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DOES CHILDHOOD PSYCHOLOGICAL ABUSE STRENGTHEN OR WEAKEN MSW SOCIAL WORKERS AND ALLIED PROFESSIONALS' COMPASSION FATIGUE AND COMPASSION SATISFACTION?

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DOES CHILDHOOD PSYCHOLOGICAL ABUSE STRENGTHEN OR WEAKEN
MSW SOCIAL WORKERS AND ALLIED PROFESSIONALS' COMPASSION
FATIGUE AND COMPASSION SATISFACTION?

DISSERTATION

A dissertation submitted in partial fulfillment of the requirements for the degree of
Doctor of Philosophy in the College of Social Work at the University of Kentucky

By

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Director: Dr. David Royse, Professor of Social Work

Lexington, Kentucky

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ABSTRACT OF DISSERTATION

DOES CHILDHOOD PSYCHOLOGICAL ABUSE STRENGTHEN OR WEAKEN MSW SOCIAL WORKERS AND ALLIED PROFESSIONALS' COMPASSION FATIGUE AND COMPASSION SATISFACTION?

The purpose of this study is to investigate the factors of social worker and allied professional's professional quality of life, particularly the impact of the professional's childhood psychological abuse on compassion fatigue and compassion satisfaction scores. Variables such as perceived resilience, social support, childhood psychological abuse, evidence-based practice training, years of experience, percentage of clients with trauma narratives, and case-load number are explored both conceptually and as risk or protective factors to social worker and allied professional's compassion fatigue and compassion satisfaction. A conceptual model is provided to visually show the direction of the proposed research.

The sample used in this study consists of two-hundred-eighteen social worker and allied professionals in the United States who predominantly have a master's degree or higher. A simple correlation analysis will be used to see any direct correlations between variables used in this study: childhood psychological abuse and its three components, compassion satisfaction, burnout, compassion fatigue, perceived resilience, social support and its three components, evidence-based training, education level, caseload, percentage of client trauma, and years of experience in the field. Multiple regression analysis will

also be utilized in this research study to identify any relationship between the aforementioned variables and compassion satisfaction and compassion fatigue.

In focusing on the research question for this study, an examination of the simple correlational matrix found, for this sample of MSW social workers and allied professionals, no significant correlation between childhood psychological abuse and compassion fatigue or compassion satisfaction. Additionally, in running two separate regression models, one for predicting compassion fatigue and one for predicting compassion satisfaction, childhood psychological abuse was not a significant predictor for this sample's study.

Findings from this study disagree with the only study that attempts to measure childhood psychological abuse of the social worker and their reaction to secondary traumatic stress (Nelson-Gardell & Harris, 2004). There are two main differences between the two study samples: education, training level, and work experience, perhaps suggesting that social workers who are master's level educated or higher are better protected from compassion fatigue related symptomology, or that the Nelson-Gardell & Harris study's predominantly child welfare worker sample is encountering client trauma in a way that is unique from this study's sample. Implications from this study's findings are explored suggesting further research into the effects of education and evidence-based training as a protective factor from the effects of childhood psychological abuse on compassion fatigue and compassion satisfaction.

KEYWORDS: Childhood Psychological Abuse, Compassion Fatigue,
Compassion Satisfaction, Education, Evidence-Based Training,
Burnout

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Chapter One: The Problem of the Cost of Caring and Related Concepts

The archetype of a *wounded healer* describes a professional's own personal struggles as what helps these individuals to better serve others (Guggenbuhl-Craig, 1971; Nouwen, 1972; Sedgwick, 1994). The giving of self, out of one's own wounds, to better help others going through struggles is honorable, but the wounded healer is susceptible to negative repercussions for caring for others, and potentially being profoundly damaged by this work. Might wounded healers lose the very compassion that makes them so helpful? That is one question this dissertation will examine.

The word compassion derives from the Latin "compati," which means to "suffer with." So, to be compassionate means that you are participating in another's suffering. Compassion should not be conceptualized as empathy, pity, or sympathy (Brill & Nahmani, 2017). Compassion is an emotion of its own, that feeling of being "moved by another's suffering and wanting to help" (Lazarus, 1991, p. 289).

Many in the mental health professions join the field because they have been hurt in the past, and they want to help others to navigate their difficult times (Gil, 1988). O'Brien and Haaga's study found that those who choose to be psychotherapists are better at handling difficult emotional trauma stories because "therapists may be drawn to the field because they are especially resilient listeners" than non-psychotherapists, and that it might not be the training that equips them to handle the trauma stories (2015, p. 418). Even founding mental health theorists such as Sigmund Freud, Alfred Adler, Carl Jung, and Henry Stack Sullivan found healing through helping others (Shannon, 1995).

Drawing from your own personal struggles to help others navigate their struggles makes some logical sense. Some theorize that it is critical for the psychotherapist to

discover compassion for their clients in order for the clients to develop self-compassion (Brill & Nahmani, 2017). Although, many in the mental health field have concerns about the role of a wounded healer mentality (Dickstein & Hinz, 1992; Fink & Tasman, 1992; Fisher, 1994). One major concern about the wounded healer is impairment. Impairment can occur if professionals allow their own personal distress to impact their clinical work (Jackson, 2001), and can lead to serious disciplinary action from professional licensing boards of psychotherapists. Additionally, within the profession of social work, the National Association of Social Work's Code of Ethics urges social work professionals to consult with colleagues who are impaired due to personal problems, psychosocial distress, substance abuse, or mental health difficulties, and if that colleague is not taking "adequate steps to address the impairment, (the colleague) should take action through appropriate channels established by employers, agencies, NASW, licensing and regulatory bodies, and other professional organizations" (NASW, 2008, ethical standard 2.08b). This calls attention to the importance of self-care for psychotherapists; however, many in the helping profession may be blind to their need to practice better self-care (Barnett, Baker, Elman & Schoener, 2007).

Perhaps the experience of independently licensed social workers is uniquely different from their allied professional peers. Social workers – of which this study's sample heavily relies upon – are trained differently than other allied professionals. Social work is a values-based profession that focuses on the improvement of well-being for all people, but with a uniquely specific interest in those who are vulnerable, oppressed, and living in poverty (NASW, 2008). Well-cited studies, like the adverse childhood experiences research of the late nineties, highlight the correlation between those who

have experienced trauma from childhood and negative future emotional and physical outcomes (Felitti, Anda, Nordenberg, Williamson, Spitz, Edwards, Koss, & Marks, 1998), increasing the likelihood that if a professional is practicing social work, that professional is more than likely working with a client population who has experienced some form of trauma.

Another concern about the wounded healer is the potential for countertransference. Countertransference is a foundational concept in the helping professions, with its roots in psychoanalysis, and has been widely discussed since the beginnings of psychology with the likes of Freud and Jung. Countertransference is the feelings a psychotherapist has toward a client that can lead to emotional entanglement (Stefana, 2017). It can lead to decreased ability to be emotionally present, over-identification, projection, and a personal agenda in the therapy process (Briere, 1992; Gil, 1988), as well as boundary confusion or violation (Briere, 1992). Although the negative outcomes of unchecked countertransference are obviously unhealthy for a therapeutic relationship, research has discovered some positive outcomes of a wounded healer with well-checked countertransference. They can better empathize, understand painful experiences, appreciate how difficult therapy can be, provide more patience and tolerance when client progress is slow, and show greater faith in the therapeutic process (Gelso & Hayes, 2007; Gilroy, Carroll, & Murra, 2001). Although this study will not measure countertransference directly, the psychological distress that can occur through unchecked countertransference could manifest itself similar to compassion fatigue, and well checked countertransference – which could lead to better caring outcomes – could be similar to compassion satisfaction.

How much woundedness is enough to be a helpful wounded healer?

Woundedness is on a continuum, so the wounded healer archetype does not depend on the amount of woundedness but on the wounded healer's ability to draw from his or her woundedness to better help the other (Zerubavel & O'Dougherty Wright, 2012). This suggests that it is psychotherapists' ability to understand their own woundedness, no matter the degree, in order to produce more compassionate care for those they work with. Still, questions arise: At what point is the therapist's woundedness helpful and hurtful? Might there be a difference between the woundedness of a single past trauma or polytrauma, a continually ongoing trauma, or one that happened and is no longer occurring? The psychotherapist role of working with client trauma stories is a difficult one, one that can lead to negative emotional consequences for the psychotherapists. Does a "wounded" psychotherapist ever reach a point where he or she is unable to draw upon that woundedness to better help the client? And when might that woundedness be too much to handle?

The wounded healer is a commonly accepted characteristic of those in the helping professions, and when personal wounds are understood well, they may be of great use. But the helping profession, particularly that of a psychotherapist, is a uniquely emotionally difficult job. A helper immersed in suffering daily will be changed by it, just as walking through water will get you wet (Remen, 1996). The therapeutic encounter should be a fully immersed process "in which the doctor, as a person, participates just as much as the patient" (Jung, 1951, p. 116). Jung (1966) pointed out that it is natural for psychotherapists to deny how deeply they are influenced by their patients. But the problem is that in order to be an effective psychotherapist, you must emotionally engage

with your clients, but that engagement can have a cost to the helper. This immersion can have negative consequences.

Compassion fatigue is used to describe the potential “costs of caring, empathy, and emotional investment in helping the suffering” (Figley, 2002, p. 1433) and is “a state of tension and preoccupation with the traumatized patients by re-experiencing the traumatic events, avoidance/numbing of reminders persistent arousal (e.g. anxiety) associated with the patient. It is a function of bearing witness to the suffering of others” (Figley, 2002, p. 1435). It is a condition where compassion gradually decreases over time (Sorenson, Bolick, Wright, Hamilton, 2016). Psychotherapists work alongside clients who have experienced traumatic events, and they discuss, in detail, those trauma stories. Compassion fatigue is a consequence for helpers who become so closely associated with those they are helping that the professional becomes immersed in the client’s pain and trauma (Stewart, 2009). Although not all psychotherapists may experience symptoms related to compassion fatigue, they are susceptible to the potential of experiencing it because of the nature of their work.

Compassion fatigue among health care workers can lead to other problems like patient turnover, decrease in quality care, and patient safety issues, and can lead to provider problems such as annoyance, disconnection, intolerance, melancholy, depression, lessened compassion and empathy for their clients (Hooper, Craig, Janvrin, Wetsel, & Reimels, 2010). The work of psychotherapy with clients, particularly those who are clients who have experienced trauma, can lend itself to physical health symptoms such as back and neck pain and tiredness as reported by a study of psychologists in training (Kaeding, Sougleris, Reid, van Vreeswijk, Hayes, Dorrian, &

Simpson, 2017). The difficulty in providing psychotherapy, the energy needed to achieve the mental and emotional demands, can lend itself to burnout, which have a negative effect on client outcomes (Delgadillo, Saxon, & Barkham, 2018). Additionally, the immersive experience of working with clients can lead to unsettling dreams for the psychotherapist. Research of psychotherapist reported dreams about clients highlighted a theme of role reversal in the therapeutic relationship, where the client was in a position to help the psychotherapist (Kron & Avny, 2003). One study only partially revealed a cross-sectional relationship between level of trauma work and psychotherapist trauma-like symptoms, where level of stress of clinical work and quality of trauma training were significant predictors of trauma symptoms (Makadia, Sabin-Farrell, & Turpin, 2017).

What are the consequent behaviors and emotions related to compassion fatigue? Figley (1995) describes compassion fatigue as "A state of tension and anxiety related to individual or cumulative trauma narratives, including the effects of cumulative stress/burnout, which manifests itself in one or more ways such as reexperiencing traumatic events, avoiding reminders of traumatic events, or sustained arousal." Therefore, compassion fatigue symptomology is considered similar to Post-Traumatic Stress Disorder (PTSD). Re-experiencing the client trauma story, wanting to avoid the client and triggers of the client trauma story, and hyper arousal because of the knowledge of the client trauma story are all compassion fatigue symptoms (Figley, 1995, 2002; Jenkins & Baird, 2003; Schauben & Frazier, 1995). These symptoms could understandably be alarming to a psychotherapist devoted to the helping profession.

But compassion fatigue is not the only term used to describe this phenomenon. Stamm (2005) explains compassion fatigue as similar to *secondary traumatic stress*, the

indirect exposure to another's trauma story. But it is important to differentiate that while a psychotherapist can be exposed to another's trauma story (secondary trauma), they may not experience the symptoms of compassion fatigue (Pehlivan & Güner, 2018).

Compassion fatigue relates to the physical and emotional toll on the helper, while secondary traumatic stress, or vicarious trauma, refers to the shift in worldview from helping others who have experienced trauma (Pearlman & Saakvitne, 1995). Both the terms compassion fatigue and secondary traumatic stress are often used in the literature interchangeably, but compassion fatigue is more commonly used in recent years, with the preferred term starting with Charles Figley's work in *Compassion Fatigue as Secondary Traumatic Stress* (1995).

Burnout is unique from compassion fatigue and secondary traumatic stress.

Burnout is a "psychological syndrome in response to chronic interpersonal stressors on the job" (Maslach, Schaufeli, & Leiter, 2001 p. 399), and it is a gradual feeling that your work is worthless (VanHook & Rothenberg, 2009), while compassion fatigue is not understood to be a gradual onset. A protective factor to burnout is a supportive work environment (Maslach, 1982). Burnout does not include exposure to secondary or vicarious trauma. Rather, it has to do with work overload, too much work or too much work-related stress. The term professional quality of life incorporates the positive (compassion satisfaction) and negative (compassion fatigue) aspects of working directly with those who have experienced trauma, as well as the concept of burnout (Stamm, 2010). In professional quality of life, the concepts of burnout, compassion satisfaction, and compassion fatigue are understood together to better capture the emotional and physical effects associated with working in the helping professions.

Compassion fatigue research is still relatively new, and further research must be done. More understanding of protective factors and risk factors can help providers better understand their emotional responses and possibly resilience when working with clients who have experienced trauma. Additionally, a better understanding of the compassion fatigue concept, and related experiences, can provide a clearer conceptual framework for the phenomenon (Pehlivan & Güner, 2018).

Protective Factors

Researching factors that protect against pathology is a means for understanding why some individuals seem immune, or protected, from negative outcomes. It is the investigation of traits, experiences, or resources to individuals that protect them from unwanted consequences. A better understanding of protective factors associated with compassion fatigue-related experiences may lead to bolstering the professional lives of psychotherapists.

Research has shown that psychotherapists can help protect against compassion fatigue by working through their feelings related to clients' trauma stories, managing their caseloads well, detaching appropriately both emotionally and physically from work when off duty, and enhancing compassion satisfaction related to working with their clients (Figley, 2002).

The literature also suggests that those who have worked as psychotherapists longer are more likely to report higher compassion satisfaction, and those who feel adequately trained in evidence-based practices are less likely to report compassion fatigue experiences, and that "Identification of trauma specific training as an adaptive strategy to address burnout provides support for the notion that the investment in

professional development has benefits beyond the acquisition of knowledge” (Craig & Sprang, 2010, p. 336). Even the perception of the quality of work meetings can be a predictive factor for compassion satisfaction (Cetrano, Tedeschi, Rabbi, Gosetti, Lora, Lamonaca, Manthorpe, & Amaddeo, 2017).

