping, exaggerated physical reflexes, be more emotionally reactive, and be hypervigilant (Figley, 1995). Therapists may also suffer from depression, nightmares, loss of interest in work and personal life, and intrusive thoughts. Such symptoms can manifest in the emotional, intellectual, physical, and psychological functioning of therapists. Thus, it seems that compassion fatigue may hold great potential for both personal and professional hazards for therapists.

Compassion fatigue, being rooted in the way a therapist empathizes with a client, has implications for those whose work relies on developing a deep connection. Those therapists who value relationships and are trained to use them as a clinical tool may then be at greater risk (Negash & Sahin, 2011). In addition, the therapist who is experiencing fatigue may be less able to provide that empathy required for clients to heal. This, in turn, puts clients at risk. Compassion fatigue, then, not only poses a threat for therapists, but it can endanger clients as well, leading to potential re-traumatization. Ethically, then, therapists should maintain an awareness of symptoms related to compassion fatigue and seek assistance in their own recovery.

Connection between Vicarious Trauma, Burnout and Compassion Fatigue

There are certainly similarities in the concepts of vicarious trauma, burnout, and compassion fatigue. For example, all three have been used to describe and quantify the detrimental effects of working in human services. However, as articulated above, the symptoms and specific domains of impact vary. Although vicarious trauma, burnout and compassion fatigue appear to have different indicators, there still seems to be a lack of clarity in the field around distinguishing features (Baird & Kracen, 2006; Cieslak, et.al, 2014; McKim & Smith – Adcock, 2014). For example, some have used secondary traumatic stress interchangeably with compassion fatigue and vicarious trauma (Cieslak, et.al, 2014). Others suggest that the terms vicarious trauma and compassion fatigue are not entirely distinct (McKim & Smith-Adcock, 2014). Thus, there may be a lack of clarity on what construct is actually being measured in research studies. Many studies, in fact, examine one or more of these conditions at the same time. This makes it difficult for the field to draw clear conclusions about the measurement and existence of any of these constructs.

The method of measurement itself may influence what is being assessed. The Professional Quality of Life (ProQOL) scale (Stamm, 2010), for example, includes measures for both burnout and compassion fatigue in the same instrument. The instrument has questions that pertain to burnout and secondary traumatic stress, as well as compassion satisfaction. The creators of the ProQOL explain that compassion fatigue has elements of both secondary traumatic stress symptoms (ex. invasive thoughts, depression, difficulty functioning) as well as burnout (exhaustion). Therefore, while the instrument measures secondary traumatic stress, compassion satisfaction and burnout, the subscales include items that overlap with other constructs. This is particularly relevant, as many quantitative studies use the ProQOL (e.g., Baird & Kracen, 2006; Cieslak, et.al, 2014).

There is evidence that these three concepts of vicarious trauma, burnout, and compassion fatigue are related and co-exist (Cieslak, et.al, 2014). Cieslak, et.al. (2014) conducted a meta-analysis of 41 quantitative studies in which participants worked with traumatized clients. The analysis indicated that there were two main categories of negative impact of working with clients who have experienced trauma. The first was defined as secondary traumatic stress (STS) and included PTSD symptoms, vicarious trauma, and compassion fatigue. It may be important to note that in this analysis, three potentially distinct concepts were combined into the category of STS. This was likely due to the variance of concepts measured in the original studies. At the same time, combining them all into one category for this analysis means that some of the distinguishing features are lost. It is also an example of the ways the literature can lead to confusion and the blending of terms. Job burnout was the second category identified in the Cieslak, et. al (2014) study. Using their created categories, they found that there was a significant positive relationship between burnout and secondary traumatic stress. The analysis indicated that the strength of the relationship between job burnout and STS was determined by the measurement used, with studies using the ProQOL showing stronger correlations. The analysis also uncovered the idea that the ProQOL used a broader definition of secondary traumatic stress, unlike others that either looked solely at PTSD type symptoms or vicarious trauma.

The meta-analysis also examined moderating factors between STS and burnout. Cieslak, et.al. (2014) determined that gender was a moderator between STS and burnout, with females showing stronger connections between the two concepts. Thus, women seemed to have a stronger connection between job burnout and secondary traumatic stress as it was defined in the study. Another interesting finding was that workers with a combination of direct and indirect

exposure to trauma (due to the nature of the workplace) resulted in having less association between STS and burnout than professions with only secondary exposure (as in mental health professions). In other words, there was a greater connection between STS and burnout for those professionals who experienced trauma only through their clients. Professions who might be directly exposed to trauma, such as medical professionals or emergency responders, did not have as high of a connection between STS and burnout. The study suggests that more research is needed to explore both risk and protective factors that differentiate between compassion fatigue, burnout, and secondary PTSD. In addition, this study showed preliminary evidence that there is something unique about secondary exposure that has the potential for increased cost to a therapist.

Despite the interconnection between the terms and the fact that therapists may experience one or more of these conditions, this study will examine compassion fatigue. This has the most sudden onset and is thought to be the most curable or preventable (Stamm, 2002). Compassion fatigue seems to encompass the broader definition of the negative effects of working in the field of trauma. Thus, therapists suffering from compassion fatigue may have higher costs to their personal and professional well being, not to mention the cost to the clients they serve. Lastly, compassion fatigue seems to have the strongest connection to the therapeutic relationship and the use of empathy, which is critical in working in therapy with traumatized clients. This is a distinguishing feature that did not appear to be present in the literature on vicarious trauma or burnout. Vicarious trauma appears to affect thoughts and belief systems. It does not appear to be as linked to specific therapeutic processes as much as it is to the type of clients and workload. Burnout is clearly applicable in almost any line of work. Since the primary interest of this writer

is in the training and support of therapists, compassion fatigue is the most relevant concept to explore.

Factors in Developing Compassion Fatigue

Therapists are impacted by their clients' traumatic experiences in different ways (Figley, 2002; Hensel, et al., 2015; Pearlman & MacIan, 1995; Sinclair, et al., 2017). Just as clients may have varied responses to similar experiences, therapists will not all be impacted by their work in the same way. Why are some therapists moved to tears when they witness the painful stories of their clients while others feel nothing? Perhaps it is related to the level of the relationship, the awareness of the therapist, or the theoretical model from which they operate. Perhaps it is something about individual therapists themselves, or the circumstances that have brought them to that particular point in time. It is intriguing enough that it has been the subject of many studies (Cocker & Joss, 2016; Figley, 2002, Maslach, 1976; Pearlman & Mac Ian, 1995; Sinclair, et al, 2017). This section will explore the factors identified in the development of compassion fatigue.

Researchers have focused on understanding the concept of compassion fatigue and identifying risk factors associated with its development (Craig & Sprang, 2010; Figley, 1995; Figley, 2002; Ray, Wong, White, & Heaslip, 2013; Sprang, et al., 2007; Way, VanDeusen, Martin, Applegate, & Jandle, 2004). Personal experiences and characteristics, as well as workplace environments have been recognized as possible variables contributing to compassion fatigue. Some specific categories of risk include age, gender, number of trauma cases, personal history of trauma, workplace stress, and work environment. Some of the more consistently identified factors are detailed below. All of the studies conducted were in the United States, unless otherwise noted.

Gender, age, and experience. In their study, Sprang, et al. (2007) found that the risk of compassion fatigue was influenced by gender. The participants included 1121 mental health practitioners in a rural southern state. Roughly 70% were female, while the other 30% identified as male. Compassion fatigue was assessed using the ProQOL (Stamm, 2010). A multivariate analysis of variance indicated that females were at an increased risk for compassion fatigue. Rossi, et.al., (2012) also used the ProQOL to assess compassion fatigue in 260 professional psychiatric staff in Italy. They also concluded that females in their sample were at an increased risk for compassion fatigue. Contrary to these findings, there have also been studies that did not find gender to be a variable in compassion fatigue (Craig & Sprang, 2010). In some cases, females may have reported more stress or compassion fatigue, but gender was not a statistically significant predictor of compassion fatigue (Thompson, et al., 2014).

Although findings have been mixed, age has been found to be a significant factor in some studies of compassion fatigue (Craig & Sprang, 2010; Sodeke-Gregson, Holttum, & Billings, 2013). In their study, Craig and Sprang (2010) examined age as a variable for compassion fatigue. They surveyed 532 clinical psychologists and social workers using the ProQOL III (Stamm, 2005). Using hierarchical regression, the investigators found that age was a significant predictor in the development of compassion fatigue. Younger therapists tended to have more compassion fatigue. However, as additional variables were added into the model, age was no longer statistically significant, instead, the amount of experience was significant. Those with less experience were at a greater risk of developing compassion fatigue.

Amount of exposure. The amount of trauma therapists are exposed to is also considered a risk factor in compassion fatigue. Exposure can be defined as how many trauma cases a therapist carries, as well as the number of years someone works in the field. In their study,

Sodeke-Gregson, et.al. (2013) surveyed 253 therapists working in the UK. They measured compassion fatigue using the ProQOL (Stamm, 2005). Results indicated that 70% of therapists whose caseload consisted solely of adult trauma survivors were at high risk for compassion fatigue. It may be concluded that having entire caseloads of traumatized clients increases the incidence of compassion fatigue.

Additional studies have also found that the amount of exposure to traumatized cases is connected to compassion fatigue. An increased percentage of PTSD clients on a caseload increases risk for compassion fatigue and burnout (Craig & Sprang, 2010; Sprang, et al., 2007). However, other studies did not find the same association (Adams, Boscarino, & Figley, 2006). There seems then to be additional factors that determine whether caseload and exposure result in compassion fatigue.

Training. Some studies have addressed both the discipline of professionals in the field as well as the specific trauma training that therapists may have received. Most research samples have included professionals from a variety of disciplines (Baird & Kracen, 2006; Craig & Sprang, 2010; Huggard, et al., 2017; Ray, et.al., 2013; Pearlman & MacIan, 1995). In some cases, the differences in profession were examined as to whether that influenced the risk for developing compassion fatigue. In their study, Sprang, et al. (2007) found that psychiatrists were at greater risk for compassion fatigue than other mental health professionals. This may indicate that the type of professional background or the specific job tasks, as well as trauma focused training impacts the degree to which therapists may develop symptomology.

Workplace stress. There is an interconnection between compassion fatigue and work environments. In their study, Ray, et al. (2013) received surveys from 169 frontline mental health care professionals from Ontario, Canada. Frontline health care professionals included full

and part time staff who had direct care of clients. The specific professions included nurses, social workers, psychologists, case managers, and mental health workers with various educational backgrounds. Roughly 80% of the respondents were female and 78 of the professionals were those with either a diploma or bachelor's degree. The measures included the ProQOL (Stamm, 2010) Areas of Work Life Scale (Leiter & Maslach, 2000), the Maslach Burnout Inventory (Maslach, Jackson, & Leiter, 1996), and a demographic questionnaire. The researchers were able to confirm their hypothesis that greater compassion satisfaction and lower compassion fatigue, along with a greater match in work life predict lower rates of burnout. One interesting finding was that while those with a trauma history had higher scores in compassion fatigue and emotional exhaustion, the results were not statistically significant. The authors suggest that the lack of significance may have been related to the size of the sample. They also state that support and/or supervision may help to minimize the risk of exhaustion and compassion fatigue for those with trauma histories.

In his qualitative study, Killian (2008) interviewed 20 clinicians who were working in agencies in metropolitan Texas that served survivors of childhood sexual abuse. There were 16 females and four males included in the study, and the length of experience ranged from two to 16 years. Ten were licensed as Social Workers, two were PhD Counseling Psychologists, four were licensed Professional Counselors, and there was one licensed Marriage and Family Therapist. Semi-structured interviews were conducted and results were analyzed. The main categories participants identified included recognizing symptoms of work stress, risk factors in developing burnout, definitions of self-care, and specific self care strategies. They also generated a list of risk factors, including high caseloads, history of personal trauma, lack of regular supervision, lack of a supportive work environment, social isolation, worldview, and lack of self awareness.

There are some conclusions that can be drawn from the literature on factors related to compassion fatigue. It appears as though the length of time in the field and the degree to which one is exposed to secondary trauma increases risk (Sodeke-Gregson, et al., 2013). In addition, the type of training one receives both professionally and specifically related to trauma may decrease risk for compassion fatigue (Sprang, et al., 2007). There is also significant information indicating the work environment weighs heavily on compassion fatigue (Killian, 2008; Ray, et.al, 2013). However, there still seems to be a lack of clarity on the significance of individual factors. This seems critical to the understanding and prevention of compassion fatigue. Therefore, this next section will examine the role of personal trauma in compassion fatigue.

Personal trauma. Research has shown that the clinician who experienced personal trauma in their own history may have increased risk for compassion fatigue or vicarious trauma (Cunningham, 2003; Hensel et al., 2015; Killian, 2008; Pearlman & Mac Ian, 1995). In their study, Pearlman and Mac Ian (1995) surveyed 136 participants who considered themselves to be trauma therapists. Seventy two percent were female, 93% were White, and they ranged in age from 23 to 74. Participants reported working with trauma survivors an average of 9.59 years. Researchers developed a questionnaire inquiring about work with trauma, whether the clinician had a trauma history, age, income, work setting, use of personal therapy, and whether they received supervision regularly. Dependent measures included the Traumatic Stress Institute Belief Scale (Pearlman, 1995), the Impact of Event Scale (IES; Horowitz, Wilner, & Alvarez, 1980), the Symptom Checklist – 90 – Revised (SCL-90-R; Derogatis, 1977), and the Marlowe-Crowne Social Desirability Scale (Crowne & Marlowe, 1964). Multiple regression analysis indicated that those with personal trauma history and those who had personal therapy had the most significant negative impact. Sixty percent of the participants answered “Do you have a

trauma history” positively. Further analysis showed that personal trauma resulted in significant differences in Safety, Self-Trust, Self-Esteem, Other-Trust, and Other-Intimacy subscales of the TSI Belief Scale. While the authors conclude that those with personal histories were suffering more, it was not clear whether it was due to their own trauma or to their exposure in clinical work. An interesting finding was that newer therapists seemed to have the most difficulties. This group was also serving the most distressed clients and was not receiving supervision. While this study measured disrupted schemas more closely related to vicarious trauma, it does point to the importance of several variables, including personal trauma, personal therapy, supervision, and client composition.

In their epidemiological study using levels of evidence, Baird and Kracen (2006) examined all existing research on vicarious trauma and secondary traumatic stress. Due to the relative newness of the concepts, the lack of clarity on the constructs, various methodological issues within studies, and a lack of peer reviewed publications, they performed a research synthesis. In doing so, they rated research findings according to whether they were published in peer reviewed journals, or if they had methodological weaknesses or were not peer reviewed (dissertations or book chapters, for example). The codes reflected levels of evidence, with “persuasive” being the highest, followed by “reasonable”, then “some”. Their results indicated there was “persuasive evidence” that a personal history of trauma was a risk factor for vicarious trauma. They also concluded that previous research provides “reasonable evidence” that personal trauma history is connected to developing secondary traumatic stress. Interestingly, there was also “reasonable evidence” that personal trauma history is not a risk factor for secondary traumatic stress. Clearly, there is a discrepancy as to the risk that personal trauma presents for clinicians. Baird & Kracen also found “persuasive” evidence that the amount of

exposure increased risk for developing secondary traumatic stress, while “some evidence” existed for exposure not increasing risk. There was “reasonable evidence” that exposure did not increase risk for vicarious trauma. The authors conclude that more studies that determine additional risk factors are needed.

In her study, Thomas (2013) found that more personal distress contributed to higher compassion fatigue and lower compassion satisfaction. In the study, 171 Licensed Clinical Social Workers from one southern US state completed surveys sent through the mail. They ranged in age from 31 to 80 years old, and over 81% were female. Fifty five percent reported some childhood trauma history and 43% reported experiencing trauma in adulthood. Measures included the ProQOL (Stamm, 2010) and the Interpersonal Reactivity Index (IRI, Davis, 1980). The most significant variable in compassion fatigue, burnout, and compassion satisfaction was personal distress, as measured by the IRI (Davis, 1980). Regression analysis showed that those who reported history of adult trauma had higher compassion fatigue scores than those with no reported adult trauma. Adult trauma was not found to have a significant relationship with burnout or compassion satisfaction. The authors suggest that a more robust measure of trauma may provide a better understanding of its impact on compassion fatigue.

Rossi, et.al., (2012) also found that experiencing recent negative life events increased compassion fatigue. Their study measured the levels of compassion fatigue, burnout, and compassion satisfaction of 260 mental health professionals in a community mental health center in Italy. They used the ProQOL (Stamm, 2005), the General Health Questionnaire (GHQ-12; Piccinelli, Risoffi, Bon, Cunico, & Tansella, 1993), and a socio-demographic questionnaire. Some of the findings indicated those with more recent negative life events had higher burnout and compassion fatigue scores. Specifically, recent negative events, personal lifetime traumatic

events, and general distress were associated with higher compassion fatigue scores. Participants with psychological distress also had higher scores on burnout and compassion fatigue and lower compassion satisfaction. There was a significant correlation between burnout and compassion fatigue as well as between burnout and distress. There was also a negative correlation between compassion fatigue and compassion satisfaction, suggesting that compassion fatigue may prevent a clinician from experiencing compassion satisfaction. However, the study did not measure coping skills or other training specific to working with trauma. The authors suggest that this should be explored in further studies.

The evidence for the impact of personal trauma on therapists appears inconclusive (Baird & Kracen, 2006; Thomas, 2013). Some studies found that personal trauma has raised the level of risk for negative effects. However, it calls into question how that was measured. For example, some surveys simply asked whether the therapist ever experienced a traumatic event (Pearlman & MacIain, 1995). Others measured level of distress, which may or may not have been related to personal trauma (Thomas, 2013). Most people are exposed to at least one violent or life-threatening situation during the course of their lives (Ozer, Best, Lipsey, & Weiss, 2003). Therefore, it would seem that any therapist could have increased risk for compassion fatigue. There may be other levels of variance, other than the experience itself, that contribute to whether a therapist with personal trauma develops compassion fatigue. This study aims to identify not just whether therapists have experienced trauma, but whether they have experienced growth as a result. The amount of healing may be one of the factors that determines whether the therapists own trauma leads to increased risk for compassion fatigue or, conversely, to compassion satisfaction.