Resiliency. Resiliency is conceptualized as an individual’s ability to bounce back from adversity and grow from the experience (Benard, 2004). Research has spanned from examining resilience as a process (Cohen, Ferguson, Harms, Pooley, & Tomlinson, 2011), an inherent trait (Carlson, Cacciatore, & Klimek, 2012), and something fostered or taught from outside support (Beddoe, Davys & Adamson, 2013; Grant & Kinman, 2012; Pidgeon, Ford, Klassen, 2014). Resilience research focuses on protective factors that involve supports from the community, family, relationships, and is seen as a potential within everyone (Benard, 2004). But no research has explored if a psychotherapist’s perceived resilience has a relationship to compassion fatigue and/or compassion satisfaction scores.

Perceived Social Support. Perceived social support is the perception of the number of people an individual has quality connectedness to; however, it is not the robustness of a person’s social support, but rather their perception of their social support (Antonucci & Israel, 1986). Some people may prefer a large community circle, while others feel supported when they have one individual in which to confide. Social supports such as professional supervision, peer support, and support from friends and family are important and often used coping strategies during difficult times (Bride, 2004; Iliffe & Steed, 2000; Pearlman & Mac Ian, 1995; Pistorius, Feinauer, Harper, Stahmann & Miller, 2008). For mental health staff, feeling like you belong in your workplace is a strong

predictor of compassion satisfaction and low burnout levels (Somoray, Shakespeare-Finch & Armstrong, 2016). Even access to clinical supervision or consultation can potentially mediate psychotherapists' vicarious trauma-related symptoms (Farrenkopf, 1992; Follette, Polusny, & Milbeck, 1994; Jackson, Holzman, & Barnard, 1997; Pearlman & Mac Ian, 1995; Rich, 1997)

Risk factors

Investigating risk factors is a commonly used approach for understanding pathology. Through understanding what makes some individuals more susceptible to negative outcomes, researchers and practitioners know what to avoid or strengthen to prevent the unwanted experience. By knowing what the compassion fatigue risk factors are, the helping professions can strengthen the future professional lives of helpers.

Personal trauma history of the psychotherapist (Follette et al., 1994; Ghahramanlou & Brodbeck, 2000; Kassam-Adams, 1999; Pearlman & Mac Ian, 1995; Dagan, Ben-Porat, & Itzhaky, 2016), age (Ghahramanlou & Brodbeck, 2000), gender (Kassam-Adams, 1999), amount of exposure to traumatized clients (Brady, Guy, Poelstra, & Browkaw, 1999; Chrestman, 1999; Kassam-Adams, 1999; Schauben & Frazier, 1995), length of time providing sexual abuse treatment to clients (Brady et al., 1999; Chrestman, 1999; Pearlman & Mac Ian, 1995; Rich, 1997; Steed & Bicknell, 2001; Way, VanDeusen, Martin, Applegate, & Jandle, 2004), and lack of social and supervisory support (Figley, 1999; Devilly, Wright, & Varker, 2009; MacRitchie & Leibowitz, 2010; Manning-Jones, de Terte, & Stephens, 2016; Caringi, Hardiman, Weldon, Fletcher, Devlin, & Stanick 2016; Adams, Boscarino, & Figley, 2006; Rzeszutek, Partyka, & Gołąb, 2015) could also be potential risk factors to compassion fatigue-related

experiences and symptoms of psychotherapists. Even neuroticism (Somoray, Shakespeare-Finch & Armstrong, 2016) and work environment conditions are potential risk factors to compassion fatigue (Cetrano, Tedeschi, Rabbi, Gosetti, Lora, Lamonaca, Manthorpe, & Amaddeo, 2017).

As previously stated, perception of adequate evidence-based training was a protective factor against compassion fatigue, and a lack of evidence-based training is a predictor of burnout (Craig & Sprang, 2010). Compassion fatigue research needs to continue to focus on both protective factors and risk factors as there are very few studies exploring perceived social support, psychotherapist past childhood psychological abuse, and perceived resilience in relationship to compassion fatigue symptoms.

There is only one research study on the relationship of the psychotherapist's past childhood psychological abuse and compassion fatigue, and that is from a study in 2003 that predominantly relies upon a sample of child welfare workers with a bachelor's level degree (Nelson-Gardell & Harris). A further investigation into this relationship might reveal that psychotherapist's past childhood psychological abuse is a risk factor that could cause unconscious grief to the psychotherapist through re-hearing their own client trauma stories. Research on this topic might also reveal that a psychotherapist's past childhood psychological abuse turns out to be a protective factor, one in which the psychotherapist is bolstered by drawing upon their past to further help their clients overcome their current traumas, with compassion satisfaction as that potential indicator. Future research could help with encouraging psychotherapists to increase their self-awareness and recognizing that their past and who they are can affect their work (Somoray, Shakespeare-Finch & Armstrong, 2016).

Purpose and Rationale for Study

It is common for the wounded healer mentality to be a part of the helping profession of psychotherapy. People join this field because they want to help others, and it is also common for therapists to report higher levels of confidence in their skills (Brammer, 1997; Vallone, Griffin, Lin, & Ross, 1990). This sets up a concerning situation-- perhaps psychotherapists who are wounded healers attempt to draw from their own traumas to help others but in doing so struggle to see how impaired they have become by the cost of caring for their traumatized clients and have become susceptible to compassion fatigue. Because there is evidence that past childhood psychological abuse history is a risk factor to compassion fatigue for predominantly bachelor's level social workers (Nelson-Gardell & Harris, 2003), this exploratory study will investigate which components of past childhood psychological abuse lead to higher rates of compassion fatigue among social worker and allied professionals who predominantly have attained a master's degree or higher.

Chapter Two: Literature Review

This chapter includes relevant studies and articles from the literature related to key variables in this study. Those variables are ones highlighted in the aforementioned models that this study will explore in relation to the cost of caring for social worker and allied professionals.

Support and Coping Related Literature

Particularly important to this proposed research are the themes of personal history of crisis and coworker and supervisory support.

An examination was conducted of a sample of 154 social workers who primarily worked in family violence or with sexual assault survivors regarding their relationships with their coworkers, work team, and as well as the supervisor support and secondary traumatic stress they felt (Choi, 2011). A majority of the sample (93.5%) held master's degrees, the average years of experience in their current agency setting was 8.3 years, with the most common type of client traumas reported as child abuse (74.7%), intimate partner abuse (70.1%), and sexual assault or rape (65.6%) (Choi, 2011). In this study, social workers who received more support from their coworkers, work team, and supervisors yielded lower levels of secondary traumatic stress (Choi, 2011). Coworker, work team, and supervisor support was measured using the Social Structural Scale (Spreitzer, 1995, 1996) a 7-point Likert scale that assesses the dimensions of work context: sociopolitical support, access to strategic information, access to resources, and organizational culture. Additionally, secondary traumatic stress was measured using the Secondary Traumatic Stress Scale (STSS: Bride, Robinson, Yegidis, & Figley, 2004). This study indicates that the support and relationship between the supervisor and

supervisee is important as a protective factor against the cost of caring for clients who have experienced trauma.

The role of personal characteristics and professional factors in setting up boundaries from the potential risk of compassion fatigue was explored in a qualitative study of nine Adult Protective Services (APS) social workers, who primarily worked with geriatric clients. Personal characteristics was defined as a composite of themes from the interviews such as social work education, personal history of crisis, sense of achievement, APS job experience, and preventative actions (Bourassa, 2012). Professional factors that aided with the development of boundaries was defined as a composite of themes from the interviews such as coworker support and lack of supervisory support that fosters independence (Bourassa, 2012).

Personal history of crisis included “a substance-abusing parent or significant other, history of an eating disorder, history of chronic mental illness in the family, and history of an attempted suicide of a family member, and the sudden death of a spouse” (Bourassa, 2012, p. 1705). The respondents reported that their personal history of crisis helped them to better set up boundaries to protect against compassion fatigue by empathizing well with clients’ crises and to better understand the clients’ families and their situations (Bourassa, 2012). Coworker support was seen as a major reason why the nine APS social workers stayed in their field, and did not elect to drop out, stating that their coworker relationships felt familial and that the shared experience of working as APS social workers helped them understand each other better (Bourassa, 2012). Below is a quote from the study (Bourassa, 2012, p. 1707) to help illustrate the shared feeling of camaraderie:

“I wouldn’t be here without them, um, cause until you are in our shoes and do our jobs, no one else understands. I think it’s honestly the mere fact that they are the only ones who understand. I mean who else can you walk up to and say that you were in a roach-infested home today or you found a dead body today. No one else understands.”

A lack of supervisory support was discovered in this qualitative study to be a reason for the APS social workers to develop greater independence, thus lending them to further develop more confidence with their ability to do their job (Bourassa, 2012). One respondent went as far to say: “...there’s no support from our supervisors... you can’t really count on them” (Bourassa, 2012, p. 1708). Eight of the nine respondents reported that their supervisors were not social workers, and that the supervisor’s lack of training in their field was a major concern in identifying with the work that the APS social workers do (Bourassa, 2012). This is counter to previous research that states that social workers without supervisory support may be more susceptible to compassion fatigue (Figley, 1999).

A study of 225 home-based family therapists was conducted to explore the relationship between workload and clinical experience with professional quality of life (Macchi, Johnson, & Durtschi, 2014). In this study perceived workload and clinical experience had direct impact on the home-based therapists’ professional quality of life, and both variables were also mediated by the home-based therapist’s frequency of self-care activities and clinical supervision (Macchi, Johnson, & Durtschi, 2014). The way the authors measured and conceptualized self-care activities was through the use of one 5-

point Likert item: “How often do you engage in activities that you consider as self-care?” The only indicator used for clinical supervision was the item: “How many hours of supervision do you receive per week?” This study brings up interesting questions to be further researched, such as the quality of self-care activities, and the quality of supervision, or anything related to the supervisor and supervisee relationship and its ability to protect against negative professional quality of life components such as compassion fatigue or burnout.

In a systematic literature review, conducted by Ireland and Huxley (2018), of thirteen articles related to the problems facing clinical professionals who work with children who have experienced trauma, five main themes were identified: “lack of organizational support, lack of health work-life balance, lack of appropriate training, failure to use self-care techniques, and staff failure to share when they are experiencing symptoms” (2018, p. 141). The implications of these themes identified by this systematic literature review are many, but of particular note to the proposed research is the importance of evidence-based practice training and healthy support-- both professionally and personally to protect against the cost of caring for those who have experienced trauma.

Deville, Wright, and Varker (2009) surveyed 152 mental health professionals from Victoria, Australia in order to cross-sectionally measure secondary traumatic stress, vicarious trauma, and workplace burnout. The relevant measures used in the study are the 17-item Secondary Traumatic Stress Scale (STSS) to measure secondary traumatic stress (Bride, Robinson, Yegidis, & Figley, 2003), the TSI Belief Scale-Revision L (TSI-BSL) to measure vicarious trauma (Stamm, 1996), and the 12-item Interpersonal Support

Evaluation List (ISEL-12) to measure social support (Cohen, Mermelstein, Kamarck, & Hoberman, 1985). Additionally, the researchers measured affective distress by using the Depression, Anxiety and Stress Scales (DASS-21), a 21-item self-report instrument that measures depression, anxiety, and tension/stress (Lovibond & Lovibond, 1996). A regression analysis identified the relationship between the variables and their ability to predict affective distress. Work stressor-related burnout was the strongest predictor of therapist affective distress, and a model including “burnout, ‘duration of career as a mental health professional’, ‘beliefs about safety of the self’ (VT), and ‘beliefs about intimacy with others (VT)’” predicted 44% of the variance observed (Devilley, Wright, & Varker, 2009, p. 382).

The study findings question the existence of secondary trauma-related phenomena, because the measures for secondary traumatic stress and vicarious trauma were not significantly affected by exposure to patients’ trauma narrative (Devilley, Wright, & Varker, 2009). This is counter to the model that exists for how secondary trauma develops (Figley, 1995). Higher social support is understood as a protective factor for burnout, thus affirming that social support can help protect against affective distress for mental health professionals (Devilley, Wright, & Varker, 2009).

MacRitchie and Leibowitz (2010) conducted a study with the aim to “explore the psychological impact on trauma workers who work with ‘victims’ of violent crimes, specifically focusing on the level of exposure to traumatic material; level of empathy; level of perceived social support and their relation to STS” (2010, p. 149). Their study consisted of a non-probability sample of South African trauma workers (n=64) from the Gauteng region around Johannesburg, South Africa. The researchers administered self-

report questionnaires to those individuals available and willing to fill out their survey.

The sample consisted of mostly white female trauma workers whose years of counseling experience ranged from 1-15 years (mean=3.31). There was no reported measure of level of training in this article for the sample.

The measure used for compassion fatigue was the Compassion Fatigue Self-Test (Stamm & Figley, 1996). This instrument is a 66-item measure of three subscales – compassion fatigue, burnout, and compassion satisfaction. The Traumatic Institute Belief Scale (TSI-BLS) was the instrument used to measure STS. The TSI-BLS measures the disruptions in beliefs about self and others from psychological trauma or vicarious exposure to trauma material through helping another who has been exposed to trauma (Pearlman, 1996). Lastly, social support was measured through use of the Crisis Support Questionnaire (CSQ) that measures a person's perception of support they can access after a traumatic event (Joseph, Andrews, Williams, & Yule, 1992).

The study yielded a significant moderate negative relationship between STS and social support ($r = -0.36$; $p < 0.05$), and social support was a weak significant moderator of compassion fatigue ($r = -0.28$; $p < 0.05$) (MacRitchie & Leibowitz, 2010).

Additionally, personal previous exposure to trauma and the professional's level of empathy were also significantly related to STS.

Manning-Jones, de Terte, & Stephens (2016) conducted a study with 365 health professionals; 103 social workers, 76 nurses, 72 counselors, 70 psychologists, and 44 medical doctors. Participants were primarily New Zealand professionals who were recruited through advertisement and participated through an online survey. The goal of the study was to explore the relationship between coping strategies and psychological

outcomes of vicarious traumatic exposure and to understand the differences between health professional groups (Manning-Jones, de Terte, & Stephens, 2016). The measure used for STS was the Secondary Traumatic Stress Scale (STSS; Bride et al., 2003). Social support was measured by using the Social Support Scale (SSS; Caplan, Cobb, French, Van Harrison, & Pinneau, 1975).

In looking at all professions, total support ($r = -0.30$, $p = 0.01$), peer support ($r = -0.16$, $p = 0.01$), supervisory support ($r = -0.24$, $p = 0.01$), and friend/family support ($r = -0.26$, $p = 0.01$) were all significantly and negatively correlated to STS scores. Additionally, total support ($r = 0.12$, $p = 0.05$) and peer support ($r = 0.18$, $p = 0.01$) were significantly positively correlated to post-traumatic growth scores, while supervisory support and friend/family support were not significantly related. Social support was significantly positively correlated with post traumatic growth, and significantly negatively correlated with STS. The dimensions of peer support, support from supervisors, and support from friends and family were all significantly correlated with STS. Social support from friends and family was also a significant negative predictor of STS, “with 4% of the variance in STS over and above the variance explained by self-care” (Manning-Jones, de Terte, & Stephens, 2016, p.26).