To summarize, there have been several factors identified as having an impact on compassion fatigue. Some factors, such as age and gender, have been shown to be significant in some studies and insignificant in others. There are also some factors that appear to have a more consistent effect, such as experience and the amount of exposure to trauma via caseload. Workplace variables, such as the amount of support, supervision, and hours worked also seem to influence risk. There have also been findings linking the therapist's personal trauma to higher compassion fatigue, but inconsistent findings seem to warrant further exploration.

Factors that Decrease Compassion Fatigue

As noted above, there are several areas of risk associated with increased compassion fatigue. There have also been findings that acknowledge protective factors. These areas can be viewed as contextual or workplace factors, as well as personal attributes. Several of the studies in this section include compassion satisfaction as a measure of decreased compassion fatigue. Compassion satisfaction as a construct will be discussed later in the chapter.

While some have found that personal variables do not reduce compassion fatigue (Bober & Regehr, 2006; Killian, 2008), more recent research indicates that personal lifestyle practices may be beneficial to therapists. In their study, Thompson, et al., (2014) examined five personal resources that were believed to influence compassion fatigue, burnout, and compassion satisfaction. The sample included 213 self-identified mental health workers in the US who completed an online survey. Measures included Perceived Working Conditions Scale (created for this study), the brief COPE Inventory (Carver, 1997), the Mindfulness Attention Awareness Scale (MAAS; Brown & Ryan, 2003), and the ProQOL (Stamm, 2010). The investigators found that mindfulness and coping strategies significantly influenced compassion fatigue and burnout. Their findings also seemed to support the notion that workplace factors contribute more to

burnout, whereas personal factors have more influence on compassion fatigue. Specific personal resources such as mindfulness and positive coping strategies were associated with decreased compassion fatigue as well as decreased burnout. The study also found that compassion satisfaction was the strongest predictor and inversely related to burnout. The authors suggest that a better understanding of compassion satisfaction may be useful in preparing therapists. The study also suggests that using personal trauma as a predictor of compassion fatigue may be worth further investigation.

Some studies have identified additional personal variables that correlate with compassion fatigue, burnout, and compassion satisfaction (Pardess, Mikulincer, Dekel, & Shaver, 2014; Thomas & Otis, 2010). For example, attachment style was found to have an influence on compassion fatigue (Pardess, et.al, 2014). Pardess, et.al., surveyed 148 volunteers who worked with trauma victims in Israel. In order to measure the connection between attachment style and compassion fatigue, they used the Experiences in Close Relationships (ECR; Brennan et al.,1998) and the ProQOL – Version III (Stamm, 2005). Hierarchical regression analysis led to the finding that attachment insecurities were significantly associated with compassion fatigue. It may be important to note that the sample was not mental health professionals. This may be indicative not just of the role attachment style may play, but it may give credence to the importance of training and self-awareness in the area of clinical work with trauma.

In conclusion, there is evidence that therapists who work with traumatized clients are at risk from suffering from the negative impact of their work (Baird & Kracen, 2006; Hensel et al., 2018; Killian, 2008; Pearlman & MacJan, 1995). Numerous factors include personal characteristics, such as amount of experience, specialized training, and whether the therapists themselves experienced trauma. Contextual factors include caseload type and size, the level of

support and supervision, and the degree to which one has control in the workplace. However, the variance in the measurement of these factors, not to mention findings that are in direct opposition, call for more study.

While there is a list of risk factors in the development of compassion fatigue, there are also ways in which the harm can be reduced. Some of the research cited above included measurement of the ways in which trauma work may yield positive results for therapists. In some studies, the concept of growth or satisfaction coexisted with compassion fatigue (Killian, 2008; Thompson, et al., 2014). The next section will identify the ways in which therapists may benefit from working with traumatized clients. It will conclude with examining the possible connection between the concepts of compassion fatigue and compassion satisfaction.

The Positive Impact of Trauma Work

Much of the research on trauma assesses the negative impact and pathology that can develop as a result of exposure. While statistics show the high exposure human beings have to traumatic events, not every person develops symptoms of PTSD (Kessler, et al., 2005). Some would contend that there are several protective factors that can prevent the development of PTSD. For example, the literature on resilience points to characteristics within individuals and the environment that can assist people in overcoming adversity (Bonanno, 2008; Hambrick, 2018).

Similarly, the literature on the impact of trauma on mental health workers has focused on the detriments, the risk, and the pathology that can evolve (Figley, 2002; Hensel, et al, 2015; Killian, 2008; McCann & Pearlman, 1995). While these negative effects are certainly important to assess for and take action to prevent or treat, it is also important to be aware of the ways in which positive outcomes can result in doing this work. Researchers have identified vicarious

resilience, vicarious post traumatic growth, and compassion satisfaction as ways therapists may benefit from working with traumatized clients. These are the constructs that will be examined below.

Vicarious Resilience

Vicarious resilience is one construct that has been identified as a positive outcome of working with traumatized clients. The theory suggests that therapists undergo a transformation in their beliefs as a result of working with trauma (Hernandez, et.al., 2007). As with vicarious trauma, the resilience is based on what the therapist experiences through witnessing traumatized clients. However, rather than developing fear or mistrust, vicarious resilience leads the therapist to be open and appreciative. It is through witnessing the strength and courage of clients that therapists also develop their own sense of resiliency.

In their qualitative study, Hernandez, et al. (2007) asked 12 clinicians working in Columbia, South America, how their client's resilience had affected them. The participants all had experience working with victims of kidnapping, displacement, and political violence. Participants noted the ways in which clients taught them about human capacity to overcome adversity. They seemed to find hope through their clients and inspiration to continue doing the work. Additional findings included an appreciation of their own problems, meaning that they viewed their problems as minimal in comparison to the difficulties their clients faced. Participants also recognized the importance of spirituality as a result of their work. Vicarious resilience may be related to the ways in which therapists ascribe meaning to terrible events their clients experience, put forth an optimistic attitude, and develop a greater sense of spirituality (Walsh, 2003).

In further studies using a sample from the United States, Engstrom, et al. (2008) discovered that working with traumatized clients who showed resilience impacted therapists in significant ways. As in the Columbian study, participants worked with survivors of torture. Semi structured interviews were conducted, transcribed, and coded. Some of the themes that emerged included a deeper appreciation for one's ability to thrive, a shift in meaning and value of life, and recognition of the value of therapeutic work. The researchers note that these shifts have cognitive, emotional, and behavioral ramifications. While the studies of vicarious resilience identify the profound beneficial effects the work can have on therapists, the way in which this develops is less clear.

Vicarious Post Traumatic Growth

When tragic or painful events occur, most people are aware of the distress that can follow. Indeed, that is likely why assistance is offered to those who suffer, and medical and human services fields have developed interventions to ease such suffering. However, those who endure such pain can also experience growth and renewed motivation to overcome adversity. Post traumatic growth (PTG) is a term that has been used to describe the benefits that some experience after an illness or life threatening event (Tedechi & Calhoun, 2001). Theorists include three dimensions in PTG. They are a new sense of self, changes in interpersonal relationships, and a deeper understanding of the meaning of life (Arnold, et.al., 2005). This type of growth is observed many times in survivors who organize groups to raise awareness of the experience or event from which they recovered (or continue to fight). Very often, those who have survived an ordeal have a desire to both share their wisdom and help others. There is a sense of altruism or a way in which survivors aspire to make a difference in the lives of others. In doing so, they also gain something from the process.

Vicarious post traumatic growth is built upon the notion of post traumatic growth. It has been used to describe the positive changes in therapists who work with traumatized clients that demonstrate growth (Arnold, et.al, 2005). Vicarious post traumatic growth can account for the ways therapists change personally and develop new views of the world and their purpose. In their qualitative study of 21 licensed psychotherapists from the Southeast United States, Arnold, et.al (2005) found that 74% of clinicians first responded with the positive impact of working with traumatized clients, whereas the other 24% began with the negative effects. An incredible 100% of the participants acknowledged having a negative response at some time to the work, and 90% stated they had experienced intrusive thoughts or nightmares at one point during their careers. However, clinicians also articulated having deep and powerful positive experiences because of their work. The researchers note that the areas of impact are very similar to those of post traumatic growth, echoing changes to their sense of self, relationships, and philosophies of life. Some specific areas of enhancement included a deeper sense of spirituality, a new appreciation of the human spirit, and increased compassion, tolerance, insight, and sensitivity. This study leads one to question whether the positive and negative effects can coexist. Does the growth and shift in perspective outweigh the adverse symptoms?

In another study on vicarious post traumatic growth, Brockhouse, Msetfi, Cohen & Joseph (2011) surveyed 118 therapists in the United Kingdom who worked with traumatized clients. They measured the amount of exposure to trauma by calculating years of experience as well as the number of hours spent working with traumatized clients. The other instruments included the Jefferson Physician empathy scale (Hojat, et.al., 2002), the Sense of Coherence Scale (Antonovsky, 1993), the Perceived Organizational Support Scale (Eisenberger, Stinglhamber, Vandenberghe, Sucharski, & Rhoades, 2002), and the Post Traumatic Growth

Inventory (PTGI, Tedeschi & Calhoun, 1996). Regression analysis confirmed that vicarious exposure to trauma positively predicted growth. In addition, empathy was found to be the only significant moderating variable between exposure and growth. In other words, the amount of growth was influenced by the level of empathy measured in the therapist.

These studies are significant in that they confirm the ways that therapists may experience growth as a result of their work, even when they also experience adverse effects. The nature of vicarious growth is that it builds over time. Therefore, it raises the question as to whether it takes experience and exposure to develop such growth. The Brockhouse, et.al. (2011) study also points back to the critical role of empathy. While compassion fatigue models suggest empathy poses risk, the study on post traumatic growth suggests empathy increases benefits to the therapist.

In the literature for both vicarious post traumatic growth and vicarious resilience, there seems to be evidence of the ways in which therapists can benefit in both their personal as well as professional lives. The measurement of vicarious post traumatic growth has included quantitative measures designed to measure change after traumatic experiences (Tedeschi & Calhoun, 1996), whereas vicarious resilience has been identified by mostly qualitative measures. However, both concepts highlight similar areas of positive change for the personal and professional self of the therapist.

Compassion Satisfaction

Another construct that addresses the benefit of therapy work with trauma is compassion satisfaction. Compassion satisfaction was derived as a way to address the positive aspects of human services work (Radey & Figley, 2007). It is a condition that looks specifically at the pleasure of helping others heal from trauma through therapeutic work. After years of

researching compassion fatigue, Figley and colleagues called for a paradigm shift. In other words, they encouraged the field to change its focus towards the positive aspects of working with people who were suffering (Radey & Figley, 2007). According to Radey and Figley (2007), compassion satisfaction is based in Frederickson's broaden-and-build theory. Frederickson's theory was centered on the idea of positivity and the ways it impacts negativity. The belief is that focusing on the positive can alter negative thoughts and feelings. Radey and Figley applied this concept to compassion satisfaction and compassion fatigue, arguing that focusing on the positive aspects of trauma work (compassion satisfaction) and building upon them might balance out the negative components (compassion fatigue).

Compassion satisfaction includes the sense of accomplishment therapists may experience when they feel as though they are able to make a change in the world (Stamm, 2002).

Compassion satisfaction is also influenced by how well therapists perceive they are doing their job. The amount of control individuals have over their exposure to traumatic material has an impact on this perception. Lastly, compassion satisfaction is influenced by how much support a therapist experiences in and out of the workplace (Stamm, 2002).

Studies have identified the factors that contribute to therapist's experiencing compassion satisfaction. These include social support, clinical supervision, education and experience, training in trauma work, use of coping skills, and perception of control (Craig & Sprang, 2010; Dehlin & Lundh, 2018; Figley, 2002; Killian, 2008; Rossi et.al., 2012). In fact, many of the factors that influence compassion satisfaction are the same elements that impact compassion fatigue. The relationship between satisfaction and fatigue will be discussed later in the chapter.

In the quantitative component of his study, Killian (2008) surveyed 104 therapists who specialized in trauma work. Measures included Social Support Index (McCubbin, Patterson, &

Glynn, 1982), the 28-item Brief COPE (Carver, 1997), and the ProQOL III (Stamm, 2003). Multiple regression was used to find three factors that influenced compassion satisfaction. These included social support, hours of contact with clients, and locus of control in the workplace. Having support from friends and family had the most significant effect on increasing compassion satisfaction. Therapists sensing greater control over the workplace also had increased compassion satisfaction. Lastly, having more hours in contact with traumatized clients reduced compassion satisfaction.

In another study of trauma specialists, Craig & Sprang (2010) surveyed 532 Social Workers and Psychologists from the US. The sample included 34% males and 65% females, with an average age of 50. The amount of experience ranged from 1 to 58 years, with the average being 22.9. The measures included the ProQOL III (Stamm, 2005), and the Trauma Practices Questionnaire (TPQ; Craig & Sprang, 2009). Results indicate therapists who had specialized training in trauma seemed to have greater compassion satisfaction. Increased experience and the use of evidence based practices was also found to decrease compassion fatigue and increase compassion satisfaction. Other factors found to have significant positive effects on compassion satisfaction include a sense of spirituality and personal locus of control (Zerach, 2013).

While constructs such as vicarious resilience, vicarious post traumatic growth, and compassion satisfaction have been identified, it seems that they also coexist with the risks of doing trauma work. In other words, therapists may reap the benefits as well as bear the risks associated with working with trauma. Some studies suggest that an increase in satisfaction may minimize the risk of fatigue (Samios, et.al, 2013). Therefore, it seems important to better understand the factors that contribute to a better balance, where benefits outweigh the risk.

In summary, compassion satisfaction has been identified in larger samples using quantitative measures. As with compassion fatigue, variables include personal factors as well as those related to the workplace. Examples include the number of years of experience, the length of time exposed to traumatized clients, and the amount of support received from friends and family. Additional factors include spirituality, a sense of control, and perception of accomplishment. Since some of these same variables also influence development of compassion fatigue, looking at the two constructs together seems most appropriate.

Relationship between Compassion Fatigue and Compassion Satisfaction

Some research has concluded that compassion fatigue and compassion satisfaction co-exist and influence the other (de Figueiredo, Yetwin, Sherer, Radzik, & Iverson, 2014; Rossi, et.al, 2012). In some studies, there was a significant negative correlation between compassion fatigue and compassion satisfaction (Rossi, et.al, 2012). In other words, if a therapist has increased compassion fatigue, they are less likely to have high compassion satisfaction. It is less clear, though, if there is a causal relationship between the two.

In their study, de Figueiredo, et al. (2014) used both qualitative and quantitative methods to assess compassion fatigue and compassion satisfaction in case managers, psychology fellows, staff psychologists, and clinical social workers from the same institution in California that served highly traumatized youth and families. There were a total of 36 participants who completed an online survey, and 25 of them also participated in focus groups. Findings indicated that roughly 86% of the providers had personal histories of trauma. Several themes emerged with regard to compassion fatigue and compassion satisfaction. Themes were identified as client, personal, professional, and organizational factors. Client factors that increased compassion fatigue included working with clients suffering from complex trauma. Professional factors were being

new to the field and having great expectations and managing the pressures and tasks of the job.

Having a diverse caseload and influence also lessened risk for compassion fatigue.

Organizational factors that led to burnout were the multiple demands placed on staff, especially with regard to paperwork and productivity standards. Participants listed personal factors as stress and lack of balance between work and home life. While most participants identified as having a trauma history, they felt that their history influenced their world view, which could then become a risk factor for compassion fatigue. Findings suggest that having clients with complex trauma was one of the largest factors in developing compassion fatigue. It also appeared that working with very young children further activated the nurturing and empathic response from some professionals, increasing their risk. Client progress was a significant factor in compassion satisfaction.

In her qualitative study, Hunter (2012) interviewed eight therapists from counseling agencies in Sydney, Australia about the therapeutic bond. The sample included five Master's level therapists, two with diplomas in therapy, and one with an undergraduate degree. The years of experience ranged from less than two to over 10 years. Six of the eight therapists reported that over 50 percent of their caseload was considered "difficult". The interviews were designed to gain information about both the joys and challenges of the work. Important themes that emerged included empathic resonance, client investment in the therapeutic process, mutual affirmation between therapist and client, and the satisfaction and risk of working with trauma. Hunter found that what was gained through the intense therapeutic experience assisted in lessening feelings of traumatization. She surmised that therapists may have altered their belief systems as a result of witnessing the trauma of their clients.

To summarize, studies have addressed the development and coexistence of compassion fatigue and compassion satisfaction. It seems that there may be an inverse relationship, such that as compassion satisfaction increases, compassion fatigue decreases. Some of the factors that contribute to this include the age of clients as well as the number that suffer from complex trauma. Being new to the field is also a factor, as is personal history of trauma. This study, then will look at both compassion fatigue and compassion satisfaction and focus on further clarifying the role of personal trauma.

Personal History of Trauma

While some studies have shown that a personal history of trauma leads to more fatigue, it is unclear whether this is due to the fact that the personal trauma was unresolved. In fact, working through personal trauma may lead to greater self awareness, and increase the ability for a therapist to remain present in recognizing the clients' pain. Literature on post traumatic growth identifies this possibility (Tedeschi & Calhoun, 1996). Additionally, therapists who may have experienced growth from their own traumatic experience may be more likely to see growth in their clients. I would argue that such a stance would increase a therapist's effectiveness, which could ultimately increase their satisfaction.

In her research, Leonard (2008) studied the impact of both personal and workplace factors on both compassion satisfaction and compassion fatigue. She surveyed members of The International Society for Traumatic Stress Studies as well as the Association for Traumatic Stress Specialists. A total of 98 participants completed the ProQOL-III (Stamm, 2005), the Stressful Life Experiences (Short Form), and the Psychologists Burnout Inventory (Stamm, 1997). The findings indicated that the sample had some personal traumatic experiences, although the degree was not "substantially high". The correlations between workplace and individual factors on

compassion fatigue was as expected: less perceived control at work, more over involvement with clients, and more exposure to traumatized clients increased fatigue. Compassion satisfaction was correlated with greater control, less over involvement, and less exposure to traumatized clients. However, Leonard (2008) also found that more personal experiences with trauma increased compassion satisfaction. Compassion satisfaction was also positively correlated to the number of years of experience.

In their research, McKim & Smith-Adcock (2014) explored the interconnection between compassion fatigue and compassion satisfaction. They surveyed only mental health providers and used workplace and personal characteristics as variables. Their hypothesis was that therapists with personal traumatic experiences, tendency towards over involvement with clients, more clinical experience, less supportive work environments, high risk clients, and higher exposure to secondary trauma would have more compassion fatigue. They also hypothesized that these same factors in reverse would increase compassion satisfaction. Participants were psychologists, social workers, and professional counselors who were also members of The International Society for Traumatic Stress Studies (ISTSS) or the Association for Traumatic Stress Specialists (ATSS). There were a total of 98 participants whose surveys were used in the study. Instruments included the ProQOL (Stamm, 2010), the Psychologist's Burnout Inventory (PBI), the short form of Stressful Life Experiences (Stamm, 1997), and demographic information.

Multiple regression was used to determine the relationship between individual and workplace factors on both compassion fatigue and compassion satisfaction. Due to the fact that personal trauma history was not correlated in the bivariate analysis, it was not included in the equation for compassion fatigue. The three variables that had significant relationships with

compassion fatigue included Control, Over-involvement, and Secondary Exposure. The three variables that accounted for 26% of the variance in compassion satisfaction were personal trauma history, years of experience, and control (as measured by the PBI). The results indicated that personal trauma history was significant and positively related to compassion satisfaction. Control was significant in the negative direction with compassion satisfaction. There was not a significant relationship between years of experience and compassion satisfaction. Personal trauma was not significant in compassion fatigue. Leonard (2008) argues that the compassion satisfaction and compassion fatigue may have an indirect relationship, which is mitigated by other factors. This differs from the original idea by Stamm (2002) that the two constructs have direct inverse relationships.

McKim and Smith-Adcock (2014) were not expecting personal trauma history to have a positive relationship with compassion satisfaction. They conclude that trauma counselors who had their own experience with trauma are more satisfied and enjoy their work. They surmise that the population studied may have been more drawn to trauma work and more likely to have a sense of purpose. While the study produced a significant finding for personal trauma having a positive impact, there was not a measure of the degree to which therapists had healed from their own trauma. The authors also argue that replication of the finding may allow other therapists to actually acknowledge their own trauma, rather than hide from it and possibly continue to suffer.

The feeling of shame connected to trauma is a part of the perpetuation. In other words, if therapists still feel shame about their own trauma and somehow believe that they must “have it together” in order to do this work, they may in fact deny the impact of trauma (Negash & Sahin, 2011). This may be a link to the increased compassion fatigue, as perhaps the trauma was kept hidden or not worked through. Trying to deny the feelings or triggers then, would seem to

naturally lead to exhaustion. Most studies (Baird & Kracen, 2006; McKim & Smith-Adcock, 2014) use a checklist to measure whether therapists experienced traumatic events. However, few studies, if any, have assessed whether therapists have symptoms related to their own trauma or inquire as to whether they received any help.

In their study, Linley and Joseph (2007) sought to identify factors that contributed to both the positive and negative impacts of working with trauma. They looked at nine occupational factors to determine whether they were associated with negative or positive attributes of working with trauma. These included receiving personal therapy, supervision, personal trauma history, gender, therapy training, practice orientation, length of time in practice, and current workload. They also included four psychological factors: coherence, empathy, therapeutic alliance, and social support.

Linley and Joseph (2007) mailed 400 surveys to clinical and counseling psychologists who were listed in Directories of Chartered Psychologists & Expert Witnesses and the Counselling and Psychotherapy Resources in Britain, as well as randomly selected independent practitioners. A total of 156 completed surveys were used in the analysis. Participants included 122 women and 34 men from 27 to 85 years old. Ninety seven percent were white. Thirty nine percent had diplomas, 32% had Masters degrees, and 14% had doctoral degrees. Fifty eight percent worked part time and 42% worked full time. The amount of experience participants had ranged from 2 to 40 years.

Measures for the Linley & Joseph (2007) study included the Crisis Support Scale (Joseph, Williams, & Yule, 1993), the Jefferson Scale of Physician Empathy (Hojat, et.al., 2002), the Working Alliance Inventory (Horvath & Greenberg, 1989), the Professional Quality of Life Inventory (Stamm, 2005), the Sense of Coherence Scale (Antonovsky, 1993), the Post Traumatic

Growth Inventory (Tedeschi & Calhoun, 1996), and the Changes in Outlook Questionnaire (Joseph, et.al., 1993). Using multivariate analysis of variance, results indicated that participants who received therapy (either in the past or currently) reported more personal growth, positive changes, and less burnout. Those who received clinical supervision also reported greater levels of personal growth. Therapists who had personal trauma history also reported greater personal growth. Lastly, females also reported higher levels of personal growth. However, 78% of the sample had received their own therapy in the past. It may be then, that the difference between personal trauma contributing to compassion fatigue as opposed to compassion satisfaction is related to whether the therapist had healed from their own trauma.

There still seems to be a question of what factors contribute to therapists experiencing growth or satisfaction. Indeed, recent studies point to inconsistencies in factors that determine risk or growth (de Figueiredo, et. al., 2014). There have also been mixed findings due to methodology, with qualitative studies showing stronger effects of working with trauma than quantitative studies (de Figueiredo, et.al., 2014). In addition, samples have been taken from across geographical areas and from different professions. Lastly, de Figueiredo and his colleagues noted that few studies looked at those whose client base was primarily children and adolescents, If we are intending to train professionals who will help communities heal from trauma, it seems important that we discover ways to ensure they are able to handle the work.

It is unclear whether studies that have included personal experience of trauma as a factor have clearly determined the extent to which that trauma impacts the therapist. For example, if the traumatic event has not been worked through and continues to cause distress to the therapist, it makes sense that the personal experience would contribute to compassion fatigue (Figley, 1995). However, it may also be possible that therapists were able to heal from their own trauma

or even have a post traumatic growth experience (Ben-Porat, 2015). In these cases, it may be that the personal experience and healing from trauma leads to greater compassion satisfaction and diminishes the negative impact of the work.

Critique of Current Research

Despite the ways in which the issue of compassion fatigue and compassion satisfaction have been identified, researched, and understood in the field, there are inconsistencies that point to the need for continued research. For example, the terms burnout, vicarious trauma, and compassion fatigue are sometimes used interchangeably (Craig & Sprang, 2010). Quantitative studies more clearly identify what is being measured because of the scales. Yet, there are times when the works cited refer to studies of burnout, but the author refers to the findings as being related to compassion fatigue (Negash & Sahin, 2011). It seems that the overlap between terms and symptoms may be causing confusion in the field, further contributing to the need to have clear definitions and concepts measured in studies.

The methodology of previous studies may also cause one to question what constructs are being measured or under what category the results are being classified. For example, qualitative studies rely upon how the participants define these constructs (Engstrom, et.al, 2008). This may lead to studies that define what causes distress in the work and personal life of participants, as opposed to defining vicarious trauma, compassion fatigue, or burnout.

Lastly, the idea of compassion fatigue is linked directly to being in a therapeutic relationship with others. Many of the studies here have participants who range in role and training, from medical support staff to case managers, who may not actually be working in therapy with traumatic material (Cocker & Joss, 2016; Rossi, et.al, 2012; Zerach, 2013). Studies

that include therapists also range in professional title, from psychiatrists to social workers and residential mental health staff (Huggard, et al., 2017; Rossi, et.al, 2012). The ways and intensity in which these professions engage with the traumatic material may differ. Such differences may naturally skew the amount of exposure and therefore degree to which professionals are at risk for compassion fatigue or find compassion satisfaction.

Other researchers have also critiqued the fact that samples have been small or limited and that results are not clearly explained or generalizable (Morse, et.al, 2012). Studies to date have called for there to be more empirical research as to the prevalence, causes, effects, and effective interventions for burnout (Paris & Hoge, 2010).

Need for the study

While the field of trauma has grown and with it the understanding that clinical work with traumatized clients has an impact on the therapist, there are still areas that call for more study. There are many constructs that some will use interchangeably. There are distinct definitions, but the measurements of the factors that contribute have not always been consistent (McKim, Smith-Adcock, 2014). In addition, Stamm (2010) and others seemed to indicate that compassion fatigue and compassion satisfaction were directly related, whereas more recent studies may indicate that compassion satisfaction may be a separate construct. There is some evidence to suggest that both negative and positive constructs can exist simultaneously (Killian, 2008; Paris & Hoge, 2010). Thus, there appears to be a need to continue to define and hone in how compassion fatigue and compassion satisfaction coexist and have an overall impact on therapists.

While there have been clear findings with regard to workplace context and ways to reduce risk for compassion fatigue, there have been conflicting findings about the impact of the trauma of the therapist. Studies that have included the therapist's own trauma as a factor have

not measured trauma in a consistent fashion or in a way that allows researchers to know the full extent of the therapist's trauma. For example, some studies merely included the variable if the participant indicated they had any personal exposure (Baird & Kracen, 2006). As we know from the study of trauma, the severity of the trauma, whether it is acute or chronic, and the relationship to the perpetrator all have an influence on the potential for symptomology to develop. Certainly, a therapist who was currently experiencing trauma would be in a different position as compared to one who had recognized their own trauma and its impact. The fact that very few studies define this may contribute to the mixed findings on the role of personal trauma.

Therefore, this study will attempt to discover what contributes to the level of impact a therapist's own trauma has on compassion fatigue as well as compassion satisfaction. It is hypothesized that there are individual factors intervening in the development of either compassion fatigue or compassion satisfaction. The extent of the therapists' own trauma and whether there are still symptoms as a result will be measured. Additionally, the extent to which a therapist has experienced their own post traumatic growth as a result of trauma will be assessed. It is believed that this is the mediating variable that helps to determine whether personal trauma is more likely to lead to fatigue or satisfaction.

Chapter Three: Methodology

Research Questions:

The purpose of this study was to examine the role of post traumatic growth as a mediator between personal trauma history and both compassion fatigue and compassion satisfaction.

Research Question 1: Does post traumatic growth mediate the relationship between personal trauma and compassion fatigue?

Hypothesis 1: Therapists with personal experiences of trauma who have little post traumatic growth will have greater compassion fatigue.

Hypothesis 2: Therapists with personal experiences of trauma who have experienced post traumatic growth will have less compassion fatigue.

Hypothesis 3: Therapists with no personal experience of trauma and no post traumatic growth will have less compassion fatigue.

The figure below illustrates the proposed model for Research Question 1:

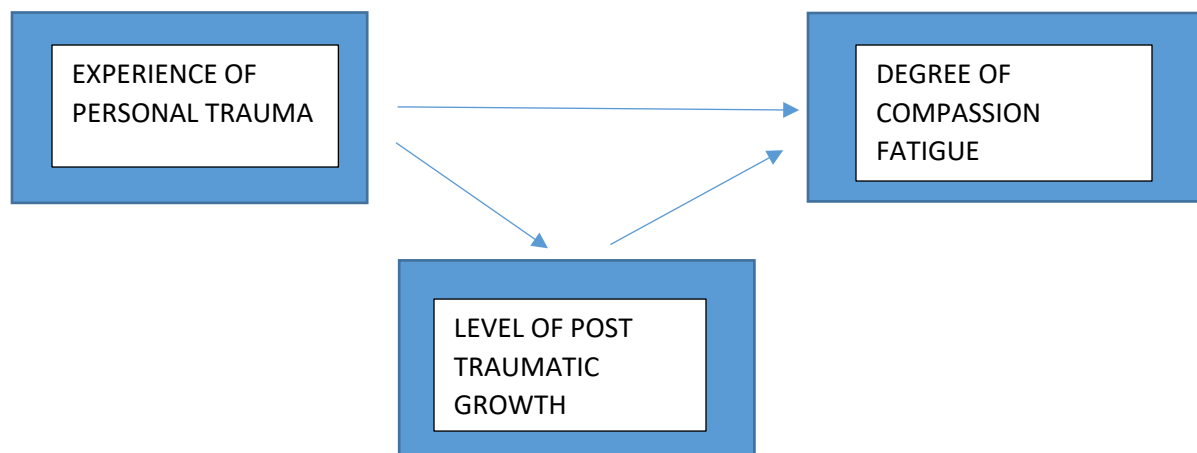


Figure 2: Post traumatic growth as a mediator between personal experience of trauma and level of compassion fatigue.

Research Question 2: Does post traumatic growth mediate the relationship between personal trauma on compassion satisfaction?

Hypothesis 4: Therapists who have experienced personal trauma and post traumatic growth will have greater compassion satisfaction.

Hypothesis 5: Therapists who have experienced personal trauma and no post traumatic growth will have less compassion satisfaction.

Hypothesis 6: Therapists who have not experienced personal trauma and no post traumatic growth will have less compassion satisfaction.

The figure below illustrates the model for Research Question 2:

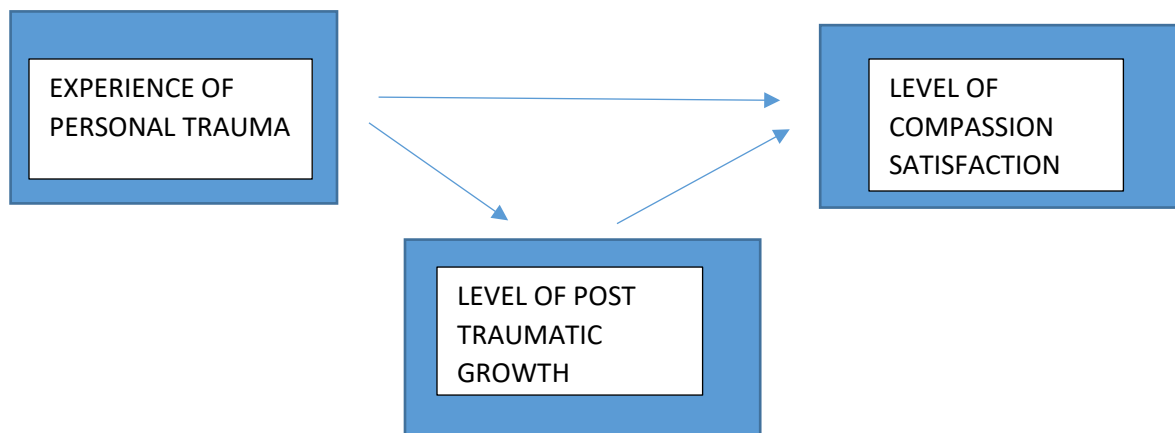


Figure 3: Post traumatic growth as a mediator between personal experience of trauma and compassion satisfaction.

Design

This was a cross sectional survey of therapists in the central New York area. Self report questionnaires were used.

The analysis involved multiple regression using a mediator variable (Baron & Kenny, 1986). PROCESS analysis (Hayes, 2018) in SPSS was used to calculate the mediation. Post traumatic growth was the mediator, with the hypothesis that it influences the relationship between a therapist's own trauma and compassion fatigue. Post traumatic growth was also used as the mediator between a therapist's trauma and compassion satisfaction.

Sample

The study included a convenience sample of psychotherapists working in mental health settings in the central New York area. Therapists were from a variety of professional disciplines, including psychology, social work, mental health counseling, and marriage and family therapy. Participants were licensed practitioners as well as students in training programs who provide therapy to clients. The sample included 149 individuals

Workplaces ranged from private practices, mental health clinics, and not-for-profit agencies that provide therapy to those who have been traumatized. The range in site as well as profession was intended to gather a robust sample and also to determine whether any differences exist. Similarly, student therapists were included in the study since they are already practicing as interns in many local agencies. There was also the possibility of comparing student scores with those of seasoned professionals in order to assess whether the amount of experience makes a difference in compassion fatigue or compassion satisfaction.

Recruitment

Roughly five percent of participants were recruited in person through various local agencies that employ psychotherapists and/or student therapy interns. Agency and program directors provided permission for the researcher to distribute surveys to staff. The researcher distributed packets at staff meetings and collected them at the end and also sent surveys through agency listserves. Participation was voluntary and individuals were informed that they could choose to withdraw from the study at any time.

Ninety five percent of participants were recruited through an online survey distributed to Central New York Association for Marriage and Family Therapy (CNYAMFT), a large private practice consortium, a large community mental health agency, registered providers of a psychotherapy trauma model and a University alumni group.

Procedure

There was one set of surveys that was collected at a staff meeting. During the meeting, the researcher described the research and procedures to the group of therapists. Afterwards packets containing the surveys (see Appendix A: Demographic Form, Appendix B: ProQOL, Appendix C: Life Events Checklist, Appendix D: PTSD Checklist, Appendix E: Post Traumatic Growth Inventory) and the informed consent form (see Appendix F) were distributed. All potential participants were asked to read and sign the informed consent form before completing the packet. The informed consent was collected before participants began the surveys.

The researcher sat to the side of the room while participants completed the questionnaires. It took approximately 20 minutes to complete the surveys. When the packets were complete, participants placed them in an envelope provided. The researcher then collected the envelopes when the group was finished.

For online data collection, CNYAMFT, and list serve members were sent an email inviting them to participate in the study. Participants then clicked an anonymous link to complete consent forms and then self-report inventories via Qualtrics. The time to complete all questions was estimated to be around 20 minutes.

Measures

The measures included a demographic form, the Professional Quality of Life Scale – Version 5, (ProQOL, Stamm, 2010) the Life Events Checklist (LEC - 5, Weathers, Blake, Schnurr, Kaloupek, Marx, & Keane, 2013) and Post-Traumatic Stress Disorder Checklist – Civilian Version (PCL- C, Weathers, Litz, Huska, & Keane, 1994), and the Post Traumatic Growth Inventory (Tedeschi & Calhoun, 1996).

Demographic Information. The demographic questionnaire included questions related to age, gender, education, professional identity, and years of experience. Dichotomous questions inquired about the use of theory and trauma specific training. Information about the workplace, such as amount and quality of supervision received and the percentage of caseload with traumatized clients was also collected. Finally, use of self care practices, social support, and the use and quality of personal therapy were also included in the survey. Some questions were open ended, others were forced choice, and two included a three-point scale.