Not all studies show a protective factor relationship between supervision and the cost of caring. A study conducted by Furlonger and Taylor (2013) of thirty-eight Australian telephone and online volunteer therapists who worked with children and young adults (ages 5-25 years old) and parents of children, held 50,979 counseling sessions in 2008 with approximately 44% of those sessions involving trauma. No significant findings between the therapist’s supervision and vicarious traumatization were

found. Supervision quality was measured through the 19-item and 7-point Likert scale Supervisee Form from the Supervisory Working Alliance Inventory (SWAI) that assesses the working relationship from the supervisor and supervisee perspectives (Efstation, Patton, & Kadash, 1990). Although there was no relationship between supervision and vicarious traumatization, the therapist caseload size was strongly related to vicarious traumatization and to negative coping styles that was measured using the Coping Strategy Indicator (CSI), an assessment tool that measures the frequency of using different coping strategies, including the negative coping style of avoidance (Furlonger & Taylor, 2013). Might the relationship between the supervisor and supervisee be different for telephone and online crisis line volunteer workers when compared to a traditional psychotherapist?

Caringi et al. (2016) conducted a study to examine secondary traumatic stress (STS), compassion fatigue, burnout, and compassion satisfaction for Montana social workers, and how organizational factors and peer support relate to the previous constructs. The sample included independently licensed social workers in the state of Montana (n= 256, response rate = 56%). The researchers mailed recruitment letters to all independently licensed social workers in the state of Montana (women= 197, men= 59).

The measures used in that study were the Secondary Traumatic Stress Scale (STSS; Bride et al., 2003), The Professional Quality of Life Scale (ProQOL; Stamm, 2008) to measure compassion fatigue, and thirteen closed-ended scaled questions with two open-ended questions regarding peer support. These 15 peer support items were created to measure “the type and quality of perceived peer support available in the work place as well as the level of desire for increased opportunities for collegial peer support to help cope with stressful situations” (Caringi et al., 2016, p. 189).

The study found that licensed clinical social workers in Montana “are likely to experience levels of STS, compassion fatigue, and burnout similar to those found in other studies” (Caringi et al., 2016, p. 193). Additionally, peer support was a significant protective factor to diminish the symptoms of STS, where social workers in this study identified that shared experiences, humor to reduce stress, multiple available peers for support, the nature of informal help, and camaraderie all helped to diminish symptoms of STS (Caringi et al., 2016). The study’s limitations were a lack of control group, self-selection bias, no use of a randomized sample, and the use of telephone interviews for qualitative data collection (Caringi et al., 2016).

Adams, Boscarino, and Figley (2006) carried out a study to assess the psychometric properties of a compassion fatigue scale and to examine that scale’s predictive validity on social workers (n=236) who lived in New York City after the September 11 attacks. The sample was randomly attained through the National Association of Social Workers (NASW) membership list. Six-hundred social workers were contacted through the mail with a two-week follow up mailing. Only social workers who were involved in clinical practice were included in the sample.

The measure for compassion fatigue was the 30-item Compassion Fatigue (CF) Scale—Revised (Gentry et al., 2002) that was originally created by Figley (1995). For psychological distress, the researchers used the 12-item version of the General Health Questionnaire (GHQ-12; Goldberg & Huxley, 1992; McDowell & Newell, 1996). Social support was captured using the Social Support Scale (SSS; Sherbourne & Stewart, 1991).

The study found that for this sample of social workers, the Social Support Scale scores were significantly and negatively correlated to Compassion Fatigue Scale Long

scores ($r = -0.235$, $p = .001$) as well as to the Compassion Fatigue Scale Short scores ($r = -0.193$, $p = .01$). Social support scores were also significantly and negatively correlated to work burnout ($r = -0.204$, $p = .01$). Social support scores were not significantly related to secondary trauma scores for this sample. Identified limitations to this study, according to the authors, was a small sample size, the use of cross-sectional data and its inability to allude to anything outside that point in time, and the ever-evolving concept of compassion fatigue – particularly that compassion satisfaction was not included in this study due to that a compassion satisfaction component not a part of the CF measure when the data were collected (Adams, Boscarino, & Figley, 2006).

Rzeszutek, Partyka, and Gołąb (2015) measured secondary traumatic stress disorder symptoms and attempted to examine the relationship of STS to temperament traits and social support among trauma therapists ($n = 80$) in Poland. Participants in the research had to have a masters in clinical psychology and a professional license in trauma therapy. Through the use of mailed surveys, the researchers attempted to recruit 210 therapists but 80 of the trauma therapists participated (38% response rate). The sample consisted of 21 men and 59 women with a mean age of 39.48 (Rzeszutek, Partyka, & Gołąb, 2015).

The researchers used the PTSD Questionnaire: Factorial Version (PTSD-F; Strelau, Zawadzki, Oniszczenko, & Sobolewski, 2002), the Formal Characteristics of Behavior-Temperament Inventory (FCB-TI; Strelau & Zawadzki, 1995), and the Berlin Social Support Scale (BSSS; Schulz & Schwarzer, 2003).

The study found that only perceived support of the BSSS was significantly related to secondary traumatic stress symptoms measured through the PTSD-F global scale.

Perceived support was significantly and negatively correlated to PTSD-F scores ($r = -.32$, $p = .01$). The three individual subscales within the Berlin Social Support Scale are: need for support, support seeking, and actual support, and they were not individually significantly related to the secondary traumatic stress measure for this study's sample (Rzeszutek, Partyka, & Gołab, 2015). Limitations of this study were the use of cross-sectional data that cannot be used to infer causality, the use of the PTSD-F questionnaire that is sensitive to general distress and may not be capturing the uniqueness of STS, and the researchers felt that not asking the sample of trauma therapists about their own traumatic experiences.

Five-hundred and six professional counselors were examined to understand the relationship between the counselors' professional quality of life, career-sustaining behaviors, and wellness (Lawson & Myers, 2011). Career-sustaining behaviors were measured using the Career-Sustaining Behaviors Questionnaire, a 34-item 7-point Likert scale that measures the use of effective strategies to retain a positive attitude in their professional work (CSBQ, Kramen-Kahn & Hansen, 1998). Wellness was measured using the 91-item and 4-point Likert scale called the 5F-Wel (Myers & Sweeney, 2004, 2005), that measures dimensions in the IS-Wel model, "a way of life oriented toward optimal health and well-being, in which body, mind, spirit are integrated by the individual to live life more fully within the human and natural community" (Myers, Sweeney, & Witmer, 2000, p. 252). The study found that those who reported higher wellness scores, through the 5F-Wel, also engaged in more career-sustaining behaviors, and also reported higher compassion satisfaction scores (Lawson & Myers, 2011). This finding shows that there is a relationship between positive or healthy work-related

behaviors and the professional's wellness, and that those variables have a relationship with the professional's ability to be appropriately compassionate with their clients.

But is it always easy to practice career-sustaining behaviors when you're a psychotherapist? One study explored the barriers to seeking mental health care for two-hundred-sixty psychologists (Bearse, McMinn, Seegobin, & Free, 2013). The most common theme reported by the psychologists was the need to seek mental health care for fear of burnout in their work, and the most common obstacles to their care were finding an appropriate psychotherapist, and having enough time to seek their own therapy (Bearse, McMinn, Seegobin, & Free, 2013). Psychotherapists who are interested in seeking their own mental health care, and therefore attempting positive professional self-care behaviors, also known as career sustaining behaviors, might not have the structured time to pursue such help. What could become of psychotherapists who need mental health care, but who have obstacles in their way to pursue such help? Additionally, in order to help maintain ethical standards, psychotherapists must seek out a psychotherapist for their own mental health care that they do not already know from their professional circles, which limits their choices compared to the public.

Lee and Miller (2013) explored conceptual frameworks to understand dimensions of self-care. Personal and professional self-care are conceptualized as two separate concepts (Collins, 2005; NASW, 2009) that are connected (Skovholt et al., 2001). Personal and professional self-care are therefore distinctly separate, but interrelated. A psychotherapist's personal self, for example their social support, perception of their resilience, or their past childhood psychological abuse, is an important component to the psychotherapist's professional quality of life as well. This includes the act of hearing, and

emoting appropriate compassion to their clients for quality psychotherapy, when encountering client trauma narratives.

One study measured the associations between self-compassion, compassion fatigue, well-being, and burnout among fifty-four student counselors in their final year of classes (Beaumont, Durkin, Hollins-Martin, & Carson, 2016). The instruments used in this study included the Professional Quality of Life Scale (ProQOL, Stamm, 2009), Self-Compassion Scale (Neff, 2003), the short Warwick and Edinburgh Mental Well-Being Scale (sWEMWBS, Tennant, Hiller, Fishwick, Platt, Joseph, Weich, Parkinson, Secker, & Stewart-Brown, 2009), and the Compassion For Others scale (CFO, Pommier, 2011). The study found students who reported high scores for self-compassion and well-being also reported less compassion fatigue and burnout, which highlights the importance of the thoughts about self that a professional holds and the thoughts about the self's impact on a psychotherapist's professional quality of life (Beaumont, Durkin, Hollins-Martin, & Carson, 2016). Might a psychotherapist's thoughts about their social support and their perceived resilience be connected?

According to a study by Mullen, Morris, and Lord (2017) of one-hundred-forty counselors, higher frequency of encountering ethical dilemmas in practice can lead to higher counselor burnout and counselor-reported stress (2017). The CBI (Lee, Baker, Cho, Heckathorn, Holland, & Newgent, 2007) was used to measure burnout among five dimensions: Exhaustion, Incompetence, Negative Work Environment, Devaluing Client, and Deterioration in Personal Life. Counselor stress was measured using the Perceived Stress Scale (PSS; Cohen, Kamarck, & Mermelstein, 1983), a 10-item scale to measure the degree of stress. A particularly unique finding of this study was that higher rates of

reflecting on an ethical dilemma did not have a relationship with counselor burnout or stress (Mullen, Morris, & Lord, 2017). The authors suggest that future research should incorporate measuring counselor resiliency, among other variables related to therapist professional quality of life (Mullen, Morris, & Lord, 2017).

In sum, the findings from the research around psychotherapist professional quality of life experience and support are not all in agreement. Most of the studies find a positive relationship between psychotherapist professional quality of life and supervisory support, but some do not find a relationship (Bourassa, 2012; Furlonger & Taylor, 2013). But, all of the studies show a positive relationship between psychotherapist professional quality of life experiences and peer or co-worker support. Additionally, self-care and positive personal and/or professional coping strategies are very important to psychotherapist well-being in their difficult job as helpers of those who have experienced trauma, although incorporating those positive behaviors is difficult.

Resilience

There is scant research related to professional quality of life experiences and perceived resilience. Further research should focus on the relationship between professional quality of life and perceived resilience. Still, one preliminary qualitative study, with the participation of only seven psychotherapists in South Africa, showed themes of perceived resilience as a protective factor to compassion fatigue (De Lange & Chigeza, 2015). Although it is only one study with a very small number of preliminary qualitative interviews, psychotherapists did perceive their resilience as a buffer to compassion fatigue in their practice.

Effects of Hearing of Trauma

Is there anything about therapy with clients that could help psychotherapists to handle hearing client trauma stories in a way that wouldn't leave a negative effect? In a study of trauma therapists (N=100) who worked with torture survivors in Germany, Austria, and Switzerland, the relationship between professional quality of life experience and the therapist's work with the client's trauma narrative was explored (Deighton, Gurriss, & Traue, 2007). It was shown that the degree to which a therapist works through the client's trauma during therapy, or even advocates to the client that working through the trauma should occur, makes a difference in the psychotherapists' risk for cost of caring symptoms, such as lowering psychotherapist compassion fatigue, burnout, and distress (Deighton, Gurriss, & Traue, 2007). This points to the unique benefits that can occur through proper therapy with a client's trauma narrative, that is beneficial to the psychotherapist.

In a study comparing two groups of clinicians, with 95 who treated sexual trauma survivors and 250 who treated sex offenders found that 76% of clinicians reported being traumatized at least once as a child, and 53.6% reporting multiple childhood trauma (Way, VanDeusen, Martin, Applegate, & Jandle, 2004). The purpose of the study was to compare coping strategies when faced with client trauma narratives, either as survivor or as offender. Coping strategies were broken down into three categories: negative strategies (i.e., viewing pornography, drinking alcohol, or using illegal drugs), positive professional strategies (i.e., seeking consultation, obtaining supervision, or participating in clinical or professional support groups), and positive personal strategies (i.e., participating in physical exercise, utilizing spiritual practices, seeking support from family or friends,

seeking own therapy) (Way, VanDeusen, Martin, Applegate, & Jandle, 2004). The study found no significant difference between the two groups – those who worked with sexual trauma survivors and those who worked with sex offenders in level of vicarious trauma symptoms. However, clinicians who reported higher levels of negative coping strategies were more likely to report higher levels of trauma effects (Way, VanDeusen, Martin, Applegate, & Jandle, 2004), perhaps suggesting that they have not found appropriate ways to handle the trauma wounds that they have carried since childhood. Additionally, a short length of time providing sexual abuse treatment to survivors was a predictor of psychotherapists' intrusive thoughts, potentially suggesting, regardless of working with victims or offenders, that working alongside clients and their trauma through a therapeutically comprehensive sense is not only helpful to the client, but also to the clinician who is impacted personally by the client's trauma narrative (Way, VanDeusen, Martin, Applegate, & Jandle, 2004). All of these studies show that there is a potentially problematic relationship between psychotherapist personal trauma, and the effect of hearing client trauma narratives.

Education, Training, and Experience

Craig & Sprang (2010) investigated the relationship between professional quality of life experiences on the variables of compassion satisfaction, compassion fatigue, and burnout among a national sample of trauma specialists (N=532). Utilizing the Professional Quality of Life Scale (Stamm, 2005), they surveyed trauma specialists to understand the relationship of professional quality of life experiences relative to variables such as age of therapist, years of experience in trauma work, and the use of evidence-based practices in working with their clients. The researchers found that younger

therapists reported higher levels of burnout, more experienced therapists reported higher levels of compassion satisfaction (an identified protective factor for compassion fatigue) and the use of evidence-based practices in therapy predicted statistically significant decreases in compassion fatigue and burnout, and increases in client compassion satisfaction (Craig & Sprang, 2010). The use of evidence-based practice in therapy was measured through the Trauma Practices Questionnaire (TPQ; Craig & Sprang, 2009; Sprang & Craig, 2007) that measures the frequency of using evidence-based practices such as EMDR, Cognitive therapy, Behavioral therapy, Psychodynamic therapy, Eclectic therapy, and Solution Focused therapy (Craig & Sprang, 2010).

O'Brien and Haaga (2015) compared fourth-/fifth-year therapist in-training graduate students (n = 18), first-year therapist in-training graduate students (n = 18), and non-therapists (n = 36) on their responses to viewing a standard videotaped trauma self-disclosure. The study was interested in examining trait empathy, empathic accuracy, and compassion fatigue in response to the viewing. Trait empathy was measured using the Epstein Feelings Inventory (EFI; Mehrabian & Epstein, 1972), a 33-item questionnaire with two subscales of appreciating others' feelings and the tendency to be moved by others' positive or negative emotional experiences (O'Brien & Haaga, 2015). Empathic accuracy was measured in two ways: "coding the similarity of participants' inferences, as given in open-ended responses, to what the target had actually indicated she was thinking and feeling at the corresponding point in the video; and number of correct responses on a multiple-choice test requiring the participant to select the target's stated thoughts and feelings from a list of responses including the correct response as well as three plausible lures" (O'Brien & Haaga, 2015, p. 417).

The O'Brien and Haaga study found that therapist trainee groups reported much lower compassion fatigue scores than the non-therapist group, and they were also more empathically accurate, from the multiple-choice empathic test, to what the video-taped client was feeling, but the study did not find any differences between the freeform responses from open-ended questions that attempted to measure empathic accuracy (O'Brien & Haaga, 2015). Of particular note in this study, is that it did not find any differences in the fourth-/fifth-year and the first-year therapists in-training, suggesting that perhaps the training the students have gone through might not have an effect on student therapist ability to accurately empathize with clients, or their compassion fatigue experiences (O'Brien & Haaga, 2015).

Kinzel and Nanson (2000) explored the unique situation of crisis line volunteers, and their particular circumstances in hearing client trauma. The crisis line field is burdened with a high compassion fatigue and turnover rate due to the impact of hearing very personal trauma stories from those calling the crisis line (Kinzel & Nanson, 2000). The authors propose that an intervention method be utilized more in these work environments providing volunteers with education and debriefing. The crisis line volunteers can learn from the educational component that it is considered normal to experience negative emotional effects from working on the crisis line and that there should not be any shame in the feelings they are having. In particular, the authors cited a study that found that crisis line volunteers are less likely (54%) to answer that they have felt burned out from working on the crisis line, than they are to endorse burnout symptomology questions related to their behaviors and/or feelings (97%) (Cyr & Dowrick, 1991). This study's findings suggest that if psychotherapists are less likely to

identify that they are experiencing burnout, they might then be less likely to seek out professional mental health help. This is of great concern considering the aforementioned barriers to psychotherapists seeking their own mental health care (Bearse, McMinn, Seegobin, & Free, 2013).

Not all of the studies related to psychotherapist education and training agree. Craig and Sprang's (2010) study found that for their sample, evidence-based training was a protective factor from the cost of caring clients who had experienced trauma, but O'Brien and Haaga's (2015) study found no difference in first year counseling students and those who were about to graduate. Lastly, Kinzel and Nanson (2000) believe that an educational training for crisis line workers would be beneficial due to the tendency for helpers to not admit to being negatively emotionally affected by their work.

Helper's Personal Trauma History

A study of 188 self-identified trauma therapists found that those who have a trauma history are more likely to score higher in traumatic stress (Pearlman & Mac Ian, 1995). The TSI (Traumatic Stress Institute) Belief Scale (Pearlman, 1996) was used to measure negative reaction to the work of helping trauma populations. The only item used in this study to measure therapist trauma history was "Do you have a trauma history?" Trauma history was significantly correlated with higher traumatic stress ($r=.22$, $p<.05$) (Pearlman & Mac Ian, 1995). This study pioneered exploration into the relationship between the cost of caring for trauma populations and provider's past trauma.

Schauben and Frazier conducted a study on 148 female therapists who work with trauma populations (1995). This study found that the therapists who had a higher percentage of sexual trauma survivors in their caseload were more likely to report higher

levels of psychological distress and vicarious trauma. The study also measured personal trauma history of the therapists, but found no variance of psychological distress between those who had personal trauma history and those who did not (1995).

A survey of ninety-nine sexual assault and domestic violence counselors responded to psychometric scales such as the Compassion Fatigue Self-Test (CFST), created by Figley (1995) – the precursor to the ProQOL scale (Stamm, 2009) and revealed that counselors scored higher on the CFST when the counselors' degree of interpersonal trauma history was higher (Jenkins & Baird, 2002). This interpersonal trauma history was examined through the use of the TSI Life Events Checklist (short form; Pearlman, 1996), and was utilized in this study to “identify individuals whose histories suggested possible greater vulnerability to clients' traumas similar to their own” (Jenkins & Baird, 2002). This sample included 95 women and four men, aged twenty-one to sixty-five, with 37% holding a bachelor's degree and 47% a master's degree. This study draws attention to the risk factors of compassion fatigue for psychotherapists who have a past trauma history.

Nelson-Gardell and Harris conducted a study using 98 child welfare workers and 68 social work conference attendees to understand the relationship between vicarious trauma and childhood abuse or neglect (2003). The combined the study's sample had only 21.7% (n=36) with an MSW degree (Nelson-Gardell & Harris, 2003). The authors used the Compassion Fatigue Self-Test for Psychotherapists (CFST; Figley, 1995) and the Childhood Trauma Questionnaire (CTQ; Bernstein & Fink, 1998). The CTQ has five dimensions: emotional abuse, physical abuse, sexual abuse, emotional neglect, and physical neglect. This study found that age of therapist was the best predictor of vicarious

traumatization, and that the best model for predicting secondary traumatic stress were the subscales respondent childhood emotional abuse ($r=.372$, $p<.01$), sexual abuse ($r=.210$, $p<.05$), and age of worker ($r=-.175$, $p<.05$) (Nelson-Gardell & Harris, 2003).

A dissertation study of thirty-six disaster mental health workers from the Oklahoma Department of Mental Health and Substance Abuse Services (SAMHSA) and ancillary agencies, was, in part, conducted to understand the relationship between helper personal trauma and compassion fatigue for those who worked alongside the 1995 Oklahoma City bombing (Moore, 2004). The Frederick Reaction Index-A (FRI-A) was used to measure the presence or absence of Post-Traumatic Stress Disorder symptomology (Frederick, 1985), additionally, the Compassion Fatigue Self-Test for Helpers (CFS) was used to measure compassion fatigue related symptoms (Figley, 1995). The study found that the scores for the FRI-A were significantly related to the CFS, potentially because both derive their items from PTSD symptomology (Moore, 2004). The study found a relationship between respondent trauma and compassion fatigue, but this dissertation study's focus was on the impact of the Oklahoma City bombing that occurred months before the data was collected (Moore, 2004). Therefore, it was not the intention or design of this study to measure trauma that occurred during the respondent's childhood.

Five hundred sixty-four clinical psychologist trainees were surveyed to investigate the relationship between exposure to trauma work and well-being (Makadia, Sabin-Farrell, & Turpin, 2016). The study utilized the Secondary Traumatic Stress Scale (STSS; Bride, Robinson, Yegidis, & Figley, 2004) to measure the negative effects of working with trauma populations. Additionally, the General Health Questionnaire (GHQ-

12; Goldberg & Williams, 1988) was used to measure psychological distress and the Trauma and Attachment Belief Scale (TABS; Pearlman, 2003) was used to measure disrupted beliefs consistent with vicarious traumatization concept. The Trauma Screening Questionnaire (TSQ; Brewin et al., 2002) was used to measure therapist trauma. The study found a significant correlation to personal history of trauma to general psychological distress ($r=.12$, $p<.01$) and personal history of trauma to disrupted beliefs ($r=.22$, $p<.01$). The study results did not show a significant correlation between personal trauma and trauma symptoms as measured by the STSS. It is important to note that the TSQ is used to measure personal trauma within the last 12 months, and not the entire personal history of the respondent. Therefore, this study can claim that there is a correlation between personal trauma, but does not attempt to explain past childhood trauma, or anything prior to 12 months before filling out the survey.

A study of 217 social workers working in social services agencies in Israel found that lack of ambiguity tolerance, higher case-load volume, younger age, and social worker's past trauma contribute to the negative effects of caring for trauma populations (Dagan, Itzhaky, & Ben-Porat, 2015). Bride et al.'s Secondary Traumatic Stress Scale (STSS, 2003) was used to measure secondary trauma, while the Life Events Questionnaire (short form, Solomon & Flum, 1988) and the Traumatic Experiences Questionnaire (Nijenhuis, Van Der Hart, & Vanderlinden, 1996) were utilized to measure respondent stressors. Additionally, the Tolerance for Ambiguity Questionnaire (Freeston, Rheaume, Letarte, & Dugas, 1994) and Zimet et al.'s Multidimensional Scale of Perceived Social Support (1988) were included in this study along with demographical and work environment items. The study found the most significant contribution to the

relationship of secondary traumatization in respondent's tolerance for ambiguity, suggesting that those who were more likely to report lower secondary traumatic stress from their work in trauma were those who were okay with ambiguity (Dagan, Itzhaky, & Ben-Porat, 2015). The study found that case-load volume explained much of the variance in secondary traumatic stress. Additionally, younger social workers were less likely to ascribe to continuance commitment to their organization, and were more likely to score higher on secondary traumatization (Dagan, Itzhaky, & Ben-Porat, 2015).

From the same study sample, but published at a later date, the authors reported that the number of past traumas of the social worker was significantly correlated with higher secondary traumatic stress ($r=.16, p=<.01$) leading to the finding that "...workers who have experienced a traumatic event in the past are also at greater risk for developing secondary traumatization (Dagan, Ben-Porat, & Itzhaky, 2016, p.209)." These findings reemphasize that past trauma and age of social workers are important factors to the negative effects of caring for trauma populations. It is important to note that although this study measures past trauma, it does not measure past childhood psychological abuse. This study only "...used 6 items" from the 10-item Traumatic Experiences Questionnaire, and did not ask any questions about psychological trauma or the time frame from which the trauma event occurred (Dagan, Ben-Porat, & Itzhaky, 2016, p.207).

In summary, "...workers who have experienced a traumatic event in the past are also at greater risk for developing secondary traumatization" (Dagan, Ben-Porat, & Itzhaky, 2016, p.209). But what much of the literature does not examine is the relationship that past childhood psychological abuse has on the helper. The only study to investigate this interaction is the study conducted by Nelson-Gardell and Harris which

concluded that emotional trauma and sexual trauma from childhood are significant predictors of higher levels of secondary traumatic stress among a sample of predominantly child welfare workers who attained a bachelor's level degree at their highest (2003).

To the knowledge of this author, since 2003 there have not been any specific studies further examining the cost of caring for therapists – focusing on professional quality of life components – and provider childhood psychological abuse for higher educated social workers and allied professionals. Furthermore, this study will utilize a newly developed psychometric scale, the Multifactor Psychological Abuse Inventory (Craig, Reynolds, & Badger, unpublished), for childhood psychological abuse that has the three components of emotionally abusive threat and humiliation, domestic violence exposure, and neglect. This study will also utilize the Professional Quality of Life scale (Stamm, 2006) that is the further developed version of the Compassion Fatigue Self-Test (Figley, 1995) to measure not only compassion fatigue, but also compassion satisfaction and burnout.

Chapter Three: Conceptual Models That Shape the Problem

The previously explored concepts related to the cost of caring for social worker and allied professionals are related to the general problem of working with trauma cases: when social worker and allied professionals help their clients, they can be susceptible to two harmful extreme reactions, caring too much and experiencing secondary traumatic stress, or caring too little and experiencing compassion fatigue. An empathic professional who is aware of this dilemma, and can adequately prepare for the personal emotional impact of working with a trauma population may be better suited to work with their clients who have experienced trauma.

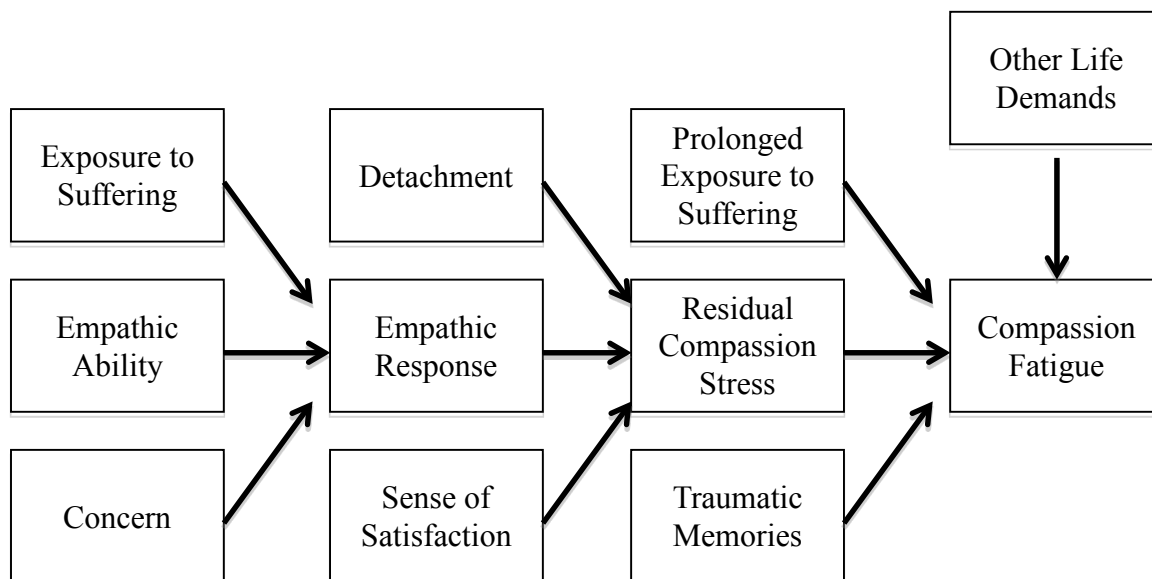
Multiple theories and conceptual frameworks are used to better understand the problem this research proposal will explore. Specifically, the proposed research draws upon Charles Figley's model of compassion fatigue, Maslach's burnout model, Stamm's professional quality of life model, Benard & Marshall's resiliency model, Truebridge's resiliency model, and Hobfoll's Conservation of Resources (COR) theory. Each of these will be discussed below.

Figley's Model of Compassion Fatigue

Charles Figley is considered the most influential writer on problems related to those who work with traumatized populations. His particular work with trauma populations, and the effects on those who work with that population, highlight the difficulties and potential problems that can impact the helping professional. In his book, *Treating Compassion Fatigue* (2001), Charles Figley illustrates a conceptual model to describe the phenomenon of compassion fatigue (see Figure 1).

Figure 1

Charles Figley's Compassion Fatigue Model



Compassion Stress and Fatigue Model (Figley, 1995, 1997)

The far-left side of Figure 1 shows the components that occur whenever a therapist works with a traumatized individual. Clients bring their traumatic suffering and the therapist has the ability to be empathic and concerned. The professional's empathic response is either emotional detachment, since the trauma can be too much for the professional to handle, or a sense of satisfaction in his or her ability to empathize. Residual compassion stress occurs and a prolonged exposure to the trauma narrative leads to compassion fatigue. The professional might also recollect the traumatic story in his or her own mind that was heard from their clients. This too can lead to compassion fatigue. Figley then draws attention to other life demands that might be additional stressors to the professional. Figley states, "Compassion fatigue is inevitable if, added to these three factors, the helper experiences an inordinate amount of life disruption as a function of

illness or a change in lifestyle, social status, or professional or personal responsibilities” (1995, p.253). Figley’s conceptual model of compassion fatigue does not address the helper’s own past trauma and its impact on compassion fatigue.

Maslach’s Burnout Model

Burnout is understood to have three main aspects: exhaustion, depersonalization, and inefficacy. The most commonly understood dimension of burnout is exhaustion, that of feeling tired from the work that one does, and it is a necessary component for burnout (Maslach, Schaufeli, & Leiter, 2001). Depersonalization occurs when the helper attempts to detach from those they are called to work with, disregarding the qualities that make the service recipient unique, and depersonalization is commonly found to have a strong relationship to exhaustion in burnout research (Maslach, Schaufeli, & Leiter, 2001). Lastly, inefficacy, or a reduced feeling of personal accomplishment, is the third aspect of burnout. Inefficacy might be a result of the previous two aspects of burnout, because it is theorized that when one is exhausted, and depersonalizes service recipients, then these individuals are likely to be less effective in their jobs (Byrne, 1994; Lee & Ashforth, 1996). However, some research has shown that inefficacy can develop parallel with exhaustion and depersonalization rather than as a result of it (Leiter, 1993).