The questions in the demographic form were chosen because the literature suggests they may be factors in the development of compassion satisfaction and compassion fatigue. For example, it may be that the number of years in practice impacts the amount of compassion fatigue or compassion satisfaction a therapist experiences. Since compassion satisfaction is connected to feeling accomplished in one's work, questions related to therapeutic effectiveness, such as theoretical models and trauma specific training were added. Lastly, items that relate to

support and growth of the therapist, such as clinical supervision, personal therapy, and self care, were included as potential factors in post traumatic growth.

Compassion fatigue and compassion satisfaction. The Professional Quality of Life Scale (ProQOL) (Stamm, 2010) was used to assess compassion fatigue, burnout, and compassion satisfaction. The ProQOL is based on the Compassion Fatigue scale designed by Figley (Bride, Radey & Figley, 2007). The scale is a 30 item self-report measure that targets experiences within the last 30 days. It contains measures for secondary traumatic stress, compassion satisfaction, and burnout. The most recent version of the ProQOL identifies both burnout and secondary traumatic stress as measures of compassion fatigue, whereas older versions called the secondary traumatic stress scale compassion fatigue (Stamm, 2010).

Construct validity has been established for the ProQOL. It has been referenced in over 200 peer reviewed journal articles (Stamm, 2010). There are three discrete scales on the ProQOL, one for secondary traumatic stress, one for compassion satisfaction, and one for burnout. There is not a composite score for the measure. The ProQOL was chosen because it has been widely used in the literature. In addition, it measures both the positive and potentially negative effects of being exposed to trauma in one's work. Permission was granted to use the ProQOL in this study.

The Compassion Satisfaction scale measures the pleasure one derives from their work. There are 10 items assessed using a 1 to 5 Likert-like scale. Some sample questions include "I get satisfaction from being able to help people", "I believe I can make a difference in my work", and "I am happy that I chose to do this work". The alpha scale reliability is .87, with an average raw score being around 37. Scores lower than 22 may indicate there are problems with one's job

or that satisfaction is found outside of work. Scores above 42 indicate that the individual likely experiences professional satisfaction from their work (Stamm, 2010).

The Burnout scale also contains 10 items that measure feelings of hopelessness and difficulties dealing with work. Some of the questions related to burnout include “I feel trapped in my job as a therapist”, “I feel overwhelmed because my caseload seems endless”, and “I feel bogged down by the system”. The reliability for this scale is .72. The average score is about 32, with scores above 42 indicating problems in the workplace. Scores below 22 indicate someone has positive feelings about being effective in their work (Stamm, 2010).

The Secondary Traumatic Stress scale also includes 10 items. This scale measures responses that related to secondary exposure to trauma through work. Examples of questions from this scale include “I think that I might have been affected by the traumatic stress of those I help”, “I feel depressed because of the traumatic experiences of the people I help”, and “I avoid certain activities or situations because they remind me of frightening experiences of the people I help”. The Secondary Traumatic Stress scale has an alpha reliability of .80. The average score is 32, with scores above 42 indicating fear or symptomology associated with exposure to secondary trauma (Stamm, 2010).

Exposure to trauma. The Life Events Checklist (LEC, Weathers, et al., 2013) was used to determine whether therapists experienced a traumatic event. It includes 17 items that list potentially traumatic events that may have occurred at any time in one’s life. Some items include “Natural disaster”, “Physical assault” and “Life threatening illness or injury”. Participants indicate whether an event happened to them, whether they witnessed it, learned about it, or if they were exposed as part of their job. Choices also include “not sure” and “doesn’t apply”.

The LEC has demonstrated good stability and convergence with other solid measures of trauma history, such as the Traumatic Life Events Questionnaire (Gray, Litz, Hsu & Lombardo, 2004). Studies have shown that the LEC has adequate reliability and validity and is one of the most commonly used measures of trauma for adults (Elhia, Gray, Kashdan & Franklin, 2005). The LEC was chosen as a measure because it is easily accessible and lists several different types of traumatic events. It also inquires whether someone witnessed an event, rather than just experienced the trauma as a victim. Lastly, it indicates whether the event was experienced as part of a job, which is important given the focus of this study.

Severity of trauma. The Post Traumatic Stress Disorder Checklist – Civilian Version (PCL-C, Weathers, et al., 1994) was used to measure symptoms a therapist may be experiencing that are related to his or her own trauma. The PCL-C is a 17 item self-report measure designed to identify symptoms of PTSD. It can also be used to measure change in PTSD symptoms. Respondents were asked whether they have been bothered by specific behaviors in the last month. Some sample items include “Repeated, disturbing memories, thoughts, or images of a stressful experience from the past”, “Avoid activities or situations because they remind you of a stressful experience”, and “Feeling irritable or having angry outbursts”. Items are rated on a 5 point Likert-like scale, ranging from 1, “Not at all” to 5, “Extremely”.

The PCL has been shown to have very good internal consistency ($\alpha = .94$) and temporal stability (retest $r = .88$, 1-week interval) (Blanchard, Jones-Alexander, Buckley, & Forneris, 1996). The instrument has also been found to be a valid measure of PTSD, as evidenced by several studies that compared it to other instruments (Keen, Kutter, Niles & Krinsley, 2008; Walker, Newman, Dobie, Ciechanowski, & Katon, 2002). The PCL – C was chosen for this study because it is easily accessible and measures symptoms of post-traumatic

stress. The ability to determine whether a therapist is suffering from symptoms related to their own trauma is important for this study.

Post traumatic growth. The Post Traumatic Growth Inventory (PTGI, Tedeschi & Calhoun, 1996) is a 21 item self-report inventory designed to measure growth after traumatic events. Respondents indicated whether they have experienced growth or change after exposure to traumatic events. Some sample items include “a willingness to express my emotions”, “I’m able to do better things with my life”, and “I learned a great deal about how wonderful people are”. Participants use a 6 point scale to indicate the degree to which they may have experienced change. The choices range from 0, “I did not experience this change as a result of my crisis” to 5, “I experienced this change to a very great degree as a result of my crisis”.

Tedeschi and Calhoun (1996) report the reliability of the PTGI to be .90, indicating it is a solid measure for assessing growth after a stressful event. The instrument has been validated by comparing responses to other reports of growth evidence (Shakespeare-Finch & Enders, 2008; Weiss & Berger, 2006). In addition, studies have found that PTGI scores are not correlated with measures of social desirability (Tedeschi & Calhoun, 1996). Five factors were identified in the literature, replicated across diverse populations and confirmed via factor analysis (Taku, Cann, Calhoun, & Tedeschi, 2008; Tedeschi & Calhoun, 1996). These factors include: New Possibilities, Relating to Others, Personal Strength, Appreciation of Life, and Spiritual Change.

The PTGI was chosen to measure the benefit that may come from traumatic experiences. Tedeschi and Calhoun (1996) postulate that those with more severe trauma report more growth. Since one of the key variables in this study is the personal trauma of the therapist, this measure was used to indicate whether a therapist has experienced growth from their own trauma. This is separate from the growth they experience from witnessing the growth of clients. It is also this

growth, as measured by the PTGI, which served as the mediator between personal trauma and compassion satisfaction. Permission was granted to use the PTGI in this study.

Reliability analyses were conducted on all of the standardized measures used in this study. The Cronbach's Alpha for Compassion Satisfaction scale on the PROQOL was .884, indicating the scale was a reliable measure. The ProQOL Burnout scale was also reliable, with a Cronbach of 0.821. The last scale in the ProQOL, Secondary Traumatic Stress, had a Cronbach Alpha of 0.847. The reliability for the PCL-C was also high, as the Cronbach's Alpha was 0.911. Lastly, the Post Traumatic Growth Inventory had a Cronbach's Alpha of 0.956.

Data Analysis

Results from the demographic questionnaire were initially used to describe the sample. The mean scores for groups were also tested for significant differences.

Personal experience of trauma was indicated if participants checked that they had a potentially traumatic event from the Life Events Checklist (Weathers, et. al., 2013) either happen to them or if they witnessed such an event. They were considered to have had exposure to a personal trauma if they experienced or witnessed just one event.

The PCL-C (Weathers, et.al., 1994) was used to determine whether the event was experienced as a trauma and the extent of the impact of that event. This measure, used in conjunction with the LEC, assisted in identifying whether participants were currently suffering from their own traumatic event, or having symptoms related to the traumatic material from their clients. The cut off score for overall symptom severity on this measure was 35. This is in keeping with standard score used for the general population (VA National Center for PTSD,

2014). In other words, any participant who scored 35 or higher was considered to have symptoms of PTSD as a result of their own traumatic life experiences.

The Post Traumatic Growth Inventory (Tedeschi & Calhoun, 1996) determined whether participants experienced any growth as a result of their own trauma. Although the instrument identifies five factors that contribute to growth, this study used the total score as an indicator for growth. Responses from all 21 items were averaged. Since three is the score that reflects a moderate level of growth, participants scoring an average of 3 or more were identified as having experienced post traumatic growth.

The sub scales on the ProQOL determined the degree to which participants experienced compassion satisfaction and compassion fatigue. Although Stamm (2010) uses t scores to identify cut scores, raw scores were used in this analysis. The cutoff score for high compassion satisfaction was 42. Scores over 42 indicated high compassion satisfaction. Those scoring below 22 were less likely to experience compassion satisfaction as a result of their work. The cut off score for secondary traumatic stress scale was 42. Those above 42 indicate a high level of secondary traumatic stress. Scores below 22 were indicative of little secondary traumatic stress.

As mentioned above, statistical analysis involved mediator analysis. The PROCESS method was used, as it simplifies the analyses for mediation (Hayes & Rockwood, 2017). In their article Hayes & Rockwood (2017) explain that Structural Equation Modeling (SEM) requires multiple regression to be run using multiple steps. In the case of mediation, three separate steps are required to identify direct and indirect effects of factors on the outcome variable. Each step takes more analysis and also introduces the potential for error. The PROCESS method in SPSS performs all the computations in one step. Thus, the PROCESS

analysis is easier for the researcher and reduces the potential for error (Hayes & Rockwood, 2017).

The proposed theory is that post traumatic growth can be used to explain the relationship between therapist personal trauma and compassion fatigue as well as personal trauma and compassion satisfaction. Initial correlation tests were conducted to ensure there is a relationship between personal trauma and compassion fatigue. The relationship between trauma and post traumatic growth as well as the relationship between post traumatic growth and compassion fatigue were also assessed. Post traumatic growth was entered into the analysis to determine whether it mediates the relationship between personal trauma and compassion fatigue. The same test was repeated for compassion satisfaction. There was a test for the relationship between personal trauma and compassion satisfaction, as well as the relationships between trauma and post traumatic growth and post traumatic growth and compassion satisfaction. The final analysis determined whether post traumatic growth mediates the relationship between personal trauma and compassion satisfaction.

Missing data was addressed in two ways. First, those respondents who did not complete the surveys or left entire scales unanswered were deleted from the study. In the case of random missing data, the researcher left those to be calculated in SPSS. Since the analysis was focused on multiple regression using PROCESS, missing values were dropped from the mediation analysis.

Chapter Four: Results

The purpose of the study was to determine whether post traumatic growth has an impact on compassion fatigue and compassion satisfaction for those who have experienced personal trauma. This chapter will address the results of the study. Demographics and statistical analysis around the research questions are presented below.

Participants: Demographics

A total of 149 people completed the surveys. However, 23 of those did not contain complete data. Therefore, the sample consisted of 126 participants. The sample was 84% female, 14% male, and 2% transgender. (See Table 2). The age of participants ranged from 24 to 75 years, with the average age being 42. The sample was predominantly Caucasian at 81%. Roughly 7% identified as African American, 3% identified as Asian, 2% as Hispanic/Latino, 2% as mixed race, 3% Jewish, and 2% chose not to indicate their race. Table 3 lists the frequencies for race and ethnicity.

The majority of participants were clinicians with master's degrees. Eighty one percent of the participants held masters, 15% held doctorates, and 4% were at the bachelor degree level. (See Table 4). There was a range of clinical experience within the sample, from 0 to over 15 years. Roughly 44% were in practice between 0 and 5 years, whereas 31% were in the field over 15 years. Another 25% had between 6 and 15 years of experience. (See Table 5 for the data related to the number of years in the field.) Participants also identified as belonging to specific professions within the field of mental health. Forty five percent identified as Marriage and Family Therapists, 32% as Social Workers, 10% as Psychologists, 8% as Mental Health Counselors, and 5% identified as another mental health profession. (See Table 6).

Approximately 95% of therapists in the survey identified serving traumatized clients. Fifty percent of participants had 71% to 100% of their caseload focused on trauma. Roughly 60% of the sample had over half their caseload containing clients who had experienced trauma. (See Table 7). Table 8 shows that 83% of the participants reported receiving specific training related to trauma. Most respondents reported some level of supervision. Forty eight percent reported receiving excellent supervision, 41% reporting having adequate supervision, and roughly 11% indicated they had either poor or no supervision. (See Table 9). Approximately 95% of the sample reported having social supports.

Roughly 92% of the sample experienced at least one type of personal traumatic event. On average, participants experienced four traumatic events in their personal life. Transportation accidents were the highest direct experience from the Life Events Checklist, with 66% indicating they experienced this. A large number of participants, 59.5%, also reported experiencing an unwanted or uncomfortable sexual experience. Seventy six percent reported a direct experience of some other stressful life event, 45% directly experienced physical assault, and 23% experienced sexual assault directly. See Table 10 for a chart of items from the Life Events Checklist. Approximately 83% reported receiving personal therapy, and 94% engaged in some form of self care. (See Tables 11 and 12).

Descriptive Statistics: Means and Correlations

The mean scores for the standardized measures can be seen in Table 13 below. Means were compared with the norms set by ProQOL developers (Stamm, 2010). The mean for Compassion Satisfaction ($M=41.25$, $SD = 5.16$), indicated that there was average Compassion Satisfaction. The mean scores for Secondary Traumatic Stress ($M=22.12$, $SD = 6.11$) and Burnout ($M = 21.59$, $SD = 5.49$) indicate that the sample had lower Secondary Traumatic Stress

and Burnout than the national sample (Stamm, 2010). According to Stamm (2010), compassion fatigue is a combination of secondary traumatic stress and burnout. Therefore, those two scales were combined to create the Compassion Fatigue score ($M = 43.95$, $SD = 10.29$).

Table 13. *Mean Scores for Standardized Measures*

<i>Scale</i>	<i>n</i>	<i>M</i>	<i>SD</i>
<i>CS</i>	122	41.25	5.16
<i>STS</i>	121	22.12	6.11
<i>BO</i>	122	21.59	5.49
<i>PTG</i>	126	3.51	1.20
<i>PTSD</i>	126	29.94	10.26
<i>CF</i>	118	43.95	10.29

The score for Post Traumatic Growth ($M = 3.51$, $SD = 1.20$) indicated that on average, the sample had experienced post traumatic growth. As noted in Chapter 3, a mean score of 3 on the Post Traumatic Growth Inventory would indicate that there had been some moderate level of post traumatic growth (Tedeschi & Calhoun, 1996). Using the cutoff of 3 on the PTGI to identify evidence of post traumatic growth, the amount of respondents who experienced post traumatic growth was 68%. Thirty two percent did not demonstrate growth based on the PTGI cut off score. The PTSD scale ($M = 29.93$, $SD = 10.26$) signaled that the average for the sample was very close to the indicator for Post Traumatic Stress Disorder. Using the cutoff scores from

the PTSD checklist, over 26% of participants' scores were indicative of PTSD, based on their personal experiences of trauma.

Correlations between the main variables in the study were first tested. See Table 14 below. Personal trauma (PT) (M= 4.65, SD = 3.15) was moderately and significantly correlated with post traumatic growth (PTG), $r=.335$, $p < .001$. However, there were no significant correlations between personal trauma and PTSD, or between personal trauma and any of the ProQOL scales. PTSD, which was also considered as an indicator for personal trauma, was significantly correlated with all of the ProQOL scales. There was a strong significant correlation between PTSD and Secondary Traumatic Stress (STS) (M=21.8308, SD = 6.05), $r=.613$, $p < .001$, a strong correlation with PTSD and Burnout (BO) (M=21.3893, SD =5.45), $r= .573$, $p < .001$, and a negative moderate correlation between PTSD and Compassion Satisfaction (CS) (M=41.1832, SD = 5.13), $r= -.294$, $p < .001$. PTSD (M=29.78, SD = 10.21), also had a low, significant correlation to post traumatic growth, $r=.188$, $p < .05$.

Table 14. *Correlations Between Measures*

VARIABLES	1	2	3	4	5	6	7
1. STS	1						
2. CS	-.338**	1					
3. BO	.582**	-.712**	1				
4. CF	.902**	-.575**	.876**	1			
5. PTG	.226*	.296**	-.127	.097	1		
6. PTSD	.613**	-.294**	.573**	.661**	.188*	1	
7. PT	.157	.109	.066	.134	.335**	.159	1

* $p < .05$, ** $p < .001$

Post traumatic growth ($M=3.49$, $SD = 1.22$) proved to have low, significant correlations with Secondary Traumatic Stress $r=.226$, $p < .05$, and Compassion Satisfaction, $r=.285$, $p < .001$. Post traumatic growth was not significantly correlated with Burnout or Compassion Fatigue.

There were also significant correlations among the ProQOL scales. Secondary Traumatic Stress was negatively, moderately correlated with Compassion Satisfaction, $r=-.338$, $p < .001$, and positively, strongly correlated with Burnout, $r=.582$, $p < .001$. Therefore as secondary stress increased so did burnout, while compassion satisfaction decreased. Compassion Satisfaction was significantly negatively, strongly correlated with Burnout, $r=-0.712$, $p < .001$. As satisfaction increased, burnout decreased. Lastly, Compassion Fatigue was negatively, strongly correlated with Compassion Satisfaction, $r = -.575$, $p < .001$, and positively, strongly correlated with PTSD, $r=.661$, $p < .001$. As fatigue rose, the likelihood of meeting criteria for PTSD also rose, while compassion satisfaction decreased.