Stamm’s Professional Quality of Life Model

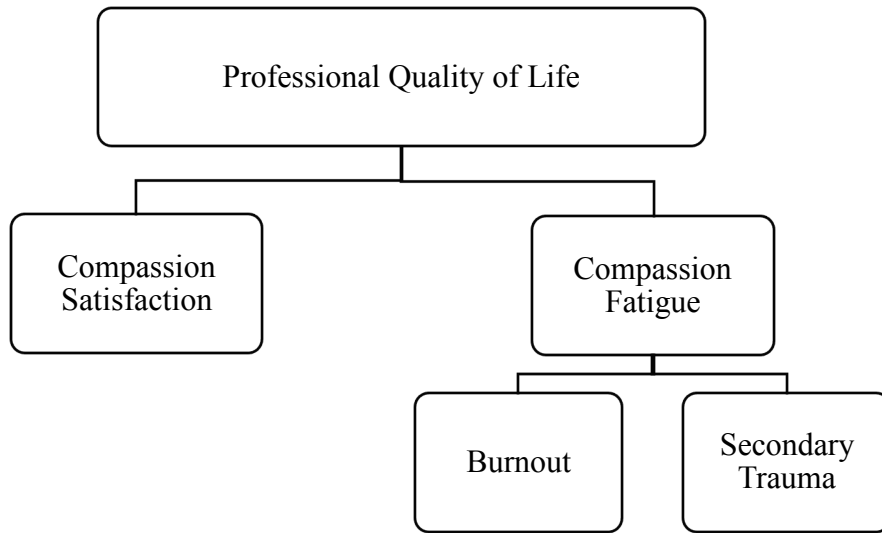
Stamm’s professional quality of life model (2009) reconceptualized and expanded the previous conceptual model of compassion fatigue as described by Charles Figley. Compassion satisfaction is understood as the positive aspects deriving from helping others, and is thought to be an important protective factor for preventing or mitigating compassion fatigue. Additionally, Stamm added the concepts of burnout, or work-related

stress, and secondary trauma, the exposure to another's trauma narrative, to Figley's model to give a fuller understanding of the negative aspects of helping.

Figure 2 below shows Stamm's conceptual model visualizing compassion satisfaction as the counterbalance to the negative effects of helping.

Figure 2

Stamm's Professional Quality of Life Model



Benard, Marshall (1997), and Truebridge's (2010) Theories of Resilience

Some research in the helping professions is focused on pathology and problem-based thinking; focusing on what a client does well, their strengths, is a relatively new research focus. Problem-based research should not be disregarded, but appropriate attention should be given to an individual's strengths, the things he or she has within himself or herself that encourages health and flourishes growth: what enhances resiliency.

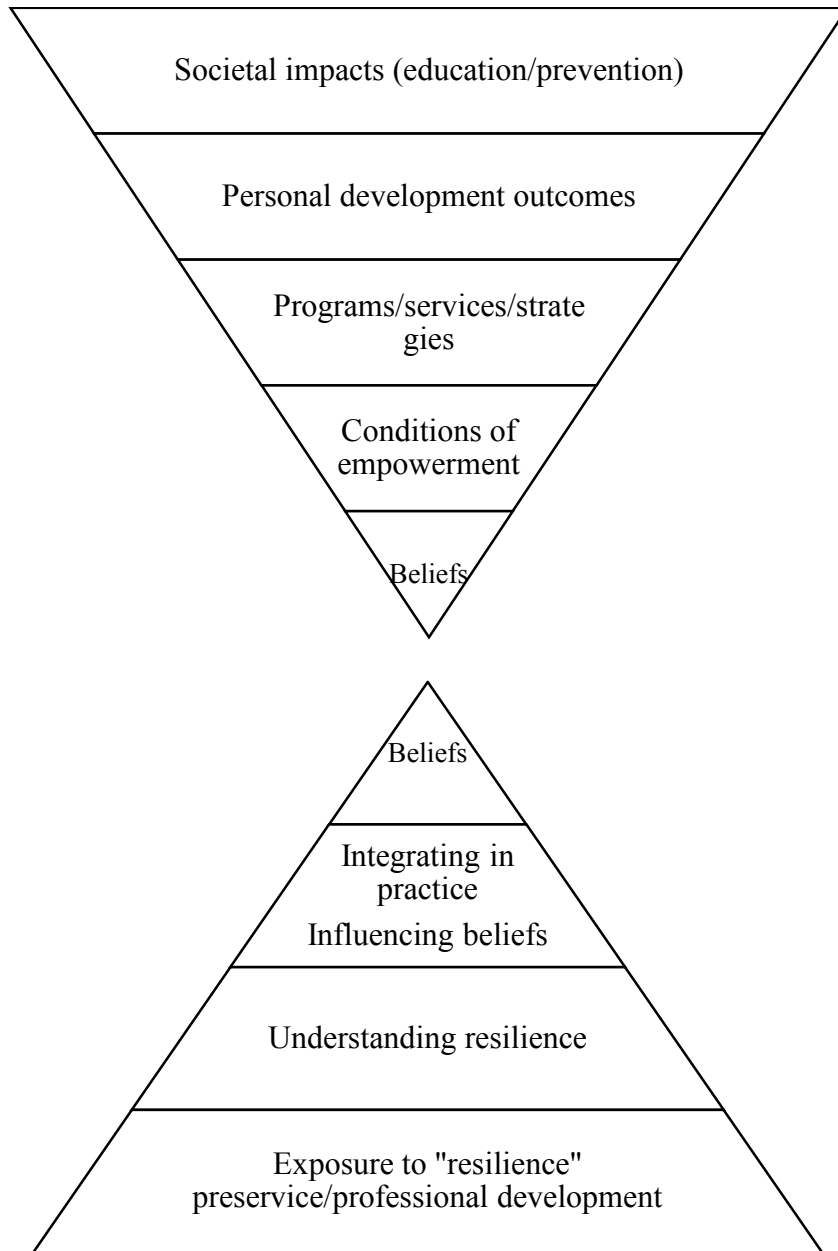
Benard and Marshall (1997) created a conceptual model of resilience in the top triangle illustrated in Figure 3 below. Their unique focus is on beliefs, and the role that beliefs play in how a professional develops resilience with their clients. Drawing upon client beliefs, professionals can set up conditions of empowerment for their clients.

These conditions make way for the professional's approaches to assist their clients in programs, services, or strategies. These services lead to personal development outcomes such as growing in competence, increasing problem-solving skills, and fostering a sense of purpose. Lastly, this process, that starts with beliefs and builds to utilizing resources and fostering self-efficacy, leads to reduced negative societal impacts, because the client utilizes their own resilience, further playing into their beliefs about self.

Truebridge (2010) created the bottom triangle illustrated in the bottom portion of Figure 3 below. It is a conceptual model showing how a mental health professional becomes educated in resilience. From the bottom, the educational process starts with exposure to professional development on the concept of resilience. From there, the mental health professionals grow in their understanding of resilience, and will integrate their newfound understanding into practice. Lastly, their beliefs about resilience will be changed, resulting in going through the same process as the top triangle, by working toward fostering resilience with their clients. The key to this model is to understand the professional's role in fostering client resilience, that the professional's beliefs about their client impact how they build upon their client's resilience. This conceptual model is a process that continually occurs in the professional setting, building upon itself.

Figure 3

Benard, Marshall (1997), and Truebridge (2010) Resilience Model



Benard, Marshall (1997), and Truebridge (2010) Resilience Model

Glaser's Psychological Abuse in Childhood Conceptual Framework

Childhood psychological maltreatment or abuse, or also known as emotional abuse, is a hard accusation to substantiate. The concept of childhood psychological abuse usually focuses on the relationship between a child and the primary caregiver, and requires no physical contact, and does not need any intention to do harm (Glaser, 2002). Psychological abuse can cause harm to a child's development, and can continue into their adult life (Hart, Binggeli, & Brassard, 1998). Unique from childhood sexual abuse and physical abuse, childhood psychological abuse is often observable with the abuser among those closest to the child (Glaser, 2002).

The definition of psychological abuse/maltreatment, according to the American Professional Society on the Abuse of Children's practice guidelines, involves the consistent behavior of a caregiver that communicates that the child is "worthless, flawed, unloved, unwanted, endangered, or of value only in meeting another's needs" (APSAC, 1995). Additionally, the APSAC denotes six forms of psychological maltreatment: spurning, terrorizing, exploiting/corrupting, denying emotional responsiveness, isolating, and mental, health, medical, and educational neglect (APSAC, 1995).

Glaser (2002) identifies five new categories to understand the concept of psychological maltreatment. Emotional unavailability, unresponsiveness and neglect (1), negative attributions and misattributions to the child (2), developmentally inappropriate or inconsistent interactions with the child (3), failure to recognize or acknowledge the child's individuality and psychological boundary and using the child for the fulfillment of the parent's psychological needs (4), and failing to promote the child's social adaptation (5).

Glaser and the APSAC's concepts of identifying psychological abuse are important because the two conceptual frameworks help to create a fuller understanding of psychological abuse and thus provide a helpful guide for those in the helping professions to potentially identify childhood psychological abuse. This study's measurement of childhood psychological abuse will be explained in the next chapter.

Social Support

As previously mentioned in this proposal, social support is the perception of the number of people an individual can have quality connectedness to, and social support is not necessarily the robustness of a person's social support, but rather their perception of their social support that is meaningful (Antonucci & Israel, 1986). What this means is that the protective factor of social support is an incredibly interpretive factor: how individuals perceive their social support is everything. One person's perception of a quality social support system is most likely very different than another's. This transitions into the final theoretical framework that this proposal draws upon.

Tedeschi & Calhoun's Posttraumatic Growth Concept

Although it is a long-held belief that someone can be made stronger because of their personal trials, Tedeschi and Calhoun developed a conceptual model to help researchers talk about the personal growth that can occur from such trials. Posttraumatic growth can be a "...result of the struggle with highly challenging life crises" (Tedeschi & Calhoun, 2004, p.1). The conceptualized results from posttraumatic growth can be increased appreciation for life, more meaningful relationships, increased sense of personal strength, changed priorities, and a richer spiritual life (Tedeschi & Calhoun, 2004). What this means for the helper, particularly one who works closely with trauma

populations, and has experienced trauma her/his self, is that any person can experience growth after a traumatic event based upon one's "individual characteristics, support and disclosure... (and whether or not) significant cognitive processing involving cognitive structures (is) threatened... by the traumatic events" (Tedeschi & Calhoun, 2004, p.1). Posttraumatic growth is conceptualized as something that is a continual process that is always occurring as the individual continues to live their life. This has implications not only for the helper personally, but also for the helper to better compassionately connect with their client who has experienced trauma. This study will not attempt to measure posttraumatic growth since the study is cross-sectional in nature.

Hobfoll's Conservation of Resources (COR) Theory

In Hobfoll's COR theory, how people navigate through stressful times is a matter of protecting resources, or rather "...people strive to retain, project, and build resources and that what is threatening to them is the potential or actual loss of these valued resources" (Hobfoll, 1989, p.513). For Hobfoll, a person can navigate through difficult stress by gaining mastery of the resources that help them to cope with their current or chronic situation. These resources can be understood as environmental, such as social support from family, friends, and workplace, and as personal resources, such as the personality traits that an individual has within themselves that help them to cope with stress. What this means in light of therapy and working with trauma populations, is "...mastery is manifested in the ability of therapists to differentiate between their personal and professional lives, and the perception that they are in control of their world" (Dagan, Itzhaky, & Ben-Porat, 2015, p.594). Additionally, it means that it is important for a professional to have environmental resources, such as friend, family, and work

environment support, as well as a personal sense of resiliency and ability to handle the work of helping trauma populations.

Synthesis of Concepts to Be Used in Study

This study will attempt to conceptualize how one's own personal psychological abuse impacts ability to provide compassionate care to clients who have experienced trauma. Particularly through Figley's compassion fatigue model it is believed that exposure to another's suffering through their trauma narrative might bring up one's own personal traumatic memories, potentially leading to compassion fatigue symptoms, depending on other life demands. The way in which this author will conceptualize other life demands is best understood through Hobfoll's Conservation of Resources theory—that many individuals can navigate through difficult times if they perceive and have access to resources to assist with those problems. In this study, the difficult time is the potential cost of providing psychotherapy for trauma populations. Some factors that could play a part in an individual's life demands are potentially positive resources or risk factors – depending on their absence or abundance – such as social support, perception of one's own resilience, Stamm's notion of compassion satisfaction, Maslach's conception of burnout, and personal past psychological abuse. Although posttraumatic growth was not measured during the surveying of this sample, posttraumatic growth could be involved in an individual's ability to process through client's trauma narratives when the helper's own personal psychological abuse could be interacting.

Interpretive Paradigm

Although the instruments used in this proposal will attempt to measure concepts, and will have reported validity and reliability scores, the only thing the psychometric

scales can measure is the perceived experience of the individual filling out the instrument. For example, this proposal is concerned with the concept of social worker and allied professional resilience, but that will only be measured by the particular professional's perception of his or her own resilience. Similarly, they will be asked to measure their perception of the adequacy of their social support system, but adequacy of social support is something that is uniquely different per person. In these examples, the research relies heavily of the interpretive paradigm, one that "allows researchers to view the world through the perceptions and experiences of the participants" (Nguyen & Tran, 2015, p.24). Therefore, the subjective experiences of the social worker and allied professionals are what is critical to answer the question of one's professional quality of life.

Summary and Construction of Research Model

Because social worker and allied professionals are exposed to traumatic stories from their clients, and are susceptible to negative emotional effects, a full look at the professional quality of life for these professionals is important. This is why this proposed exploratory study will focus on factors that impact not only the concept of compassion fatigue, but also compassion satisfaction and burnout through the independent variable of a respondent's childhood psychological abuse.

In gathering what the research and literature has shown about psychotherapists' professional quality of life, years of experience can bolster compassion satisfaction (Craig & Sprang, 2010), evidence-based training can be a protective factor to compassion fatigue (Craig & Sprang, 2010), perceived resilience may be a potential protective factor for compassion fatigue although there have been no studies published about the

relationship, and social support may help protect against compassion fatigue and burnout (Bride, 2004; Iliffe & Steed, 2000; Pearlman & Mac Ian, 1995; Pistorius, Feinauer, Harper, Stahmann & Miller, 2008).

There are also risk factors that impact a psychotherapists' professional quality of life. The research suggests that a psychotherapist's past trauma is a risk factor to compassion fatigue related symptoms (Jenkins & Baird, 2002; Nelson-Gardell & Harris, 2003; Moore, 2004; Dagan, Ben-Porat, & Itzhaky, 2016; Makadia, Sabin-Farrell, & Turpin, 2016). Only one of these studies investigates the relationship of childhood psychological abuse and compassion fatigue, that of Nelson-Gardell and Harris (2003). This study's data was collected in 1998, over twenty years ago, and the Nelson-Gardell and Harris study investigated childhood trauma through the CTQ (Bernstein & Fink, 1998) and the Compassion Fatigue Self-Test for Psychotherapists (Figley, 1995). The CFST has been improved upon by the creation of the ProQOL v.5, and the CTQ does not attempt to measure in-depth the different components of childhood psychological abuse, but does attempt to generally measure childhood trauma. Therefore, the social worker and allied professionals' childhood psychological abuse, with an interest in different childhood psychological abuse components, will be examined as a risk factor to professional quality of life.