Hypothesis Testing: Group Differences

This study had two main research questions. Research Question 1 posed whether post traumatic growth would mediate the relationship between personal trauma and compassion fatigue. Research Question 2 asked whether post traumatic growth would mediate the relationship between personal trauma and compassion satisfaction. There were also three hypotheses connected to each question, for a total of six hypotheses.

In order to test the first research question on whether post traumatic growth mediates the relationship between personal trauma and compassion fatigue, I will first address each hypotheses and the associated analyses.

Hypothesis 1: Therapists with personal experiences of trauma who have little post traumatic growth will have greater compassion fatigue.

Personal trauma was not found to have significant correlations with any of the ProQOL scales. In addition, it was so prevalent in this sample that testing for differences would be difficult. Part of what made this particular study different was looking at the severity of trauma, as opposed to simply whether someone had been exposed. Therefore, PTSD was used as the measurement of personal trauma in the analysis.

An Analysis of Variance (ANOVA) was conducted to determine whether there were differences in compassion fatigue between groups using PTSD and post traumatic growth as the independent variables. Groups were created based on whether respondents fit the criteria for PTSD as well as whether they had experienced post traumatic growth. As a result, there were four different groups that emerged: Those with PTSD and post traumatic growth, those with PTSD and no post traumatic growth, those without PTSD and no post traumatic growth, and those with no PTSD and post traumatic growth.

ANOVA results indicated that means for compassion fatigue were significantly different between the four groups, $F(3,114) = 14.24, p < .001$. (See Table 15). Those with PTSD and no post traumatic growth had the highest compassion fatigue scores, ($M=53.33, SD = 8.41$). Those with PTSD and post traumatic growth had the next highest scores on compassion fatigue, ($M=51.73, SD = 10.72$). Compassion fatigue was lower for those without PTSD. Those without PTSD who had no post traumatic growth had lower compassion fatigue, ($M=40.74, SD = 9.66$), and the lowest compassion fatigue scores were for those without PTSD and with post traumatic growth, ($M = 40.22, SD = 9.11$).

According to the mean scores, those with PTSD and no post traumatic growth did have the highest compassion fatigue. Therefore, Hypothesis 1 can be accepted.

Hypothesis 2: Therapists with personal experiences of trauma who have experienced post traumatic growth will have less compassion fatigue.

The mean scores for Compassion Fatigue in those with PTSD and post traumatic growth ($M = 51.73$, $SD = 10.72$) were slightly lower than those without post traumatic growth ($M = 53.33$, $SD = 8.41$). Therefore, it is possible to accept Hypothesis 2.

Hypothesis 3: Therapists with no personal experience of trauma and no post traumatic growth will have less compassion fatigue.

Again, the ANOVA results indicate that there were significant differences in compassion fatigue between those with and without PTSD. (See Table 15). The mean scores indicate that those without PTSD and no post traumatic growth had lower compassion fatigue scores, ($M=40.74$, $SD = 9.66$). However, those without PTSD who had experienced post traumatic growth had even lower compassion fatigue scores ($M=40.22$, $SD = 9.11$). It seems, then, that we can accept Hypothesis 3.

The next section will address the hypotheses related to Research Question 2: Does post traumatic growth mediate the relationship between personal trauma and compassion satisfaction? Before offering the results of the main question, I will first address hypotheses 4 through 6.

Hypothesis 4: Therapists who have experienced personal trauma and post traumatic growth will have greater compassion satisfaction.

As in the analyses with compassion fatigue, PTSD was used as the indicator of personal trauma. In addition, the 4 groups were created, based on whether respondents met criteria for PTSD and whether they experienced post traumatic growth. One way ANOVA indicated there was a significant difference in compassion satisfaction between the four groups, $F(3, 118) = 6.87, p < .001$. (See Table 16). Those with PTSD and post traumatic growth had greater satisfaction ($M=39.93, SD = 6.59$) than those with PTSD and no post traumatic growth ($M=37.00, SD = 4.29$). Those with no PTSD and no post traumatic growth had an average compassion satisfaction score similar to those with PTSD and post traumatic growth ($M=39.72, SD=4.64$). Finally, those with no PTSD and post traumatic growth had the highest compassion satisfaction score ($M=43.37, SD=3.68$). Since those with PTSD and post traumatic growth had higher compassion satisfaction, we can accept Hypothesis 4.

Hypothesis 5: Therapists who have experienced personal trauma and no post traumatic growth will have less compassion satisfaction.

The ANOVA results listed in Table 16 suggest that there is a difference in compassion satisfaction between participants with PTSD and no post traumatic growth, ($M=37.00, SD = 4.29$) and those with PTSD who have post traumatic growth ($M=39.93, SD = 6.59$). The differences in mean scores suggests that those with less post traumatic growth do have less compassion satisfaction. Therefore, Hypothesis 5 can be accepted.

Hypothesis 6: Therapists who have not experienced personal trauma and no post traumatic growth will have less compassion satisfaction.

The ANOVA results indicate there were significant differences between the four groups. (See Table 16). Those who did not have PTSD and no post traumatic growth ($M=39.72, SD =$

4.64) had mean scores that were very close to those with PTSD and post traumatic growth ($M=39.93$, $SD = 6.59$). However, there appeared to be more difference between those without PTSD who had experienced post traumatic growth ($M=43.37$, $SD = 3.68$). The highest compassion satisfaction was found in those without PTSD who also had post traumatic growth. Therefore, we must reject Hypothesis 6.

Research Questions: Mediation

This section will address each research question using mediation analysis. Research question one is: Does post traumatic growth mediate the impact of personal trauma on compassion satisfaction? Research Question two is: Does post traumatic growth mediate the impact of personal trauma on compassion satisfaction?

Mediation analysis tests whether a variable explains why an independent variable may impact the dependent variable (Baron & Kenney, 1986; Hayes, 2018). This differs from moderation, which uses a variable to assess the strength of the relationship between the independent and dependent variables (Baron & Kenney, 1986). Since this study aims to understand the relationship between personal trauma and compassion fatigue and satisfaction, mediation analyses were conducted. Mediation using PROCESS and the bootstrap method to test indirect effects are both appropriate for use with small sample sizes (Fritz & MacKinnon, 2007; Hayes, 2018).

Mediation of post traumatic growth between PTSD and compassion fatigue.

Mediator analysis using PROCESS (Hayes & Rockwood, 2017) was conducted to determine whether post traumatic growth was a mediator between PTSD and compassion fatigue. Due to missing values in some of the scales, six percent of the cases were dropped from the analysis. Step one determined that PTSD significantly predicts compassion fatigue [$b = .661$, $t(116)= 9.48$,

$p < 0.001$]. PTSD alone predicted 44% of the variance in compassion fatigue [$R^2 = .44$, $F(1, 116) = 89.95$, $p < 0.001$]. Step 2 showed that PTSD was a significant predictor for post traumatic growth [$b = .03$, $t(116) = 2.68$, $p < 0.01$]. This predicted 6% of the variance in outcome [$R^2 = 0.06$, $F(1, 116) = 7.19$, $p < 0.01$]. Post traumatic growth, when controlling for PTSD, did not significantly predict compassion fatigue, [$b = -.57$, $t(115) = -.92$, $p = .36$]. When controlling for post traumatic growth, PTSD was still a significant predictor [$b = .68$, $t(116) = 9.11$, $P < .001$]. The total model only predicted 44 % of the variance in compassion fatigue [$R^2 = .44$, $F(2, 116) = 46.50$, $p < .001$], which was not significantly different than PTSD alone.

The bootstrap method was used to support the conclusion that there is no indirect effect of post traumatic growth on compassion fatigue. In this method, a random sample is repeated thousands of times in order to estimate the indirect effects of the model (Hayes & Rockwood, 2017). If the upper and lower confidence intervals do not include 0, then the effect is significant. Using 5000 samples, the indirect coefficient in this analysis was not significant, $b = -.0145$, $SE = .0218$, $95\% CI = -.0618, .0252$. Since the range between the confidence intervals includes 0, the effect is not significant. Therefore post traumatic growth did not serve as a mediator between PTSD and compassion fatigue.

Mediation of compassion satisfaction between PTSD and compassion fatigue. In order to better understand possible mediators between personal trauma and compassion fatigue, another mediation analysis using PROCESS (Hayes & Rockwood, 2017) was conducted to explore whether compassion satisfaction served as a mediator between PTSD and compassion fatigue. Due to missing values, eight percent of cases were excluded from the analysis. As noted in the results above, PTSD is a predictor for compassion fatigue [$b = .66$, $t(114) = 9.38$, $p < 0.001$], and it accounts for 44% of the variance in compassion fatigue [$R^2 = .44$, $F(1, 114) =$

88.00, $p < 0.001$]. In Step 2, the analysis showed that compassion satisfaction, while controlling for PTSD, significantly predicted compassion fatigue [$b = -.85$, $t(113) = -7.02$, $p < .001$]. When controlling for compassion satisfaction, PTSD still significantly predicted compassion fatigue, [$b = .54$, $t(113) = 8.91$, $p < 0.001$]. However, the model using compassion satisfaction as a mediator predicted 61% of the variance in compassion fatigue [$R^2 = 0.61$, $F(2, 113) = 87.23$, $p < 0.001$].

The bootstrap method was used to support the significance of the mediation. Using 5000 samples, the indirect coefficient was significant, $b = .1144$, $SE = .0463$, 95% CI = .0324, .2148. Therefore, compassion satisfaction does have a significant indirect effect on compassion fatigue and partially mediates the role of PTSD. Figure 4 illustrates the mediation model.



Figure 4. Compassion satisfaction as a mediator between PTSD and compassion fatigue.

Mediation of post traumatic growth between PTSD and compassion satisfaction. Finally, mediation analysis was used to test research question two. PROCESS (Hayes & Rockwood, 2017) was again used to test the whether post traumatic growth was a mediator between PTSD and compassion satisfaction. Approximately three percent of cases were dropped from this

analysis due to missing values. Step one showed that PTSD significantly predicted compassion satisfaction [$b = -.148$, $t(120) = -3.37$, $p < .001$]. PTSD accounted for 9% of the variance in compassion satisfaction [$R^2 = .09$, $F(1, 120) = 11.37$, $p < .001$]. The mediation process showed that post traumatic growth, when controlling for PTSD, significantly predicted compassion satisfaction, [$b = 1.55$, $t(119) = 4.36$, $p < .001$]. When controlling for post traumatic growth, PTSD still significantly predicted compassion satisfaction [$b = -.1804$, $t(119) = -4.34$, $p < .001$]. The overall model with post traumatic growth as the mediator predicted 21% of the variance in compassion satisfaction [$R^2 = .21$, $F(2, 119) = 16.03$, $p < .001$].

The bootstrap method was used to support the significance of the mediation. Using 5000 samples, the indirect coefficient was significant, $b = .0346$, $SE = .0169$, 95% CI = .0044, .0715. Since the upper and lower confidence intervals did not include 0, we can conclude that post traumatic growth is a partial mediator between PTSD and compassion satisfaction. Figure 5 shows the mediation model.

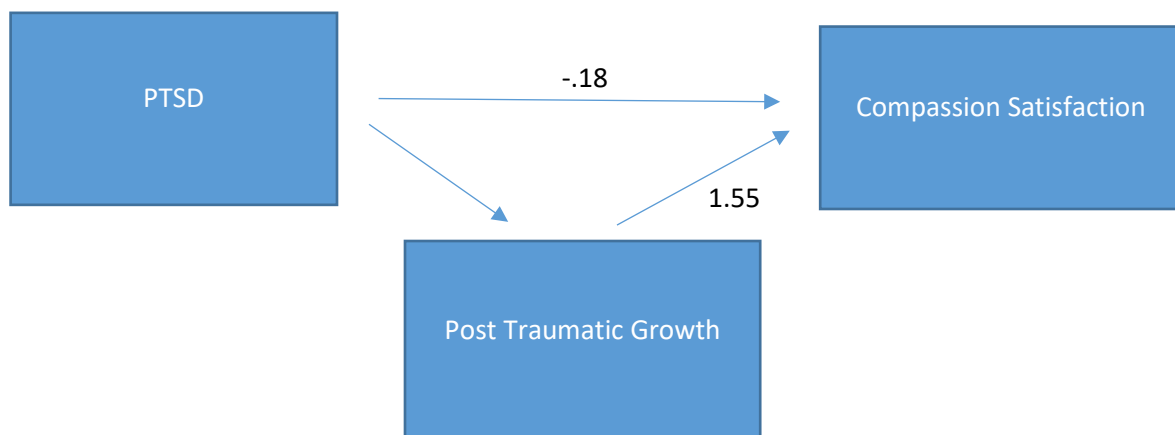


Figure 5. Post traumatic growth as a mediator between PTSD and compassion satisfaction

Additional Results

In order to better understand factors that influence the development of compassion fatigue and compassion satisfaction, additional analyses were conducted using demographic variables. A One Way Analysis of Variance was conducted to determine whether there was a difference between groups around the percentage of trauma cases and compassion fatigue, $F(4, 112) = 3.75, p < .01$. Those with higher trauma caseloads had significantly higher compassion fatigue scores. See Table 17. However, there was no difference based on the number of trauma cases and compassion satisfaction, $F(4, 116) = 1.54, p = .19$.

There were also significant differences found in compassion fatigue $F(3, 114) = 6.70, p < 0.001$ and compassion satisfaction $F(3, 118) = 3.30, p < 0.05$, based on number of years in the field. Those working between 6 and 15 years had the highest scores on compassion fatigue, whereas those over 15 years had the lowest. See Table 18 for these results. Table 19 shows the ANOVA results for compassion satisfaction according to years in the field. Those in the field over 15 years had the highest mean scores of compassion satisfaction.

Another ANOVA resulted in significant differences between those with varying educational degrees and compassion fatigue, $F(2, 115) = 7.03, p < 0.001$. Those with a Master's degree had the highest mean scores on compassion fatigue, while those with PhD's had the lowest. See Table 20. Differences were also found between educational groups with regard to compassion satisfaction, $F(2, 119) = 2.96, p < 0.05$. Those with a PhD had a higher mean score on the compassion satisfaction scale, while those with Master's degrees had the lowest. See Table 21.

Summary

Results indicate that the vast majority of clinicians in this sample experienced personal trauma. In fact, almost a third of the participants met criteria for PTSD. In addition, the majority

of this sample also acknowledged serving traumatized clients. Yet, the mean scores on Secondary Traumatic Stress and Burnout scales were lower than average. Tests using ANOVA found that there were significant differences in compassion fatigue between groups. The highest scores on compassion fatigue were from those participants with PTSD and no post traumatic growth. Mean scores for compassion satisfaction were average. ANOVA results indicated there are significant differences between groups in compassion satisfaction scores. Those with the greatest satisfaction were those without PTSD and with post traumatic growth.

The main research questions were tested using mediation analysis in order to better understand the relationship between personal trauma and compassion fatigue as well as between personal trauma and compassion satisfaction. Results indicate that post traumatic growth did not have any significant indirect effects on compassion fatigue. However, compassion satisfaction was found to be a significant partial mediator between PTSD and compassion fatigue. The hypothesis that post traumatic growth mediates PTSD and compassion satisfaction was also supported. Thus, it seems that the positive growth and satisfaction are important factors to consider around the personal trauma of therapists.

Chapter Five: Discussion

The purpose of this study was to examine the role of personal trauma and post traumatic growth in the development of compassion fatigue and compassion satisfaction in a sample of psychotherapists located in Central New York. Previous research has found that personal trauma history has a negative impact on psychotherapist functioning (Hensel, et al., 2015; Killian, Perlman & MacIan, 1995, Baird & Kracen, 2006), while other studies found trauma history had a positive impact on satisfaction (Hunter, 2012; McKim & Smith-Adcock, 2014; Thomas, 2013). The present study assessed whether post traumatic growth served as a mediator between personal trauma and compassion fatigue. It also addressed whether post traumatic growth mediated the relationship between personal trauma and compassion satisfaction. Results indicated that there was some support for these hypotheses.

In this chapter, I will first address some of the findings related to the prevalence of personal trauma in clinicians. Then, I will discuss significant findings based on demographics. Finally, I will summarize and offer an explanation for the results of the main research questions. The chapter will conclude with limitations of the study, clinical and training implications, and ideas for future research.

Personal Trauma

One of the primary foci for this study was the degree to which therapists' personal trauma history may have had an impact on their functioning as professionals. Previous studies have identified the ways in which personal trauma had both positive and negative outcomes for clinicians (Baird & Kracen, 2006; Craig & Sprang, 2010; Killian, 2008; Samios, et al., 2013). Unfortunately, there is no uniformity in how trauma is identified in previous studies. The ways

in which trauma was identified varied from personal narratives to quantitative standardized instruments to yes and no indicators (Baird & Kracen, 2006; Killian, 2008; Thomas, 2013). The type of measurement for personal trauma was significant for the results in the present study, and may have implications for the ways personal experiences are considered in future studies.

One of the most interesting findings of this research was the amount of personal trauma therapists reported. Roughly 92% of the participants experienced some type of traumatic event. This is significantly higher than the general population, where 60% of people have experienced at least one trauma (VA National Center for PTSD, 2018). Personal trauma was also reported to a much higher degree in this study than in others of mental health clinicians (Peled-Avram, 2017; Thomas, 2013). In one study of clinical social workers in Israel, Peled-Avram (2017) reported that 61.5% of participants had a history of personal trauma. One has to wonder if the large percentage reported in this study is because trauma is truly more prevalent or if it is because of how it was measured. Any response on the Life Events Checklist that was either a direct experience or witness of a traumatic event was translated into a positive response. The study did not differentiate between the severity of experiences. Thus, the potential to have had some life experience on the list was relatively high.

It may also be that therapists working in Central New York have experienced more trauma than other locations. High poverty rates, lack of sunshine, gun and gang violence, and a lack of resources affect large sections of the population in Central New York (Lane, et.al, 2017; Rubenstein, et.al, 2018). It may be that traumatic events are higher for the entire population.

Another potential explanation for the high prevalence of personal trauma is that therapists, especially those who work with survivors, are more comfortable identifying their own history. In addition, the mental health field has moved towards being more trauma informed,

which may enable therapists to recognize their own traumatic experiences. In their meta-analysis, Hensel, et al. (2015) noted that the impact of personal trauma on secondary traumatic stress seemed to lessen in publications after 2008. They hypothesize that change could be attributed to a larger focus on the hazards of working with trauma survivors. Perhaps those in the field are more educated as to the risks personal trauma may pose, so they can more readily identify their own experiences. The fact that 83% of those surveyed were specifically trained in trauma may have certainly increased the ability to identify traumatic experiences.

One of the underlying hopes for this study was to lessen the stigma connected to clinicians having their own traumatic experiences. The frequency of therapists responding positively around their history may be an indicator that the stigma has lessened. As clinicians, they likely recognize the importance of identifying trauma. The large portion of participants who had received therapy may have also contributed to both the awareness of and comfort with labeling trauma. If clinicians are aware of the risks of personal trauma, they may not only be familiar with their experiences, they may also have done their own therapeutic work to lessen any potential negative impact. Therapy around personal trauma may have also influenced the results of this study. This will be discussed further below.

This study utilized two tools to identify trauma and its impact. The second way in which trauma was measured in this study was using the PTSD checklist. Results suggest that 26% of the sample was at risk for PTSD. This number is higher than the average for the general public having PTSD (7-8%) and as high or higher than some combat veterans (11-30%) (VA Center, 2018). The fact that there may be more clinicians with PTSD than veterans is astounding. The rate of PTSD is also high when compared with other studies of clinicians and their own trauma. For example, 20% of therapists who were directly exposed to war in Israel indicated they were at

risk for PTSD (Freedman & Tuval Mashiach, 2018). Perhaps the higher percentage here was related to the fact that many respondents experienced multiple traumatic events. This would be consistent with research noting the increased risk with multiple experiences of trauma (Briere, Agee, & Dietrich, 2016). The level of PTSD may also correspond to the types of trauma participants experienced. There were significant numbers of participants who experienced unwanted sexual contact, for example. However, since there was not a thorough exploration of the types of trauma, we can only speculate that it may have had an impact.

The level of trauma and PTSD in the sample may also provide information about those in the mental health profession. Those who have experienced trauma may be more likely to be drawn to work with others who have experienced trauma. Studies on those in the mental health profession have certainly found evidence of personal trauma (Baird & Kracen, 2006; Hensel et al., 2015). Some, as in this study, found experiences and severity of trauma to be at higher rates in clinicians than in the general population (Jordan-Cox, 2018). Turgoose and Maddox (2017) suggest that traumatized people often choose professions related to trauma. Jenkins et al. (2011) also suggest that some trauma therapists are inspired to enter the profession because of their own experiences of trauma. Survivors may be highly motivated to assist others as part of their own recovery process. The desire to give back and help is identified as a strong component of healing and growth (Tedeschi & Calhoun, 1996). If healing from trauma involves helping others, one could expect there to be a high number of clinicians who also suffer from trauma. Therefore, the additional findings of this study bear weight on the care of clinicians.

Correlations

Although personal trauma history was reported at high levels, it was a variable that was not significant in many ways. There were no significant correlations between personal trauma

and any of the ProQOL scales. Personal trauma was not related to compassion fatigue, compassion satisfaction, or burnout. This finding is similar to studies that concluded personal trauma did not impact compassion fatigue (Hunter, 2012; McKim & Smith-Adcock, 2014; Thomas, 2013). Having had personal experiences of trauma does not mean that one would have negative reactions to clinical work. This finding may highlight the fact that what happens personally does not necessarily have an impact on therapeutic work or a therapist's well being. Perhaps compassion fatigue and burnout are connected more to workplace factors, rather than personal ones. It may also be that the other protective factors, such as social supports and personal therapy, have an impact on how much personal trauma correlates to compassion fatigue and burnout (Ludick and Figley, 2016). Similar arguments may be made as to why personal trauma was not correlated to compassion satisfaction. The relationship between therapist trauma and compassion satisfaction was found in other studies (Baird & Kracen, 2006; McKim & Smith-Adcock, 2014; Thomas, 2013). Again, it may be that the actual work in the field and the workplace environment have a greater influence here. Satisfaction with one's clinical experiences may not correlate to one's personal experiences. Rather, one's abilities to be effective and recognize progress may be much more significant than past trauma. The fact that personal trauma was not significant allows us to conclude that personal experiences of trauma alone, for the respondents in this study, did not lead to increases in compassion satisfaction or fatigue.

Responses to personal trauma on the Life Events Checklist were also surprisingly not correlated to PTSD. Although one would need to have experienced trauma in order to develop symptomology, in the present study, having experiences of trauma did not correlate with symptoms of PTSD. It may be that the lack of significant statistical correlation was a result of

the incredibly high percentage of those who experienced trauma compared to a relatively small percentage of those who demonstrated symptoms of PTSD. This is supported in literature that recognizes the ways in which experiences of trauma do not necessarily lead to negative consequences (Briere, Agee, & Dietrich, 2016; Kessler, et.al, 2005; VA National Center for PTSD, 2018). In addition, the amount of therapy that participants had received may have also impacted the relationship between trauma and PTSD. Since 83% of the participants received their own therapy, perhaps treatment was a factor in the lack of correlation between personal trauma and PTSD. It may also be that helping others decreases the risk of developing PTSD.

There was a correlation between personal trauma and post traumatic growth. It makes logical sense that post traumatic growth can only occur if one has experienced trauma. This seems to support findings from other studies that suggest personal trauma can have a positive impact on growth (deFiguerdo, et.al. 2014; Linley & Joseph, 2007; McKim & Smith-Adcock, 2014). According to Tedeschi & Calhoun (1996), post traumatic growth may be identified in several areas that shift after a trauma. Growth may be connected to finding new opportunities, noticing an increased sense of strength, developing greater appreciation for life, deepening one's spiritual beliefs, and experiencing a change in relationships (Tedeschi & Calhoun, 1996). Going through something that could be perceived as life threatening and then surviving could certainly shift one's perspective. These shifts, which may lead to a more positive and optimistic outlook, may be the factors that contributed to other findings in this study.

The measures used in this research support the notion that the existence of personal trauma alone does not necessitate negative outcomes. Since personal trauma was not significantly correlated with other variables, this researcher identified and relied on the severity

of the impact of the trauma as measured by the PTSD checklist. Severity of the impact, as opposed to the event itself, proved to be an important distinction in the present study.

Unlike correlations with personal trauma indicators, analyses found significant correlations between PTSD and measures of secondary traumatic stress, burnout, and compassion satisfaction. This is consistent with other studies that found personal trauma histories were associated with these concepts (Baird & Kracen, 2006, Deighton, Gurriss, & Traue, 2007; Killian, 2008; Perlman & MacIan, 1995; Rossi et al., 2012; Thomas, 2013). The difference in the present study is that the measurements are more specific. As mentioned in Chapter One, other studies that found personal trauma was connected to negative outcomes did not identify the severity of personal traumatic experiences (Baird & Kracen, 2006; Killian, 2008). The present results seem to indicate that it is not the experience of trauma itself that leads to potentially negative outcomes. Rather, the presence and severity of symptomology related to trauma should be measured. This may also explain some of the inconsistencies in studies related to whether personal trauma has an impact on professional experience and practice. In other words, if previous studies were not accounting for personal trauma in the same way, it makes logical sense that the outcomes would vary. In their meta-analysis, Hansel, et.al (2015), noted that most of the studies addressing risk factors for therapists used dichotomous measures to assess whether a clinician experienced any type of personal trauma. They found that the type of trauma and extent of exposure appeared to influence whether personal trauma was a factor in secondary traumatic stress. Those studies that measured the severity of trauma found stronger connections.

Demographic Variables

Participants in the present study differed from each other in some significant ways. These differences and their correlations are consistent with other research studies about

clinicians. Significant differences were found in the areas of experience, work exposure to trauma, training and education, and protective factors.

Experience. Some previous studies found that compassion fatigue increased with experience (Boscarino et al., 2004; Sprang et al., 2007; Turgoose & Maddox, 2017). Others, however, found that newer therapists struggle more with negative consequences of trauma work (Craig & Sprang, 2010; Perlman & MacIan, 1995; Turgoose & Maddox, 2017; Volpe, et.al, 2014). In this study, those who had been working longer also seemed to fare better with regard to lower compassion fatigue. The group with over 15 years experience also reported the greatest compassion satisfaction. This finding is similar to other studies that found satisfaction increased with experience (Craig & Sprang, 2010; Butler, Carello & Maguin, 2017). Perhaps seasoned clinicians have developed ways to find satisfaction in their work. With the increased amount of experience, they may also have had more opportunity to see the positive results of their work and note the ways they have made a difference. The role of post traumatic growth, even witnessing the growth of clients after trauma, are also likely factors here. It is also possible that those who have not been able to find satisfaction in their work after a decade or more, have left the field.

It may also be that those with more experience are able to diversify their cases and other tasks to minimize direct exposure. The group that seemed to struggle the most were those in the 6 to 15 year range. It is this stage of one's career when tough cases may be assigned and work is intense without the luxury of the support one may receive as a new professional. It may also coincide with more difficult stages of the human life cycle (for example, working and raising young children).

Work exposure. In this study, 95% of the participants served traumatized clients and over half of the sample identified trauma in 71 to 100% of their caseload. Clearly, there is a high

exposure to client trauma. Other studies have found that as many as 70% of trauma specific therapists experienced negative consequences of their work (Sodeke-Gregson, et al., 2013; Arnold, et.al., 2005). In the present study, those with higher trauma caseloads had significantly greater compassion fatigue. This is consistent with other studies that reported increased fatigue with high trauma caseloads (Craig & Sprang, 2010; Killan, 2008; Sodeke-Gregson, et.al., 2013). However, in this study, even with high trauma caseloads, participants had relatively low compassion fatigue when compared with national samples (Stamm, 2010). The lower scores here may be connected to the positive factors, such as compassion satisfaction.

In their study, Sodeke-Gregson, et al. (2013) suggested that the positive outcome of compassion satisfaction may balance negative exposure that results in secondary traumatic stress and burnout for trauma therapists. In their study, Butler, Carello, and Maguin (2017) also noted that therapists with more traumatized clients reported higher compassion satisfaction. In other words, the exposure to more traumatized clients may increase the likelihood that therapists will see growth in their clients and experience themselves as more effective. The ways in which client progress has the potential to influence the beliefs of the therapist is an example of systems theory. Low compassion fatigue in these participants may also be related to all of the protective factors identified within this sample. For example, the overwhelming majority of participants received supervision, attended training, had social supports, and practiced self care.

Training and education. There were some intriguing differences based on the level and type of education of clinicians. Those with terminal masters degrees scored significantly higher on compassion fatigue. This varied from the Sprang et al. (2007) study which found that psychiatrists had an increased risk for compassion fatigue (although there were no psychiatrists in the present study). It could be that masters' level training differs from PhD training so that

clinicians respond differently to clients, or that masters' level clinicians are treated differently once they are in practice increasing the potential for compassion fatigue. Masters' level training may be focused more on empathy and relationship building than doctoral level training. In their study, Negash & Sahin (2011) found that those who were trained specifically to use relationships as a clinical tool were at greater risk for compassion fatigue. In training programs that emphasize developing relationships, empathy is a critical component. Figley (2002) described both cognitive and affective therapy, noting that affective empathy is more of a direct experience of client's emotions. It could be that those whose clinical practice is heavily based in empathy and engaging in a relationship with the client are at a greater risk for compassion fatigue. It may be that master's level clinical training is more relationship focused than PhD level training. This may be because the sole focus in many masters programs is developing therapeutic skills. In contrast, doctoral programs focus on other types of skills, such as research and teaching. Lastly, it may be that masters level clinicians have less work support than PhD level clinicians (less financial support, less respect, less flexibility) and therefore experience more compassion fatigue.

Protective factors. The majority of the participants seemed to identify factors that would be likely to build resiliency, such as training, supervision, social support, and self care. The high percentage of these activities have been identified as factors in other research focused on compassion fatigue and compassion satisfaction in clinicians (Killian, 2008; Merriman, 2015; Perlman & MacIan, 1995; Sodeke-Gregson, et.al., 2013). Protective factors may have played a role in the level of growth and satisfaction in this study as well. For example, the below average scores in compassion fatigue may have been influenced by the level of training and supervision participants received. In addition, the lack of correlation between personal traumatic events and

compassion fatigue could also be attributed to areas of strength within individuals and their workplace systems, such as self care, supervision/ training, and social support.

Compassion Fatigue, Compassion Satisfaction, and Post Traumatic Growth

The analyses determined that PTSD was significant in both compassion fatigue and compassion satisfaction. In fact PTSD alone predicted 44% of the variance for compassion fatigue. Therapists with PTSD had higher compassion fatigue scores. This is consistent with other research that found therapist trauma was related to higher compassion fatigue (Baird & Kracen, 2006, Deighton, et al., 2007; Killian, 2008; Rossi et al., 2012; Thomas, 2013). In addition, those who met criteria for PTSD also had lower compassion satisfaction. This is also consistent with previous studies (Baird & Kracen, 2006; Thomas, 2013). In this study, those with higher risk for PTSD and no post traumatic growth fared the worst, having the highest compassion fatigue and lowest compassion satisfaction. Interestingly, the clinicians that fared best were those with no PTSD and post traumatic growth. At first glance, this seems to indicate that having PTSD means one is more likely to have compassion fatigue and less satisfaction. However, it is important to note the role of post traumatic growth. Given the significant number of those who experienced trauma, the growth from those experiences cannot be overlooked.

Some research has noted that having personal trauma can be helpful to clinicians, in that it can lead to personal growth (Linley & Joseph, 2007) and increase compassion satisfaction (McKim & Smith-Adcock, 2014). The results of this study also indicate that having personal trauma and post traumatic growth can impact compassion satisfaction as well as compassion fatigue. The group that had the highest compassion fatigue were those who had PTSD but no post traumatic growth. This makes sense in that those with their own trauma symptoms who had not benefitted from some aspect of the trauma would be more likely to exhibit stress and burnout

in their work. According to trauma and neurobiological theories, if those participants had not found ways to heal from their own trauma or develop trust in others, their ability to be open and attuned to clients may have been impaired. That experience in therapy could increase the level of frustration and reactivity of the clinician. The lowest compassion fatigue scores were in the group with no PTSD who had also experienced growth. While initially this seemed like an odd finding, it can be explained by the significant amount of those who experienced some trauma. Perhaps the growth was related to having a traumatic experience, even if it did not result in symptomology captured by the PTSD Checklist. Those traumatic events that did not result in PTSD may still have led to some growth that further decreased the risk for compassion fatigue. In other words, the experience of trauma and the resulting growth may have shifted views in ways that led to better outcomes.

Similarly, the highest compassion satisfaction was reported by those with no PTSD and with post traumatic growth. The lowest compassion satisfaction was reported in the group with PTSD and no post traumatic growth. Interestingly, the compassion satisfaction scores were nearly identical for those with PTSD and post traumatic growth and those with no PTSD and no post traumatic growth. The positive change that results from trauma could possibly have the same benefit as not having had severe trauma in the first place. This could also be explained by trauma theory and interpersonal neurobiology. If one experiences trauma, but is in a connected and healthy relationship, the negative impact of the trauma is less (Hambrick, et al, 2018). In those cases, clinicians may not have developed PTSD. Yet, their framework for connecting with others and being empathic likely contributed to their effectiveness with clients. In turn, that would certainly increase compassion satisfaction.

Therefore, the level of symptomology related to one's own trauma is connected to both the level of fatigue and satisfaction. However, it is important to distinguish here that results are connected to the severity of the trauma. Meeting criteria for PTSD appears to be of critical importance in drawing the conclusion that personal trauma has a negative impact. It is not the experience of personal trauma itself but the impact. Group differences insinuate that growth does play a role in the level of compassion fatigue and satisfaction. However, the statistical results found that post traumatic growth is not the factor that mediates the relationship between PTSD and compassion fatigue. This finding is what prompted this writer to run additional analysis for compassion fatigue. These results may be better understood by examining the mediation results, which are discussed below.

Research Questions

Post traumatic growth has been a significant predictor of compassion fatigue and compassion satisfaction in other studies (Putterman, 2005). Interestingly, post traumatic growth did not mediate the relationship between PTSD and compassion fatigue in this research. Perhaps this signifies that it is not growth from trauma that influences the experience of fatigue. Compassion fatigue is connected to secondary traumatic stress and burnout, both of which are connected to workplace factors. It could be that external factors, ones related to the workplace, have a more significant impact in the present study.

However, post traumatic growth was found to mediate the role of PTSD in compassion satisfaction. For example, PTSD alone accounted for just 9% of the variance in satisfaction. The analysis found that the proposed model with post traumatic growth as a mediator accounted for approximately 21% of the variance in compassion satisfaction. It seems to make logical sense that those who have experienced trauma but who have also grown from that experience

would report higher satisfaction. They may be more inclined to recognize healing in their clients and feel more effective in their work. This is similar to other studies that found growth after trauma helpful in clinical work (Linley & Joseph, 2007; Putterman, 2005). It is still important then to look at growth as a protective factor over the negative impact of personal trauma.

Although the original intent of this study was not necessarily to understand the relationship between compassion fatigue and compassion satisfaction, post-hoc analysis led to some interesting findings. Since this research sought to identify ways to minimize negative impacts of trauma, additional analyses were conducted to investigate other factors that could influence compassion fatigue. Other studies have looked at the relationship between compassion fatigue and compassion satisfaction (Rossi, et.al, 2012; Turgoose & Maddox, 2017). In their review of studies on compassion fatigue, Turgoose and Maddox (2017) found evidence that increased compassion satisfaction was associated with lower compassion fatigue. However, this study found that compassion satisfaction mediates the potential negative outcome of PTSD and compassion fatigue. The model that included compassion satisfaction as a mediator accounted for 61% of the variance in compassion fatigue. This seems especially interesting, as a positive response to personal trauma seems to increase satisfaction, which in turn mediates compassion fatigue. This model appears to have significant implications for training and ongoing support of therapists in the field.