Chapter Four: Methodology

The database used in this dissertation proposal was collected in 2017 by the author and obtained through the approval of the University of Kentucky Institutional Review Board. A survey questionnaire consisting of a demographic questionnaire, the Professional Quality of Life Scale (ProQOL; Stamm, 2009), the Multifactor Psychological Abuse Inventory (MPAI; Craig, Reynolds, & Badger, unpublished), the Brief Resilience Scale (BRS; Smith, Dalen, Wiggins, Tooley, Christopher, & Bernard, 2008), and the Multidimensional Scale of Perceived Social Support (MSPSS; Zimet, Dahlem, Zimet, & Farley, 1988) were included in order to get an understanding of social worker and allied professional experience, resources, and past psychological abuse, in relationship to working with clients who have experienced trauma.

The demographic questionnaire included basic demographics such as sex, gender, age, years of experience working as a helping professional providing therapy, perception of adequate training to work with clients who have experienced trauma, work place setting, profession, case load, etc. The goal of the demographic questionnaire was to obtain the characteristics of the social worker and allied professional respondents.

Dependent Variables from The Professional Quality of Life Scale

Psychometric scales are used to measure constructs or phenomenon in an attempt to quantify a particular thing. The Professional Quality of Life Scale (ProQOL) (Stamm, 2005) is used to measure an individual's self-reported compassion fatigue, compassion satisfaction, and burnout. The ProQOL v.5 is a thirty-item scale that attempts to measure three constructs (Compassion Satisfaction, Burnout, and Compassion Fatigue) through 10 items relating to each concept. The three constructs from the ProQOL, compassion

satisfaction, burnout, and compassion fatigue, will be the dependent variables for this study. Each item is a statement, and the respondent's answers range from 1-5 on a Likert scale (1= Never, 2= Rarely, 3= Sometimes, 4= Often, 5= Very Often). Though this is a frequently used psychometric scale, little literature has been published on the ProQOL v.5 scale's validity using statistical analyses. The most recent exploratory factor analysis was conducted on the ProQOL v.3, and it was published in 2010 (Craig & Sprang). The ProQOL v.5 measure, through its website, claims reliability and validity, through aggregated data that has been donated to the website, of the three components: Compassion Satisfaction $\alpha = .88$ (n=1130), Burnout $\alpha = .75$ (n=976), and Compassion Fatigue $\alpha = .81$ (n=1135), though the details of the analysis is not published, the alpha scores are published through the website. The three components of the ProQOL v.5 – compassion satisfaction, burnout, and compassion fatigue – all are connected to their own ten unique items. Five of the items related to burnout were reverse-coded to reflect that higher burnout score was reflective of the concept it attempts to measure. The total scores of the three components were each individually calculated and could range from a possible score of 10-50. Chronbach's Alpha for this study's sample was .711.

Independent Variable: The Multifactor Psychological Abuse Inventory

The Multifactor Psychological Abuse Inventory (MPAI; Craig, Reynolds, & Badger, unpublished) is a 59-item measure attempting to quantify an individual's past childhood psychological abuse. The preliminary analysis for the MPAI, originally 75-item, yielded three factors that the psychometric scale measured: emotionally abusive threat and humiliation, domestic violence exposure, and neglect, with six items cross loading and ten items failing to meet the cutoff. Fifty-nine items were left to measure the

three factors. Internal consistency for this study's sample ranged from .85 to .97 for the three aforementioned subscales. Each item in the MPAI is a statement related to how their parent(s)/primary caregivers treated them. The respondent's answers range from 0-6 on a Likert scale (0= Never, 1= Rarely, 2= Occasionally, 3= Sometimes, 4= Often, 5= Almost Always, 6= Always). An example of an MPAI item is "Threats to harm someone I loved were heard in my childhood home." The use of the MPAI for this proposed research will be as an overall measure of social worker and allied professional past childhood psychological abuse, and will also utilize the subscales to answer the research question: does the type of childhood psychological abuse effect social worker and allied professional's professional quality of life?

Resilience and Support Variables

The Brief Resilience Scale. The Brief Resilience Scale (BRS) (Smith, Dalen, Wiggins, Tooley, Christopher, & Bernard, 2008) is a six-item scale measuring an individual's perception of their resilience, or ability to bounce back after adversity. This scale will be used as a mediating variable for this proposed study. Each item is a statement, and the respondent's answers range from 1-5 on a Likert scale (1= Strongly Disagree, 2= Disagree, 3= Neutral, 4= Agree, 5= Strongly Agree). A sample item from the questionnaire is "I tend to bounce back quickly after hard times." The scale is valid and reliable when used on four separate samples of two student samples, cardiac, and chronic pain patients (Smith, Dalen, Wiggins, Tooley, Christopher, & Bernard, 2008). The validation study found that higher respondent BRS scores had a negative relationship to anxiety, depression, negative affect, and physical symptoms, and the BRS measured one construct of resilience (Smith, Dalen, Wiggins, Tooley, Christopher, & Bernard, 2008). Utilized under four different samples of two student groups, cardiac patients, and chronic pain patients, the BRS was valid and reliable with a Chronbach's alpha score ranging from .80-.91 among the four samples (Smith et al., 2008). The six items were combined into a total score that could range from 6-30. Chronbach's Alpha for this study's sample was .873.

The Multidimensional Scale of Perceived Social Support

The Multidimensional Scale of Perceived Social Support (MSPSS) (Zimet, Dahlem, Zimet & Farley, 1988) is a 12-item scale measuring the single construct of perception of social support. This scale will be used as a mediating variable for this study. Each item is a statement, and the respondent's answers range from 1-7 on a Likert scale (1= Very Strongly Disagree, 2= Strongly Disagree, 3= Mildly Disagree, 4= Neutral, 5= Mildly Agree, 6= Strongly Agree, 7= Very Strongly Agree). An example of an item from the MSPSS is "There is a special person who is around when I am in need." The scale found three factors, that of support from family, friends, and significant other, and is valid and reliable when tested on a sample of 275 university students with a Chronbach's alpha score of .88 (Zimet, Dahlem, Zimet & Farley, 1988). The twelve items were combined to create a total score for social support that could range from a possible 12-84. Because this study is interested in the effects of childhood psychological abuse, it is important to investigate the subcategories of the MSPSS- support from significant other, family and friends. These subcategories all have four unique items in the scale that measure each component. These were totaled and could range from a possible 4-28. Chronbach's Alpha for this study's sample was .921.

Additional Variables Used in This Study

Evidence-based training is measured through the single item: "I have received, and am receiving, proper training to work with the clients I currently work with." Case load number is answered through the single item: "My current case-load number is." The percentage of clients who have experienced trauma is measured through the single item: "What percentage of your clients would you estimate to have experience psychological

trauma?” Which is then categorized as an ordinal variable (0= 0, 1= 1-25, 2= 26-50, 3= 51-75, 4= 76-100). Years of experience is answered through the single item: “How many years have you currently worked in this field?” “Years of experience” will be used in this study instead of age of respondent. Gender is asked through three possible answers: male, female, or transgender. Education level is asked through the single item: “What is the highest level of education you have completed?”

Procedure

The data reported in this study was approved by the University of Kentucky’s institutional review board. The original intent of the researcher was to gather a random sample of independently licensed social workers who primarily worked with a population that has experienced trauma, but the attempts to recruit participants through a paid listserv yielded too small of a sample (n=58) to ensure a statistically rigorous validation of the MPAI. Many different sources have recommendations for subject to variable ratios for exploratory factor analysis (Osborne & Costello, 2004), yet acquiring an adequate sample can be a difficult task. The researcher decided to aim for a minimum subject to variable ratio of 2:1, which falls short of Gorsuch (1983, p.332) and Hatcher’s (1994, p.73) recommendation of a 5:1 ratio. With the MPAI having 75 items, the sample needed a minimum of 150 respondents.

A combination of two methods were used for obtaining the desired minimum sample size: the researcher utilized the previously discussed method as well as a convenience sample and snowball methods to increase the sample size. The data were collected between May 2016 and November 2017. Email advertisements were sent to recruited subjects through the National Association of Social Workers Kentucky Chapter

email listserv, social media, and email list made available through the Kentucky Board of Social Work as well as follow up emails for reminders. Additionally, those viewing the advertisement were encouraged to forward the information for the study to mental health professionals. The response rate cannot be known with certainty because recruited subjects were encouraged to forward the recruitment to other current mental health workers who may or may not have attempted to complete the questionnaire in a snowball survey.

The additional subjects from the convenience and snowball methods were not guaranteed to be independent social workers who primarily work with a trauma population, but they did self-identify as current mental health professionals: social workers, psychologists, counselors, marriage and family therapists, psychiatrists, or case workers. The additional sampling methods increased the sample size from (n=58) to (n=218).

In sum, an advertisement to participate in this survey was emailed to National Association of Social Workers who identified as working primarily with trauma clients, members of the National Association of Social Workers Kentucky Chapter, social worker's listed email from the Kentucky Board of Social Workers, and social media outlets. The snowball sample produced 218 respondents. As a participation incentive, every respondent had a chance to win one of eight Amazon gift cards worth \$50. Of those who responded, 21 did not complete the MPAI, and were discarded from this proposal, leaving a final sample of 197. The sample consisted of 79.2% females and 16.2% males, ranging in age from 23 to 84 with a mean age of 42.14. Within the sample, 84.8% had master's level degrees, 6.6% had doctoral level degrees, and 4.1% had bachelor's level

degrees. Respondent clinical experience ranged from less than 1 year to 47 years, with a mean of 13.23 years of experience. Seventy-seven percent were social workers, 13.7% were counselors, and 3% were psychologists. Ninety-three percent of the sample reported that they had received proper specialized training for treating traumatized individuals. On average, the mental health professionals from the sample reported 74.95% percent of their case load consisted of clients who have experienced psychological trauma. This sample represented 36 states, with 40.6% coming from Kentucky, 12.2% from Louisiana, and 6.1% from Alabama. This sample included no respondents from the states of Alaska, Delaware, Hawaii, Kansas, Maine, Maryland, Nebraska, New Mexico, North Dakota, Pennsylvania, South Carolina, South Dakota, Utah, Vermont, and Wyoming. The general demographics for this sample are similar to previous studies that surveyed psychotherapists and the experiences related to the cost of caring, except that this study's sample is heavily comprised of social workers (Adams, Boscarino, & Figley, 2006; Choi, 2011; Macchi, Johnson, & Durtschi, 2014; Caringi et al., 2016).

Hypotheses and Resulting Analyses

This research study utilized simple correlation matrices and multiple regression analyses in order to understand the relationship between social worker and allied professional past childhood psychological abuse and professional quality of life related components: compassion satisfaction, compassion fatigue, and burnout.

The first set of hypotheses tested through simple correlation are as follows: (H¹) Respondents who report higher rates of past childhood psychological abuse are more likely to report higher rates of compassion fatigue and (H²) respondents who report higher rates of past childhood psychological abuse are more likely to report higher rates of

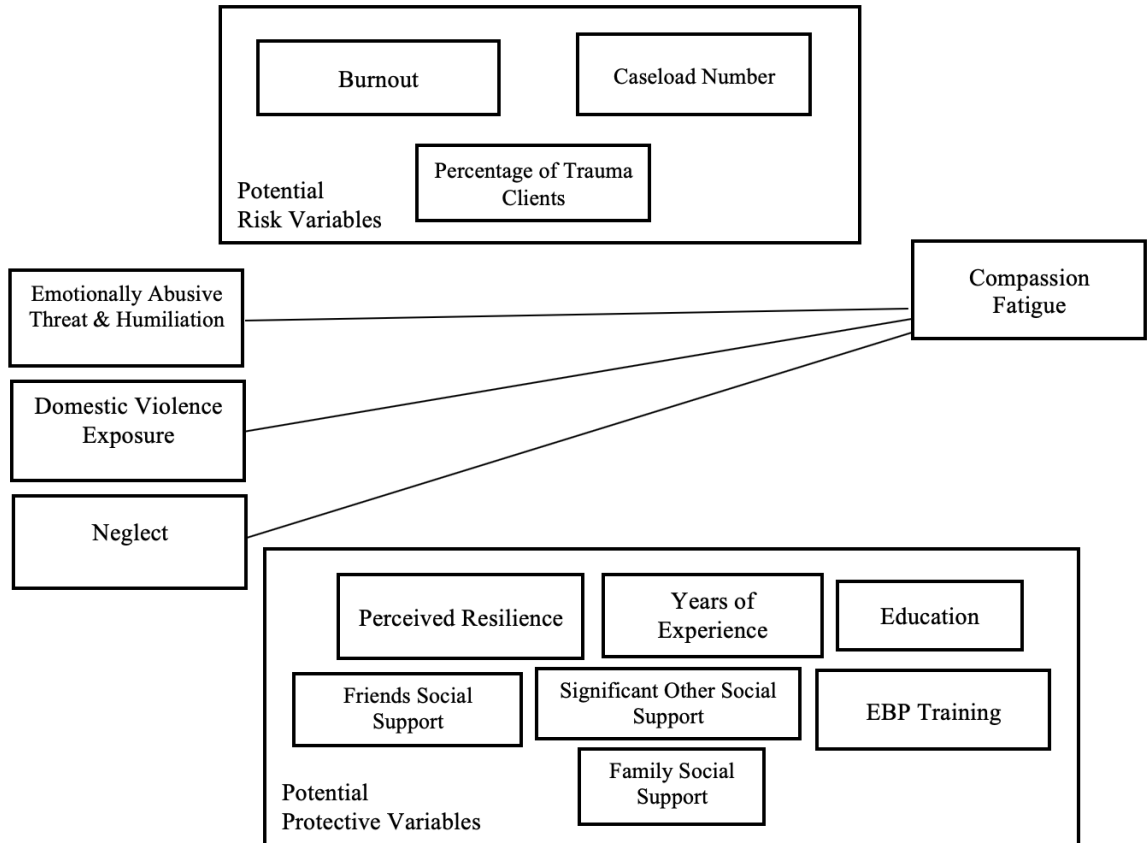
compassion satisfaction. The reasoning for this first set of hypotheses is that although there might be more risk for compassion fatigue related experiences for the professional because of past childhood psychological abuse, there may also be more opportunity for compassion satisfaction – a feeling that the act of caring for their clients is of great purpose – potentially because of the professional’s posttraumatic growth.

This exploratory study examined the relationship between the type of childhood psychological abuse – emotionally abusive threat & humiliation, domestic violence exposure, and neglect – and compassion satisfaction and compassion fatigue while controlling for variables that are related to professional quality of life in the literature.

The resulting hypothesis was tested: Respondents who report higher rates of emotionally abusive threat and humiliation, domestic violence exposure, and neglect are more likely to report higher rates of compassion fatigue (H^3). Therefore, the first regression model tested is of the predictors of compassion fatigue that will include the following control variables in relation to the independent variables total childhood psychological abuse, emotionally abusive threat and humiliation, domestic violence exposure, and neglect: EBP training, percentage of trauma clients, caseload number, burnout, perceived resilience, total social support, significant other social support, friends social support, family social support, experience, and education.

Figure 4

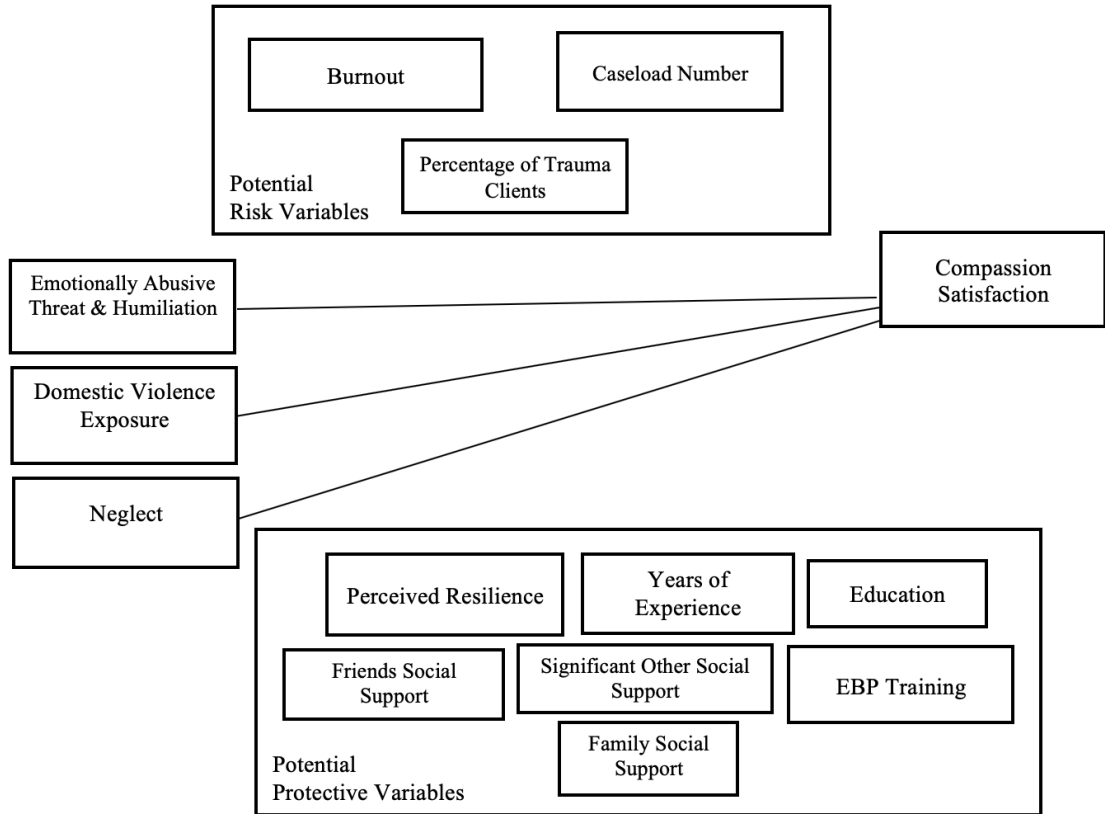
Regression Model for Predicting Compassion Fatigue



The same analytic approach was used to test the final set of hypotheses, with the different outcome variable of compassion satisfaction, respondents who report higher rates of emotionally abusive threat and humiliation, domestic violence exposure, and neglect are more likely to report higher rates of compassion satisfaction when controlling for the listed variables (H⁴).

Figure 5

Regression Model for Predicting Compassion Satisfaction



There is not be a regression model to predict the professional quality of life component of burnout with emotionally abusive threat and humiliation, domestic violence exposure, and neglect in this study because it does not conceptually make logical sense that a professional's childhood psychological abuse would be connected to work demands related to burnout. Although it does make sense that the impact of childhood psychological abuse could make an impact on protective or risk factors that are connected to a professional's burnout scores, and this can be examined through the direct

correlations with the variable of childhood psychological abuse to perceived resilience, compassion satisfaction, and compassion fatigue.

Chapter Five: Results

Descriptive Analyses

An initial factor analysis was conducted solely for the purpose of testing the variables in this study for multicollinearity. This analysis showed that the variables “respondent age” and “years of experience in the field” were multicollinear at .830 in the correlation matrix. “Years of experience in the field” was used in lieu of age of respondent for this study. No other variables registered above the .80 correlation matrix cutoff, and the items loaded on their appropriate scales well. The initial factor analysis for checking for multicollinearity was unable to yield a Kaiser-Meyer-Olkin measure due to the fact that the analysis was not positive definite, meaning that there were too many variables and too few cases to successfully produce a positive definite matrix. Gender was removed from this study as a potential variable to be tested because there were too few males (16.2%) as part of the study sample.

Most of the respondents to this study, one-hundred-twenty-two, 56% or respondents, reported high levels of compassion satisfaction, Stamm (2009) considers scores in the 42-50 range from the ProQOL v.5 Self-Test. The sample mean (\bar{x}) for compassion satisfaction was 41.56, median (*Md*) was 42, and Standard Deviation (SD) was 5.19. 44% of the respondents reported average – between 23-41 – compassion satisfaction, and no respondents reported low levels of compassion satisfaction, or any score less than 22. The range for compassion satisfaction scores was 23-50 for this study sample.

The most common burnout scores were considered low, or less than 22 according to the ProQOL v.5 Self-Test (Stamm, 2009), with a frequency of one-hundred-thirty-five

reporting, at 61.9% of the sample ($\bar{x} = 21.32$, $Md = 20$, $SD = 5.32$). 38.1% of the sample reported average burnout scores of between 23-41, and no respondents reported high burnout scores between 42-50. The burnout scores for the study's sample ranged from 11-39.

Compassion fatigue scores were low according to the ProQOL v.5 Self-Test (Stamm, 2009), less than 22, with a frequency of one-hundred-forty-three reporting at 65.6% of the sample ($\bar{x} = 21.15$, $Md = 21$, $SD = 5.79$). 33.9% of the study's sample reported between 23-41, for average compassion fatigue scores. Only one of the study's respondents (0.5%) reported high levels of compassion fatigue above 42. The compassion fatigue scores for this study ranged from 10-43. This sample's compassion satisfaction, burnout, and compassion fatigue scores are similar to mean scores from Craig and Sprang's study of predominantly master's level independent social workers (2010).

In respondent scores for perceived resilience, measured through Smith et al.'s Brief Resilience Scale (2013), a high perceived resilience score ranges from 26-30, average score from 18-25, and low score from 0-17. Fifty-three respondents qualified for the high perceived resilience category (27.5%, $\bar{x} = 23.31$, $Md = 24$, $SD = 4.08$), 64.2% ($n = 124$) reported average levels of perceived resilience, and 8.3% ($n=16$) of respondent scores for perceived resilience were considered low. The BRS scores ranged from 11-30 for this study's sample. This study's sample reported a slightly higher average score of perceived resilience than a sample of adult and pediatric intensive care staff (Colville et al., 2017).

The average social support from family and friends score, that excluded significant other component scores, from the Multidimensional Scale of Perceived Social

Support (Zimet, Dahlem, Zimet, & Farley, 1988) in the Dagan, Itzhaky, and Ben-Porat (2015) study of social workers from Israel is 49.44 ($\bar{x} = 49.44$). The reported number from the Dagan, Itzhaky, and Ben-Porat study was altered to reflect what the total score could be if it included the additional four items for significant other in the MSPSS. Additionally, an average score of only one of the three components of the MSPSS for the comparison study could be 16.48. Results from this current study's total social support scores indicate that most respondents reported higher average total social support with an average of 71.37 ($\bar{x} = 71.37$, $Md = 73$, $SD = 11.34$, $Range = 69$). 95.3% of this study's sample reported a higher total social support score – 49.44 – than the previously mentioned study of social workers in Israel. The scores ranged from 15-84, the highest possible score. When looking at the subcategories of the MSPSS – significant other, family, and friend support – the respondent scores can illustrate a more in-depth understanding of the support this study's sample are receiving. 92.7% of this study's respondents scored higher on support from significant other ($\bar{x} = 24.75$, $Md = 27$, $SD = 4.85$, $Range = 24$) than the comparison study, 16.48. The scores ranged from the lowest possible 4-28, the highest possible. 83% of this study's respondents reported higher levels of family support ($\bar{x} = 22.63$, $Md = 24$, $SD = 5.27$, $Range = 24$) than the comparison study. The scores ranged from the lowest possible 4-28, the highest possible. 94.3% of this study's respondents reported higher levels of friend social support ($\bar{x} = 24.03$, $Md = 24$, $SD = 4.13$, $Range = 22$) than the comparison study. The scores ranged from 6-28, the highest possible. This study's sample clearly reports much higher social support than the sample of social workers from Israel. Potentially, there could be a cultural difference in these two samples in how they perceive their social support systems.

Regarding respondent caseload, the median was 25 with a mean of 41.41 (SD = 66.977, R= 580), which was skewed because some respondents reported having more than one-hundred clients. The range of caseload for respondents was from 0-580. The average percentage of clients who have experienced psychological trauma was 74.95% (*Md* = 80, *SD* = 25.03, *Range* = 100).

The average age for this study's sample was 42.14 (*Md* = 38.5, *SD* = 13.88, *Range* = 61). The average years of experience in the field was 13.23 (*Md* = 10, *SD* = 10.97, *Range* = 47). The majority of this sample attained a master's level degree (n=167, 88.8%), while 6.9% (n = 13) completed their PhD or Doctorate, and 4.3% (n = 8) had a bachelor's degree. Asked if they have received, or are receiving, proper training to work with their current clients, one-hundred-nineteen "strongly agree" with that statement (62.6%), 34.2% "agree" (n = 65), 2.6% "disagree" (n = 5), and one respondent (0.5%) reported that they "strongly disagree."

This study's sample was a highly educated, properly trained, highly socially supported, predominantly female group. The median caseload was twenty-five clients who largely have experienced trauma. This study's sample generally has low levels of burnout, low-to-average compassion fatigue, and high-to-average compassion satisfaction. They also perceive themselves to be a mostly resilient group.

Hypothesis Testing

The purpose of this study was to investigate the relationship between MSW social workers and exposure to childhood psychological abuse – with its different components – and whether compassion fatigue and compassion satisfaction are found in these professionals who work with trauma populations. It was expected that respondent

childhood psychological abuse would increase the likelihood of both compassion fatigue (H¹) and compassion satisfaction (H²).

Hypotheses 1 and 2

A significant positive correlation was expected between respondent's level of childhood psychological abuse, measured through the MPAI, and compassion fatigue (H¹) and compassion satisfaction (H²). Pearson's r was .071 (p = .330) indicating no significant correlation between the summary score for the MPAI – Total Childhood Psychological Abuse, or any of the three components of the MPAI (Emotionally Abusive Threat and Humiliation, Domestic Violence Exposure, and Neglect) with compassion fatigue. (See Table 1.) Therefore, hypothesis 1 is not supported.

Pearson's correlations for the same childhood psychological abuse scales of Total Childhood Psychological Abuse, Emotionally Abusive Threat and Humiliation, Domestic Violence Exposure, and Neglect, were not found to be statistically significant with compassion satisfaction, therefore hypothesis 2 is also not supported.

Significant Correlations Between Additional Variables

In order to understand this study sample's experience, an exploration of correlations between the additional variables in this study were explored. The reason for the exploration was because some variable correlations may provide a clearer sense of the way in which this sample of social workers and allied professionals navigate their work of helping clients who have experienced trauma, and could help to provide important information to explaining results of testing the hypotheses of this study.

Components of the measures used in this study such as the MPAI (Emotionally Abusive Threat & Humiliation, Domestic Violence Exposure, and Neglect), the

Professional Quality of Life scale (Compassion Satisfaction, Compassion Fatigue, and Burnout), and the Multidimensional Scale of Perceived Social Support (Significant Other, Family, and Friends) were significantly intercorrelated with each measure's components, as expected, through an initial factor analysis of the measures. This shows that the psychometric scale subscales all helped to measure each scale's larger concept.

The Total Social Support (MSPSS) was negatively correlated with total childhood psychological abuse from the MPAI ($r = -.324, p < .01$). Negative correlations were also found between Total Social Support and the MPAI components of emotionally abusive threat and humiliation ($r = -.358, p < .01$), and domestic violence exposure ($r = -.213, p < .01$), but not with the MPAI component of neglect. Total Social Support was also correlated with the Professional Quality of Life scale's components of compassion satisfaction ($r = .165, p < .05$) and burnout ($r = .181, p < .05$). Total Social Support was also positively correlated with respondent's perceived resilience from the Brief Resilience Scale ($r = .203, p < .01$) and respondent's evidence-based training ($r = .199, p < .01$).

MSPSS's social support from a significant other was negatively correlated with emotionally abusive threat & humiliation ($r = -.157, p < .05$) and negatively correlated with burnout ($r = -.175, p < .05$). Significant other social support was positively correlated with compassion satisfaction ($r = .148, p < .05$), perceived resilience ($r = .166, p < .05$), and evidence-based training ($r = .199, p < .01$). Family social support was negatively correlated with total childhood psychological abuse ($r = -.554, p < .01$), emotionally abusive threat and humiliation ($r = -.564, p = .01$), domestic violence exposure ($r = -.417, p < .01$), and neglect ($r = -.283, p < .01$). Social support from friends had no significant

negative correlations with childhood psychological abuse. It did have a significant positive correlation with compassion satisfaction ($r = .182, p < .05$), perceived resilience ($r = .175, p < .05$), and evidence-based training ($r = .200, p < .05$).

Perceived resilience was negatively correlated with compassion fatigue ($r = -.314, p < .01$) and burnout ($r = -.402, p < .01$), and was positively correlated with compassion satisfaction ($r = .288, p < .01$) and years of experience ($r = .217, p < .01$). Evidence-based training was negatively correlated with compassion fatigue ($r = -.146, p < .05$) and burnout ($r = -.315, p < .01$) and positively correlated with compassion satisfaction ($r = .343, p < .01$), perceived resilience ($r = .192, p < .01$), and years of experience ($r = .250, p < .01$). Caseload number was not significantly correlated with any variable, nor was percentage of clients with trauma. Education was negatively correlated with the MPAI component of neglect ($r = -.184, p < .05$). Lastly, years of experience was negatively correlated with compassion fatigue ($r = -.176, p < .05$) and burnout ($r = -.204, p < .01$) and was positively correlated with education ($r = .179, p < .05$). See Table 1 below for the correlation matrix.

In summary, it was surprising to find no direct correlations between childhood psychological abuse and compassion fatigue or compassion satisfaction, because these findings contradict a study of predominantly BSW level social workers (Nelson-Gardell & Harris, 2004). The impact of childhood psychological abuse was seen in the correlations between childhood psychological abuse and family support. Evidence-based training had a strong protective relationship to compassion fatigue and burnout, and increased compassion satisfaction. Additionally, the power of perceived resilience seems

to be correlated with better social support scores in all categories, and improves the respondent's professional quality of life scores.