This finding may put a greater emphasis on the notion of compassion satisfaction and finding ways to increase the positive response to both personal trauma and clinical work with trauma. According to Stamm (2002), compassion satisfaction is related to how much clinicians sense that they are able to make a difference in the world. Compassion satisfaction is also influenced by how well therapists perceive they are doing their job. The amount of control

individuals have over their exposure to traumatic material has an impact on this perception. Lastly, compassion satisfaction is influenced by how much support a therapist experiences in and out of the workplace (Stamm, 2002). It seems that there are both individual and workplace factors then that can assist clinicians and help them become more successful. Therapists who are able to recognize the impact they make and be acknowledged for the work that they do may have greater satisfaction. The differences in level of education also beg the question as to how workplaces utilize and treat clinicians. If compassion satisfaction is important, are there ways that the workplace is actually less satisfying for master's level educated clinicians? Are there opportunities that could be offered in the workplace to change that dynamic?

The results suggest that the best way to minimize the impact of personal trauma, which is clearly prevalent, is to notice the positive changes. This conclusion is consistent with other studies that addressed protective factors. For example, in his study of first responders to disaster, Burnett (2017) found that resilience moderately mediated the relationship between compassion fatigue and burnout. In addition, Ludick and Figley (2016) also address the importance of resiliency in the model of secondary traumatic stress. It seems that the field is in a trend to look more deeply into specific and strengths based ways to assist those working with trauma.

Results from this study lent support to the need to focus on positive aspects of experiencing trauma. Specifically, post traumatic growth appears to increase satisfaction. Compassion satisfaction, in turn, mediates the relationship between PTSD and compassion fatigue. This then seems to indicate there may be a model for assisting therapists who may have PTSD due to their own traumatic experiences.

Focus on Strengths

While many studies in the past initially focused on the negative impact of trauma work and role of personal trauma in the lives of clinicians (MacIain and Perlman, 1995; Baird & Kracen, 2006), one significant finding of this study points to the importance of focusing on strengths. Van der Kolk (2014) contends that clinicians should look at the broader context of the lives of those who are traumatized, specifically to include those components that are positive and strengths based. In other words, there is more to a person and their life than their symptoms and negative experiences. The results here also highlight the significance of the positive impact of trauma work. There is more to the clinician than their traumatic experiences and symptoms. Protective factors, post traumatic growth, and compassion satisfaction hold the potential for therapists to become better clinicians as a result of their exposure to traumatic events. These findings have significant implications for training and support of clinicians, which will be discussed below.

Limitations

There were some limitations to this study that may impact the generalizability of the results. First, this was a small convenient cross sectional sample with little diversity according to race and gender. In addition, the therapists all came from the same geographical region. It is important to note that these findings may be specific to this population from this area of the United States. Another factor was the fact that the groups were not of equal size. For example, the majority of the sample experienced personal trauma, while there were fewer participants who met criteria for PTSD. Therefore, group differences may be less accurate. Additional analyses on differences between each group could also not be conducted due to the small group sizes. The fact that only five percent of the sample completed paper surveys may have also impacted

results. Since personal trauma was not significantly correlated with any dependent variable, PTSD was used as the measure of therapist trauma in the study.

The study was based on a homogenous sample in that most had experienced personal trauma, with an average of 4 traumatic experiences. This made comparison around personal trauma difficult. The analysis also did not take multiple events into account. Similarly, the type of traumatic event was not distinguished. In other words, the impact of personal trauma may have been connected to the frequency and type of trauma, but that was not accounted for in the analysis.

There may also be limitations based on the measurements used in the final analysis. Since the experience of trauma was so prevalent, the analysis fell to using PTSD as the independent variable. Results then are only significant for those who demonstrate PTSD, which is a very small subset of the population. Although meeting criteria for PTSD may present as a high risk factor for personal and professional well being, it is important to note that results are relegated to those meeting that criteria. Perhaps there are other ways to better capture personal trauma and its impact that could be generalized to a wider pool of clinicians.

Another limitation was the way in which scales were used. Although the literature states that compassion fatigue is a combination of secondary traumatic stress and burnout (Stamm, 2010), error may have been introduced by combining the two scales here. The correlations between all the scales on the ProQOL may have given some inflated significant results. In addition, the Secondary Traumatic Stress Scale and PTSD checklist each measure similar criteria. In other words, it may be difficult to separate symptoms of PTSD from symptoms connected to secondary traumatic stress. This may also have skewed results.

Another significant limitation is that the measures did not take into account the ways variables may have been influenced by work exposure. Since the caseload of the therapists had such a large portion of traumatized clients, it is possible that there were other factors outside of personal experience. For example, it is possible that PTSD and PTG were also influenced by exposure to trauma through work. Similarly, it is unclear whether participants were able to separate their experience of growth from personal trauma as distinctly different from vicarious post traumatic growth. In other words, growth indicators may have also been impacted by work related experiences that were not measured in this study.

Clinical Implications

This study has significant implications for clinicians, training, and ongoing assistance and continuing education offered to mental health professionals. This sample was overwhelmingly exposed to personal traumatic life events. It may be that the field in general, along with employers, training sites, teachers, and supervisors need to recognize the fact that therapists may have their own trauma which has the potential to impact clinical functioning. While some studies identify personal trauma as a risk (Baird & Kracen, 2006, Hensel et al, 2015; Killian, 2008), results here indicate that growth from personal trauma could contribute to better outcomes for clinicians. It seems that there should be efforts to build a training and workplace environment that promotes not only acceptance, but also targets ways to build strength and satisfaction.

Personal trauma on its own was not a significant factor in this study. However, PTSD did have a significant effect on compassion satisfaction and compassion fatigue. As such, clinicians and their supervisors should be mindful of ways symptoms related to personal trauma can impact the therapy they provide. Clinicians may benefit from attending to their own traumatic

experiences and using resources to assist in their own healing. Since PTSD seemed to have a negative impact, it appears imperative for those in the field to seek their own therapy or other supports in order to improve not only their own functioning, but their professional experiences as well.

This study signals the protective nature of positive growth by the way of post traumatic growth and compassion satisfaction. While post traumatic growth is more of an individual process, compassion satisfaction stems from individual as well as workplace attitudes. Employers and supervisors would better serve both staff and clients if they could attend to the ways therapists are able to experience themselves as effective in their work. An environment where there are natural supports and a sense of empowerment could assist in compassion satisfaction. Ways in which client and therapist success are celebrated may also increase satisfaction. The model proposed here indicates that growth and satisfaction can assist with compassion fatigue.

Some of the group differences point to factors that could be taken into consideration by clinicians and their employers. For example, therapists with less experience may be at the highest risk. It would be best to provide those in that stage of career development with training, support, supervision, and an emphasis on the ways in which the worker makes a difference. The fact that more trauma cases increased risk for fatigue and did influence compassion satisfaction suggests that careful consideration should be given to the type and amount of cases therapists are assigned. Rather than focus on shortcomings, perhaps supervisors can highlight the success of clinicians. Perhaps training can focus not just on skills, but ways to find growth and satisfaction in small ways.

This study has strong implications for training clinicians, especially those who will be working with trauma. In this study, masters-level clinicians struggled more than their PhD-level colleagues. It may be important, then, for masters training programs to be particularly sensitive to the ways that their training could be enhanced. Certainly, normalizing experiences of trauma and the development of compassion fatigue seem obvious. Helping new therapists accept their experiences and attend to their own healing are important. Developing curriculum that educates students about compassion fatigue and practices that minimize stress may also better equip future clinicians. In addition, finding ways to develop satisfaction and notice growth could also assist new therapists. There have been some models that are specifically designed to combat compassion fatigue (eg.; Klein, Riggerbach-Hays, & Sollenberger, 2017; Miller & Sprang, 2017). In their model, Miller & Sprang (2017) note that there are steps that clinicians can take to alleviate negative impacts of trauma work. These include very specific skills around engagement, regulating affect, developing a narrative around the trauma work, and finding balance. While this is a solid beginning, the model does not take personal trauma experiences or PTSD into account. Further development of such models may introduce components for clinicians who also have personal experiences of trauma.

Since it appears that experiencing trauma is likely to be prevalent, it seems that a focus on building compassion satisfaction is a way to mitigate the negative toll of trauma. Using research from neurobiology, addressing ways therapists are able to manage their own regulation and stay attuned to clients would be a way to increase a feeling of satisfaction (Barrett & Stone Fish, 2014; Surguladze, et al, 2018; Zaleski, et al., 2016). Mindfulness practices have also shown promise in increasing health and satisfaction for those who work in trauma (Brown & Ryan, 2003; Decker, Constantine Brown, Ong, & Stiney, Ziskind, 2015; Martin, et al., 2018;

Surguladze, et al., 2018; Thomas & Otis, 2010). Stamm (2002) identifies factors related to compassion satisfaction which can certainly be incorporated into both workplaces and training programs. For example, helping therapists notice the difference they make in the lives of others and highlighting success, no matter how small, may be critical. Focusing on treatment models that are effective with complex trauma cases may also help therapists build satisfaction. Lastly, acknowledging one's work and offering real support should be part of agencies or practices, especially when services are offered to traumatized people.

Future Research

Although this study focused on severity of trauma, as measured by PTSD, it did not look at specific types of trauma or multiple exposure. Since these can also have an impact, future studies may look deeper into differences based on these factors. Additional studies may look specifically into childhood trauma of clinicians, as these types of events may have a different long term effects. Also, this sample reported more traumatic events than other samples of clinicians. It may be that because the field, at the time the study was done, is more attuned to trauma than at other times and respondents are more likely to report it. In addition, this study was done in a community riddled with poverty and gun violence, so there is more trauma in the community. It would be beneficial to replicate this study in a less traumatized community. Further studies may also involve looking at the different types of traumatic life events to determine their weight on the experience of trauma or development of PTSD. Lastly, identifying trauma experienced directly in the workplace may also bring forth new information. This research only identified trauma if it was a direct personal experience or witnessed event. There were many participants, though, who also learned about trauma through others or in the context

of their job. Those experiences of trauma may have a different impact on clinical functioning and could be worth investigating.

Future studies may also look deeper into the role of empathy and compare the training of clinicians as opposed to others who work within the field of trauma. Studies may also focus on measurement of empathy and specific paths that lead to satisfaction, as some studies found that empathy is a moderator between therapist trauma and compassion fatigue (Turgoose & Maddox, 2017). In addition, some studies have found that empathy may pose a risk to clinicians, but there are mediating factors and practices that can reduce the negative impact (Surguladze, et al., 2018). Research that looks at specific training models and their emphasis on affective empathy (Figley, 2002) could solidify the ways in which deep connection to clients is a risk, a protective factor, or both. Similarly, looking specifically at the differences between masters and doctoral level clinical training around the use of empathy could be useful.

Implications thus far have alluded to larger systems, supervisors, and workplaces developing sensitivity to the needs of the therapists. However, there are individual components that have potential for further exploration as well. Putterman (2005) suggests that there may be individual personality factors that influence post traumatic growth. Others suggest that self compassion plays a role in the development of resilience and compassion fatigue (Yip, Mak, Chio, Law, 2017). Perhaps such factors may also play into the development of compassion satisfaction or growth. These theories may be worth further exploration as well.

Some of the protective factors identified in this research , such as social support, self care, and supervision, were not measured in depth. Perhaps a richer measure for support and resiliency would further the understanding of positive growth and its role in trauma work. Since there were some significant differences in level of education and trauma caseload, those areas

may be worth exploring further. In addition, future studies may look deeper into specific differences between each of the four groups identified in this study.

This study suggests a model wherein post traumatic growth mediates compassion satisfaction, which then mediates compassion fatigue. Perhaps additional studies looking at these variables together would increase understanding and lead to better inventions for support and training of clinicians. For example, what skills or assistance could be useful in increasing post traumatic growth? What workplace practices best amplify the development of compassion satisfaction? It would be very interesting to conduct an experimental study and look at specific outcomes based on interventions with therapists.

Summary

Trauma is prevalent in the world and therefore in the experiences of human beings living in it, whether they are identified as clients or clinicians. Until more recently, most research identified the deleterious effects of working with trauma, let alone the negative risks associated with trauma therapists who had also experienced personal traumatic events. The purpose of this study was to identify whether post traumatic growth impacted the work of clinicians, as a means to combat beliefs that therapists with their own trauma were more at risk professionally.

While the findings do support the idea that personal trauma does impact professional outcomes, there are many critical points of distinction. First, personal trauma in and of itself is not correlated to any increase in compassion fatigue or decrease in satisfaction. It must be noted that those who develop symptomology as a result of their own experiences are at greater risk. Yet, the findings also suggest that there are pathways to minimize even those potentially

negative effects. Focusing on personal care and growth and fostering satisfaction are two concrete ways these findings may contribute to the field.

Systems theory is foundational to understanding the concepts explored in this study. Therapists who experience trauma in their families of origin or current families, for example, may develop a decreased ability to develop trust and empathy. In turn, therapists may struggle with feeling connected to and effective with traumatized clients. Each therapists' view of self, as a person and professional, could certainly influence how much they feel satisfied in their work. Systems also provides a rationale as to how the workplace and its level of support or functioning can have a significant impact on the overall well-being of clinicians. Thus, the findings are important for individuals and the systems to which they belong.

The results may be summarized as the following: post traumatic growth does not significantly mediate the relationship between PTSD and compassion fatigue, post traumatic growth does mediate the relationship between PTSD and compassion satisfaction, and finally compassion satisfaction mediates the relationship between PTSD and compassion fatigue. In other words, clinicians in the present study who experienced growth after trauma had higher levels of compassion fatigue unless they had also found satisfaction in their work. Those clinicians who reported severe symptoms associated with traumatic events and a deep sense of satisfaction in the work they were doing, reported less compassion fatigue. These results lend support to the field which is turning focus to the positive results of trauma and the development of resiliency. There are also significant implications for enhanced training and better support of therapists. Future research may look deeper into this model and further identify practices that prove to increase satisfaction and lessen fatigue in the mental health field.

APPENDIX ADemographic Questionnaire

- 1) What is your age?
- 2) What is your gender?
- 3) What is your ethnicity?
- 4) How many years have you been in the field?
0-5 _____ 6-10 _____ 11-15 _____ over 15 _____
- 5) What is your educational degree?
- 6) What is your identified profession?
- 7) Is there a theory or framework that guides your therapy? Yes _____ No _____
- 8) The estimated percentage of my caseload that involves trauma: _____
- 9) Have you ever received any trauma specific training? Yes _____ No _____
- 10) The quality of my clinical supervision is: poor ___ adequate ___ excellent ___
- 11) I view myself as having social supports. Yes ___ No _____
- 12) I have received personal therapy. Yes _____ No _____
 - a. The quality of that therapy is/was: poor ___ adequate ___ excellent _____
- 13) Do you utilize self-care practices? Yes _____ No _____

APPENDIX B

PROFESSIONAL QUALITY OF LIFE SCALE (PROQOL)

COMPASSION SATISFACTION AND COMPASSION FATIGUE

(PROQOL) VERSION 5 (2009)

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.					
_____ 2.					
_____ 3.					
_____ 4.					
_____ 5.					
_____ 6.					
_____ 7.					
_____ 8.					
_____ 9.					
_____ 10.					
_____ 11.					
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_____ 27.					
_____ 28.					
_____ 29.					
_____ 30.					

APPENDIX C

LEC-5

Listed below are a number of difficult or stressful things that sometimes happen to people. For each event check one or more of the boxes to the right to indicate that: (a) it *happened to you* personally; (b) you *witnessed it* happen to someone else; (c) you *learned about it* happening to a close family member or close friend; (d) you were exposed to it as *part of your job* (for example, paramedic, police, military, or other first responder); (e) you're *not sure* if it fits; or (f) it *doesn't apply* to you.

Be sure to consider your *entire life* (growing up as well as adulthood) as you go through the list of events.

<i>Event</i>	<i>Happened to me</i>	<i>Witnessed it</i>	<i>Learned about it</i>	<i>Part of my job</i>	<i>Not Sure</i>	<i>Doesn't Apply</i>
1. Natural disaster (for example, flood, hurricane, tornado, earthquake)						
2. Fire or explosion						
3. Transportation accident (for example, car accident, boat accident, train wreck, plane crash)						
4. Serious accident at work, home, or during recreational activity						
5. Exposure to toxic substance (for example, dangerous chemicals, radiation)						
6. Physical assault (for example, being attacked, hit, slapped, kicked, beaten up)						
7. Assault with a weapon (for example, being shot, stabbed, threatened with a knife, gun, bomb)						
8. Sexual assault (rape, attempted rape, made to perform any type of sexual act through force or threat of harm)						
9. Other unwanted or uncomfortable sexual experience						
10. Combat or exposure to a war-zone (in the military or as a civilian)						
11. Captivity (for example, being kidnapped, abducted, held hostage, prisoner of war)						
12. Life-threatening illness or injury						
13. Severe human suffering						
14. Sudden violent death (for example, homicide, suicide)						
15. Sudden accidental death						
16. Serious injury, harm, or death you caused to someone else						
17. Any other very stressful event or experience						

APPENDIX D

PTSD Checklist – Civilian Version (PCL-C)

Client's Name: _____

Instruction to patient: Below is a list of problems and complaints that veterans sometimes have in response to stressful life experiences. Please read each one carefully, put an "X" in the box to indicate how much you have been bothered by that problem *in the last month*.

No.	Response	Not at all (1)	A little bit (2)	Moderately (3)	Quite a bit (4)	Extremely (5)
1.	Repeated, disturbing <i>memories, thoughts, or images</i> of a stressful experience from the past?					
2.	Repeated, disturbing <i>dreams</i> of a stressful experience from the past?					
3.	Suddenly <i>acting or feeling</i> as if a stressful experience <i>were happening</i> again (as if you were reliving it)?					
4.	Feeling <i>very upset</i> when <i>something reminded</i> you of a stressful experience from the past?					
5.	Having <i>physical reactions</i> (e.g., heart pounding, trouble breathing, or sweating) when <i>something reminded</i> you of a stressful experience from the past?					
6.	Avoid <i>thinking about or talking about</i> a stressful experience from the past or avoid <i>having feelings</i> related to it?					
7.	Avoid <i>activities or situations</i> because they <i>remind you</i> of a stressful experience from the past?					
8.	Trouble <i>remembering important parts</i> of a stressful experience from the past?					
9.	Loss of <i>interest in things that you used to enjoy</i> ?					
10.	Feeling <i>distant or cut off</i> from other people?					
11.	Feeling <i>emotionally numb</i> or being unable to have loving feelings for those close to you?					
12.	Feeling as if your <i>future</i> will somehow be <i>cut short</i> ?					
13.	Trouble <i>falling or staying asleep</i> ?					
14.	Feeling <i>irritable</i> or having <i>angry outbursts</i> ?					
15.	Having <i>difficulty concentrating</i> ?					
16.	Being <i>"super alert"</i> or watchful on guard?					
17.	Feeling <i>jumpy</i> or easily startled?					

PCL-M for DSM-IV (11/1/94) Weathers, Litz, Huska, & Keane National Center for PTSD - Behavioral Science Division

This is a Government document in the public domain.

APPENDIX E

post-traumatic growth inventory

Listed below are 21 areas that are sometimes reported to have changed after traumatic events. Please mark the appropriate box beside each description indicating how much you feel you have experienced change in the area described. The 0 to 5 scale is as follows:

- 0 = I did not experience this change as a result of my crisis
 1 = I experienced this change to a very small degree
 2 = a small degree
 3 = a moderate degree
 4 = a great degree
 5 = a very great degree as a result of my crisis

	<i>possible areas of growth and change</i>	0	1	2	3	4	5
<i>a.</i>	my priorities about what is important in life						
<i>b.</i>	an appreciation for the value of my own life						
<i>c.</i>	I developed new interests						
<i>d.</i>	a feeling of self-reliance						
<i>e.</i>	a better understanding of spiritual matters						
<i>f.</i>	knowing that I can count on people in times of trouble						
<i>g.</i>	I established a new path for my life						
<i>h.</i>	a sense of closeness with others						
<i>i.</i>	a willingness to express my emotions						
<i>j.</i>	knowing I can handle difficulties						
<i>k.</i>	I'm able to do better things with my life						
<i>l.</i>	being able to accept the way things work out						
<i>m.</i>	appreciating each day						
<i>n.</i>	new opportunities are available which wouldn't have been otherwise						
<i>o.</i>	having compassion for others						
<i>p.</i>	putting effort into my relationships						
<i>q.</i>	I'm more likely to try to change things which need changing						
<i>r.</i>	I have a stronger religious faith						
<i>s.</i>	I discovered that I am stronger than I thought I was						
<i>t.</i>	I learned a great deal about how wonderful people are						
<i>u.</i>	I accept needing others						

Tedeschi RG & Calhoun LG *The posttraumatic growth inventory: measuring the positive legacy of trauma* Journal of Traumatic Stress 1996; 9: 455-471

APPENDIX F



SYRACUSE UNIVERSITY

Department of Marriage and Family Therapy

DAVID B. FALK COLLEGE

OF SPORT AND HUMAN DYNAMICS

Therapists and Trauma: The Role of Post Traumatic Growth

My name is Tracey Reichert Schimpff, and I am a doctoral student at Syracuse University. I am inviting you to participate in a research study. Involvement in the study is voluntary, so you may choose to participate or not. This sheet will explain the study to you and please feel free to ask questions about the research if you have any. I will be happy to explain anything in detail if you wish.

I am interested in learning more about the role of trauma and post traumatic growth in the development of compassion fatigue and compassion satisfaction. You will be asked to complete five questionnaires, including a demographic form, the Professional Quality of Life Scale (ProQOL), the Life Events Checklist, the PTSD Checklist, and the Post-Traumatic Growth Inventory. Questions will be about your personal experiences with trauma, symptoms related to post traumatic stress, and your clinical work. This will take approximately 20 to 25 minutes of your time. All information will be kept anonymous. After you read and sign the consent form, they will be collected and stored separately from the surveys. The surveys will be kept separate and contain no identifying information other than a number. All data connected to the surveys will be identified by number only. Questionnaires will be placed in a separate envelope when completed. This means that your name will not appear anywhere and your specific answers will not be linked to your name in any way. This will be ensured as consent documents will not be returned with completed surveys.

The benefit of this research is that you will be helping us to understand therapists' experiences with trauma and post traumatic growth. This information should help us to improve training for therapists and ultimately improve delivery of clinical services. There are no direct benefits to you by taking part.

The risks to you of participating in this study are that some of the questions may cause some stress or discomfort. These risks will be minimized by the availability of the researcher to answer questions or provide resources if

necessary. In addition, trained clinicians are available to assist at either the Syracuse University Couple and Family Therapy Center, 443-3023, or Psychological Healthcare, 422-0300.

If you do not want to take part, you have the right to refuse to take part, without penalty. If you decide to take part and later no longer wish to continue, you have the right to withdraw from the study at any time, without penalty.

Contact Information:

If you have any questions, concerns, complaints about the research, contact Tracey Reichert Schimpff at 315-443-3026 or Linda Stone Fish, faculty advisor, at 443-3024. If you have any questions about your rights as a research participant, you have questions, concerns, or complaints that you wish to address to someone other than the investigator, if you cannot reach the investigator, contact the Syracuse University Institutional Review Board at 315-443-3013.

All of my questions have been answered, I am 18 years of age or older, and I wish to participate in this research study. I have received a copy of this consent form.

By signing, I agree to participate in this research study.

Signature of participant	Date

Printed name of participant

Signature of researcher	Date

Printed name of researcher

Table 2.

Participants by Gender (n=126)

Gender	Frequency	Percent
Female	106	84.1
Male	18	14.3
Transgender	2	1.6

Table 3.

Participant Race and Ethnicity (n=126)

Race	Frequency	Percent
Caucasian	102	81.0
Black/African American	9	7.1
Asian	4	3.2
Hispanic/Latino	2	1.6
Mixed race	3	2.4
Jewish	4	3.2
Other	2	1.6

Table 4.

Educational Degree of Participants (n=126)

Degree	Frequency	Percent
Bachelor	5	4
Masters	102	81
PhD	19	15

Table 5.

Participant Years in the Field (n=126)

Years	Frequency	Percent
0 to 5	55	43.7
6 to 10	20	15.9
11 to 15	12	9.5
Over 15	39	31.0

Table 6.

Profession of Participants (n=126)

Profession	Frequency	Percent
MFT	57	45.2
SWK	40	31.7
Psych	13	10.3
MHC	10	7.9
Other	6	4.8

Table 7.

Percent of Trauma Cases (n=125)

Percent of Caseload	Frequency	Percent
0 to 10	6	4.8
11 to 30	23	18.3
31 to 50	20	16.0
51 to 70	13	10.4
71 to 100	63	50.4

Table 8.

Participants That Received Trauma Training (n=126)

Training	Frequency	Percent
Yes	105	83.3
No	21	16.7

Table 9.

Quality of Supervision (n=126)

Supervision	Frequency	Percent
None	2	1.6
Excellent	60	47.6
Adequate	52	41.3
Poor	12	9.5

Table 10.

Traumatic Life Events Experienced or Witnessed (n=126)

Life Event	Frequency	Percent
Natural Disaster	49	39
Fire	22	18
Transportation Accident	84	67
Other Accident	34	27
Exposure to Toxic Sub.	5	4
Physical Assault	57	45
Assault with a Weapon	19	15
Sexual Assault	29	23
Unwanted Sexual Experience	75	60
Combat	4	3
Captivity	2	2
Life Threatening Illness	72	56
Human Suffering	37	29
Violent Death	24	19
Unexpected Death	18	14
Serious Injury	7	6
Other Stressful Event	76	60

Table 11.

Participants Receiving Personal Therapy (n=126)

Personal Therapy	Frequency	Percent
Yes	105	83.3
No	21	16.7

Table 12.

Self Care (n=125)

Self Care	Frequency	Percent
Yes	119	94.4
No	6	4.8

Table 15.

Analysis of Variance of Compassion Fatigue with PTSD and Post Traumatic Growth

Source	df	SS	MS	F	p
Between Groups	3	3375.93	1125.31	14.24	.000
Within Groups	114	9011.76	79.05		
Total	117	12387.69			

Table 16.
Analysis of Variance of Compassion Satisfaction with PTSD and Post Traumatic Growth

Source	df	SS	MS	F	p
Between Groups	3	478.20	159.39	6.87	.000
Within Groups	118	2738.93	23.21		
Total	121	3217.13			

Table 17.

Analysis of Variance of Compassion Fatigue based on Trauma Caseload

Source	df	SS	MS	F	P
Between Groups	4	1405.90	351.47	3.7524.34	.007
Within Groups	112	10491.40	93.67		
Total	116	11897.30			

Table 18.

Analysis of Variance of Compassion Fatigue Based on Years in the Field

<i>Source</i>	<i>df</i>	<i>SS</i>	<i>MS</i>	<i>F</i>	<i>p</i>
<i>Between Groups</i>	3	1855.59	618.53	6.70	.000
<i>Within Groups</i>	114	10532.11	92.39		
<i>Total</i>	117	12387.70			

Table 19.

Analysis of Variance of Compassion Satisfaction and Years in the Field

Source	df	SS	MS	F	p
Between Groups	3	248.82	82.94	3.30	.023
Within Groups	118	2968.30	25.16		
Total	121	3217.12			

Table 20.

Analysis of Variance of Compassion Fatigue by Educational Degree

Source	df	SS	MS	F	p
Between Groups	2	1349.65	674.83	7.03	.001
Within Groups	115	11038.04	95.98		
Total	117	12387.70			

Table 21.

Analysis of Variance of Compassion Satisfaction by Educational Degree

Source	df	SS	MS	F	p
Between Groups	2	152.24	76.12	2.96	.053
Within Groups	119	3064.88	25.76		
Total	121	3217.12			

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Zaleski, K. L., Johnson, D.K., & Klein, J.T. (2016) Grounding Judith Herman's trauma theory within interpersonal neuroscience and evidence-based practice modalities for trauma treatment. *Smith College Studies in Social Work*, 86:4, 377-393. DOI: 10.1080/00377317.2016.1222110

Zerach, G. (2013) Compassion fatigue and compassion satisfaction among residential child care workers: The role of personality resources. *Residential Treatment for Children & Youth*, 30:1, 72-91. DOI: 10.1080/0886571X.2012.761515

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Education

May 2019 Syracuse University, Department of Marriage and Family Therapy, Anticipated
Degree: Doctor of Philosophy.

August 1996 Syracuse University, Marriage and Family Therapy Program, Child and Family Studies Department, Degree Obtained: Masters of Arts.

May 1993 LeMoyne College, Psychology Major, Degree Obtained: Bachelor of Science.

Employment

September 2013 – Present, Director of Clinical Services, Department of Marriage and Family Therapy, The David B. Falk College of Sport and Human Dynamic, Syracuse University.

October 2008 – September 2013, Clinic Supervisor, Goldberg Couple and Family Therapy Center, Department of Marriage and Family Therapy, Syracuse University.

June 2007 – September 2008, Director of Child Welfare, The Salvation Army, Syracuse.

February 2006 - June 2007, Director of Permanency Services, The Salvation Army, Syracuse.

October 2005 – February 2006, Program Director, SAFER Program, The Salvation Army, Syracuse.

May 2003 – October 2005, Program Director, Multidimensional Treatment Foster Care, The Salvation Army, Syracuse.

September 2001 – May 2003, Clinical Supervisor, Family Services Department, The Salvation Army, Syracuse.

August 1998 – September 2001, Adoption Clinician, Hearts and Homes Program, The Salvation Army, Syracuse.

September 1997 – August 1998, Therapist/ Inclusion Support Assistant, Jowonio School, Syracuse.

September 1996 – May 1999, Instructor, Department of Child and Family Studies, College for Human Development, Syracuse University.

August 1994 – June 1997, Head Teacher, Bernice M. Wright Nursey School, Department of Child and Family Studies, Syracuse University.

Courses Taught

May 2011 – Present, MFT 643: Family Therapy with Complex Trauma. Developed graduate course for treatment of complex trauma, Syracuse University.

January 2009 – Present, MFT 760, MFT 761, MFT 762, MFT 763, MFT 764: Practicum in Marriage and Family Therapy, Syracuse University.

October 2008 – Present, MFT 750: Introduction to Marriage and Family Therapy Practicum, Syracuse University.

August 1996 – May 1999, CFS 432: Foundations and Principles of Early Childhood Education, Syracuse University.

Formal Training

October 1996 - August 1998, Prepaid Health Plan (PHP), Syracuse. Marriage and Family Therapy training in ADHD Clinic.

August 1994 – July 1996, St. Joseph's Maternal Child Health Center, Syracuse. Internship in Marriage and Family Therapy.

January 1994 - August 1998, Goldberg Marriage and Family Therapy Center, Syracuse University.

Publications

Lane, S. D., Rubinstein, R. A., **Schimpff, T. R.**, Keefe, R. H., Jennings-Bey, T., Leed, S. R., . . . Satterly, L. B. (2019). Bringing in the community: A university-community endeavor to teach marital and family therapy students about community-based violence and trauma. *Contemporary Family Therapy*.

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Busby, D. & **Reichert, T.** (2000). Sexual abuse in the family of origin: The influence on current relationship satisfaction. In D. Busby (Ed.) *Physical and sexual abuse in the family: Filling in knowledge gaps for therapists*. Iowa City, IA: Geist & Russell.

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Stone Fish, L., Jensen-Summers, M., **Reichert, T.**, Wainman, J. (2000). Anxious children and their families: Affirming courageous alternatives. In C. Everett Bailey (Ed). *Children in therapy: Using the family as a resource*. New York: Norton.

Presentations

Reichert Schimpff, T. How Vicarious Trauma Affects Burnout and Turnover. Workshop presented at New York State Children's Alliance Leadership Conference. Saratoga Springs, New York, October, 2018.

Reichert Schimpff, T. Sand Tray Therapy. Guest lecture in Play Therapy, Syracuse University, May, 2017.

Reichert Schimpff, T. Attachment and Therapeutic Interventions. Guest lecture in Advanced Practice in Social Work, Syracuse University, February, 2017.

Reichert Schimpff, T. Working with Trauma. Guest lecture in Advanced Practice in Social Work, Syracuse University, November, 2016.

Reichert Schimpff, T. How Vicarious Trauma Affects Burnout and Turnover. Workshop presented at Stand Against Child Abuse Conference. Syracuse, New York, September, 2016.

Reichert Schimpff, T. Vicarious Trauma. Presentation at Center for Court Innovation, Syracuse, New York, September, 2016.

Reichert Schimpff, T. Parenting Children with Special Needs. Presentation at the Southwest Community Center, Syracuse, New York, August, 2016.

Reichert Schimpff, T. Strategic Family Therapy. Guest lecture in Family Systems Theory, Syracuse University, July, 2016.

Reichert Schimpff, T. Secondary Trauma. Presentation for OnCare, Onondaga County, Syracuse, New York, June, 2016.

Reichert Schimpff, T. The Collaborative Change Model: Working with Trauma from a Family Systems Perspective. NASW Conference, Niagara Falls, New York, February, 2016.

Reichert Schimpff, T. Working with Trauma. Guest lecture in Advanced Practice in Social Work, Syracuse University, November, 2015.

Reichert Schimpff, T. Understanding Vicarious Traumatization. Workshop presentation at Stand Against Child Abuse Conference, Syracuse, New York, October, 2015.

Reichert Schimpff, T. Children and Families in Play Therapy. Guest lecture in Play Therapy, Syracuse University, May, 2015.

Reichert Schimpff, T. The Trauma Resiliency Model. Presentation for the Onondaga County Trauma Task Force, Syracuse, New York, April, 2015.

Reichert Schimpff, T. Working with Trauma in Children and Families. Guest lecture in Advanced Practice in Social Work, Syracuse University, November, 2014.

Reichert Schimpff, T. Children and Trauma Informed Practice. Guest lecture in Introduction to Trauma Studies, Syracuse University, October, 2014.

Reichert Schimpff, T. Sand Tray Therapy. Guest lecture in Play Therapy, Syracuse University, May, 2014.

Reichert Schimpff, T. Experiential Family Therapy Theory. Guest lecture in Family Systems Theory, Syracuse University, August, 2013.

Reichert Schimpff, T. Play Therapy. Guest lecture in Play Therapy, Syracuse University, May, 2013.

Reichert Schimpff, T. Assessing and Treating Trauma. Guest lecture in Advanced Practice in Social Work, Syracuse University, October, 2012.

Reichert Schimpff, T. Trauma and the Family System. Presentation at the Children's Mental Health Summit, Syracuse, September, 2012.

Reichert Schimpff, T. Assessing and Treating Trauma. Guest lecture in Advanced Practice in Social Work, Syracuse University, October, 2011.

Reichert Schimpff, T. Reintegration Process for Families and Children. Panel discussion at Veteran's Mental Health Conference, Syracuse, April, 2009.

Reichert Schimpff, T. Attachment and Adoption. Presented to OCM-BOCES counseling staff, Syracuse, October, 2007.

Reichert Schimpff, T. Attachment Issues with Youth in Care. Presented to residential staff at The Salvation Army, Syracuse, April 2003.

Reichert, T. & Eddy, J. Post Adoption and Support Services. Workshop presented at Regional Child Welfare Conference, New York City, July, 2000.

Reichert, T. Play Therapy. Workshop presented to Onondaga County Adoption Exchange (DSS), Syracuse, October, 1999.

Reichert, T., Jensen, M. & Wainman-Sauda, J. ADHD or BAD? Poster presentation at the American Association for Marriage and Family Therapy, Toronto, Canada, 1996.

Professional Affiliations and Reviews

November 2005 – Present, Clinical Fellow, American Association of Marriage and Family Therapy

October 2010 – Present, Approved Supervisor, American Association for Marriage and Family Therapy.

January 2010 – December 2015, Board Member, Central New York Association for Marriage and Family Therapy.

License

Marriage and Family Therapist, New York State, License Number: 000154