Table 1
Intercorrelations among Variables

Measures	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17
1. Total Childhood Psychological Abuse	-																
2. Emotionally Abusive Threat & Humiliation	.977**	-															
3. DV Exposure	.835**	.711**	-														
4. Neglect	.691**	.605**	.599**	-													
5. Compassion Satisfaction	.013	.011	.023	-.017	-												
6. Compassion Fatigue	.071	.048	.108	.122	-.402**	-											
7. Burnout	.042	.033	.064	.066	-.670**	.671**	-										
8. Total Social Support	-.324**	-.358**	-.213**	-.078	.165*	-.013	-	-									
9. Significant Other Social Support	-.122	-.157*	-.051	.053	.148*	-.053	-	.833**	-								
10. Family Social Support	-.554**	-.564**	-.417**	-	.075	.049	-.118	.792**	.461**	-							
11. Friends Social Support	-.045	-.084	.004	.085	.182*	-.036	-.138	.752**	.521**	.350**	-						
12. Perceived Resilience	-.092	-.110	.013	.020	.288**	-	-	.203**	.166*	.147*	.175*	-					
13. EBP Training	.023	.024	.062	-.079	.343**	-	-	.185*	.199**	.061	.200**	.192**	-				
14. Caseload #	-.101	-.112	-.017	-.072	.088	.107	.130	.040	.059	.008	.028	-.021	.043	-			
15. % Clients w Trauma	.048	.084	-.018	-.116	.030	.076	-.009	.001	.006	-.064	.084	-.039	.061	-.142	-		
16. Education	-.111	-.093	-.091	-.184*	.020	-.126	-.076	-.105	-.142	-.012	-.106	-.010	.057	.038	-	-	
17. Years of Experience	.028	.069	-.077	.006	.139	-	-	.003	-.083	.061	.028	.217**	.250**	.024	-	.179*	-
						.176*	.204**								.035	.014	

*Significant at the p<.05 level (two-tailed)

**Significant at the p<.01 level (two-tailed)

Hypothesis Testing Through Multiple Regression Analysis

Multiple regression analyses were conducted to test the next series of hypotheses for this study. Stepwise method was used to test the variables in models shown previously in this study to predict compassion fatigue and compassion satisfaction. The independent variables were childhood psychological abuse components of emotional abuse, threat, and humiliation, domestic violence exposure, and neglect while controlling for burnout, education, years of experience, caseload, percentage of clients with trauma, perceived resilience, social support from significant other, family, and friends, and evidence-based practice training to predict compassion fatigue (Figure 5). It was expected that emotionally abusive threat and humiliation, domestic violence exposure, and neglect from respondent scores of the Multifactor Psychological Abuse Inventory would be significant predictors of compassion fatigue (H^3).

As seen in table 2 below, compassion fatigue was not predicted significantly by emotionally abusive threat and humiliation, domestic violence exposure, or neglect in this model. Therefore, hypotheses 3 was not supported. The stepwise procedure produced three models that were statistically significant with burnout being the strongest predictor of compassion fatigue. From this analysis, it is clear that for this sample burnout is a strong predictor of compassion fatigue, and that family social support and domestic violence exposure were significant, but only slightly increased the model's ability to explain the variance. See table 2 below.

Table 2

Summary of Stepwise Multiple Regression Analysis for Variables Predicting Compassion Fatigue

Variable	Model 1			Model 2			Model 3		
	<i>B</i>	<i>SE B</i>	β	<i>B</i>	<i>SE B</i>	β	<i>B</i>	<i>SE B</i>	β
Burnout	.675	.067	.639**	.688	.066	.651**	.678	.065	.641**
Family SocSupp				1.478	.574	.161*	1.975	.610	.215**
DV Exposure							.071	.032	.146*
<i>Adjusted R²</i>		.404			.426			.440	
<i>F for change in R²</i>		101.182**			6.625*			4.808*	

* $p < .05$. ** $p < .01$.

To test the final hypothesis for this study, another regression model was tested to see if any variables were significant predictors of the dependent variable compassion satisfaction. Again, a stepwise method was used to test the independent variables from the childhood psychological abuse components of emotional abuse, threat, and humiliation, domestic violence exposure, and neglect while controlling for burnout, education, years of experience, caseload, percentage of clients with trauma, perceived resilience, social support from significant other, family, and friends, and evidence-based practice training to predict compassion satisfaction (Figure 6). It was also expected that higher scores in the subcategories of emotionally abusive threat and humiliation, domestic violence exposure, and neglect of the MPAI would yield higher compassion satisfaction scores (H⁴).

The MPAI components of emotionally abusive threat and humiliation, domestic violence exposure, or neglect were not found to be associated with compassion satisfaction in this model. Therefore, hypotheses 4 was not supported. The stepwise procedure yielded two significant models. Burnout and then the inclusion of caseload were significant predictors of compassion satisfaction when controlling for all variables in this model, and caseload predicted a small adjustment from the average compassion satisfaction score. From this second analysis, it is clear that, for this sample, burnout is a strong predictor of compassion satisfaction, and that caseload is a significant predictor of compassion satisfaction, but it only slightly increased the model's ability to explain the variance. See table 3 below.

Table 3

Summary of Stepwise Multiple Regression Analysis for Variables Predicting Compassion Satisfaction

Variable	Model 1			Model 2		
	<i>B</i>	<i>SE B</i>	β	<i>B</i>	<i>SE B</i>	β
Burnout	-.696	.059	-.698**	-.719	.058	-.722**
Caseload				.014	.004	.183**
<i>Adjusted R</i> ²		.484			.514	
<i>F</i> for change in <i>R</i> ²		139.954**			10.058**	

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

Chapter Six: Discussion

Childhood Psychological Abuse, Compassion Fatigue, Compassion Satisfaction, and Burnout

In this study, personal childhood psychological abuse has no significant correlation with compassion satisfaction, compassion fatigue, or burnout for this sample of MSW educated social workers and allied professionals. Additionally, in the regression models no aspects of childhood psychological abuse were significantly correlated with compassion satisfaction or compassion fatigue.

The regression models showed that the strongest single predictor was burnout for both compassion fatigue (adj $R^2 = .404$) and compassion satisfaction (adj $R^2 = .484$). Family social support and domestic violence exposure were also significant predictors in the final model of predicting compassion fatigue, but they only increased the model's ability to explain the variance by a little over three-percent (adj $R^2 = .440$). Caseload increased the strength of predicting compassion satisfaction by an added three-percent (adj $R^2 = .514$). The finding that burnout is a strong predictor of compassion fatigue and compassion satisfaction conceptually makes sense; an individual bogged down with work related stressors could conceptually be more predisposed to compassion fatigue and lessened compassion satisfaction.

But how can the null findings – a lack of significant relationship between childhood psychological abuse components and compassion fatigue and compassion satisfaction – be understood in light of this study and previous research?

According to Pearlman and Mac Ian, as therapists help clients through trauma work toward their healing process, they themselves are also contributing to their healing

(1995). This highlights the curative work that can occur when compassionately working with others through their own trauma. This concept aligns easily with the wounded healer trope. It could be that through working toward healing for others, that one can be fully healed from their own wounds. To this author's knowledge, there are no studies that attempt to measure the helping professional's personal healing by helping another through their own trauma narrative. Because the concept in question is so exploratory in nature, future research could start with qualitative interviews about the potentially curative interaction of helping another through trauma to better heal the professional's personal emotional wounds.

Although this could be an intriguing research study, professional ethical problems could easily arise because the helping professions do not encourage professionals to help others for the goal of healing themselves of their personal trauma, but rather, as seen in Ethical Standard 1.01 of the National Association of Social Worker's Code of Ethics, the Code of Ethics encourages professional social workers that their "...primary responsibility is to promote the well-being of clients. In general, clients' interests are primary" (NASW, 2009). Healing may occur as a secondary benefit of helping, but it should never be the goal of working with trauma, and subsequently vulnerable, populations. Additionally, as stated in the NASW Code of Ethics Ethical Standard 4.05, "Social workers should not allow their own personal problems, psychosocial distress, legal problems, substance abuse, or mental health difficulties to interfere with their professional judgement or performance or jeopardize the best interests of people for whom they have professional responsibility" (2009). This ethical standard illustrates the potential problem that can occur when the professional's personal healing is considered

first in working with a client. Future studies could follow cohorts of MSW students to gather baseline data on adverse childhood experiences, and follow them longitudinally throughout their professional careers to see any effect.

A variable that might explain the lack of significant relationship between childhood psychological abuse and compassion fatigue, for this sample, is whether or not the professional is personally receiving or has received their own therapy. A commonly stated phrase in the helping professions is: every good therapist has a good therapist. As stated throughout this study, working with trauma populations is difficult, and a primary example of quality self-care is seeking professional help through psychotherapy.

Working through the trauma stories of our clients through a professional's own therapy is theorized to be a beneficial way to protect against compassion fatigue (Figley, 2002).

This study did not measure the professional's history of treatment, and perhaps it should have. Countertransference can be potentially ethically problematic, but, as stated earlier in this study, properly checked countertransference, that may be achievable through a professional's own psychotherapy, can help the professional to better empathize, understand painful experiences, appreciate how difficult therapy can be, provide more patience and tolerance when client progress is slow, and show greater faith in the therapeutic process (Gelso & Hayes, 2007; Gilroy, Carroll, & Murray, 2001).

Might the lack of correlation between childhood psychological abuse and compassion fatigue be because of posttraumatic growth, a variable that also was not measured in this study? Posttraumatic growth is the concept that after serious personal trials, a person can become stronger through the processing of that event (Tedeschi & Calhoun, 2004). Theorized results of posttraumatic growth are: an increased appreciation

for life, more meaningful relationships, increased sense of personal strength, changed priorities, and a richer spiritual life (Tedeschi & Calhoun, 2004). Potentially, those who experienced childhood psychological abuse could have processed through their experiences and become stronger, more psychologically resilient people due to the introspection that can occur throughout a lifetime after a traumatic childhood experience. This study did not attempt to measure the respondent's personal psychotherapy history. The respondent's own personal psychotherapy – the frequency and/or time since working with a personal psychotherapist – could have influenced the results of this study.

In this study of MSW educated social workers and allied professionals, there was not a significant correlation between childhood psychological abuse and perceived resilience or compassion satisfaction. It would make logical sense that if posttraumatic growth was explaining the lack of relationship between childhood psychological abuse and compassion fatigue, then there would be a direct correlation between childhood psychological abuse and perceived resilience and compassion satisfaction. One of posttraumatic growth's outcomes can be an increased sense of personal strength (Tedeschi & Calhoun, 2004), which conceptually fits with a higher perception of how resilient one is. It also could potentially coincide with compassion satisfaction through finding work meaningful and seeing a purpose in the act of compassionately caring for another working through their trauma. Yet, this study did not find significant relationships between those variables.

Finding no correlation between childhood psychological abuse and professional quality of life components disagrees, but only in part, with the dissertation study of Moore, where therapists' trauma history and compassion fatigue had a statistically

significant positive correlation ($r = .36, p = .03$) for psychotherapists who provided therapy for survivors of the Oklahoma City bombing (2004). The Moore study found a significant correlation between prior trauma experience and compassion fatigue as measured through the Compassion Fatigue Self-Test (2004). Although there was a moderate correlation, the author expects that some respondents might have conceptualized many of their life difficulties as traumatic events, when the researcher was more interested in understanding the relationship between more traditional forms of physical trauma – those events that pose a real physical threat to self or witnessing a threatening event of others (Moore, 2004).

The Moore study did not attempt to measure anything related to emotional or psychological abuse like this current study attempted to understand. Therefore, there could be a difference in the experience of traditional trauma and the more specific psychological/emotional trauma and how the two forms of trauma impact a helping professional's ability to be compassionate toward their clients. Future research could attempt to parcel out the difference between traditional trauma and psychological/emotional trauma and its relationship to compassion fatigue and compassion satisfaction.

The Nelson-Gardell and Harris (2003) study is the most similar to this current study in attempting to measure the same phenomenon of past childhood abuse and compassion fatigue. By using the Childhood Trauma Questionnaire (CTQ; Bernstein & Fink, 1998) and the Compassion Fatigue Self-Test (Figley, 1995), this study found that, through bivariate analysis, all the subcategories of the CTQ (emotional abuse, physical abuse, sexual abuse, emotional neglect, and physical neglect) were significantly

correlated with compassion fatigue (Nelson-Gardell & Harris, 2003). Regression models for the potential predictors of compassion fatigue showed that the strongest significant predictors of compassion fatigue were emotional abuse ($r = .201$, $p = .000$) and then inclusion of sexual abuse with emotional abuse ($r = .275$, $p = .000$).

The sample used in the Nelson-Gardell and Harris study was predominantly child welfare workers ($n = 98$) and social work conference attendees ($n = 68$); the two were combined for all analyses (2003). Both samples from this study and the Nelson-Gardell and Harris study rely on social workers, but the Nelson-Gardell and Harris study relied heavily on the response of child welfare workers who were less likely to have a graduate degree than the combined portion of their sample collected from the conference (2003). Nelson-Gardell and Harris determined that the literature did not point to education or training as a protective factor to secondary trauma related experiences, so they combined the two samples (2003). But, since the Nelson-Gardell and Harris study (2003), Craig and Sprang's study, of independently licensed psychotherapists, of which 47.2% had a master's level education ($n = 240$) and 52% had a doctorate ($n = 264$), found that training and education were significantly negatively correlated to compassion fatigue scores for independent trauma therapists (2010). The Nelson-Gardell and Harris study's sample has 21.7% ($n = 36$) of social workers with a Master's degree, while this current study has 95.7% ($n = 180$) with a master's degree or PhD. This shows that the two samples are drastically different in education and training level, perhaps explaining a large part of why there was no correlation between childhood psychological abuse and compassion fatigue for this current study.

What about education or training could be helpful to the provider? Craig and Sprang (2015) propose that the experience of attending and participating in trainings with colleagues may increase personal accomplishment, a break from the routine of work, and increased peer support to help better protect against the threat of burnout. Therefore, in attending trainings, a professional could have more time to utilize peer social support, increase self-perception of ability to better serve clients, and bolster self-efficacy—all potential protective factors for professional quality of life components. Increasing educational training in the workplace could not only bolster protective factors toward the problems of the cost of caring, but could also improve client outcomes (Craig & Sprang, 2015).

The age and years of experience between this current study and the Nelson-Gardell and Harris sample were also slightly different. This current study's mean age was 42.14 ($Md= 38.50$, $Std. Dev= 13.881$) with an average years of experience in the field as 13.23 ($Md= 10$, $Std. Dev= 10.969$). The Nelson-Gardell and Harris study reported a mean age of 40.42 ($Std. Dev= 10.63$) and a mean number of years of experience at 10.70 ($Std. Dev= 9.19$) (2004). Median numbers were not reported by the Nelson-Gardell and Harris study. The univariate comparison shows that the Nelson-Gardell and Harris study was not only less educated, but was also younger on average, with less age variability than this current study, and it also had fewer years of experience than this current study. Age is understood to be a potential protective factor to professional quality of life components (Ghahramanlou & Brodbeck, 2000) along with years of experience in that they can bolster compassion satisfaction (Craig & Sprang, 2015).

The timing of when the two studies collected data is of note. The Nelson-Gardell and Harris study collected data from their two combined samples right after they both attended a training seminar on secondary traumatic stress. This current study did not involve a training component or distribute any educational material about the negative outcomes of working with trauma populations. There was no way for this current study to control what the respondents were thinking about prior to filling out the survey. Potentially, there could be some effect that occurs as the sample thinks about secondary traumatic stress as they fill out the psychometric scales, potentially influencing the scores of the respondents.

To continue with the comparison of this study's findings with the Nelson-Gardell and Harris study's sample, the experience of child welfare workers might be very different than the experience of an independently licensed social worker in that – due to the nature of child welfare cases, investigations, etc. – a child welfare worker might be more likely to see trauma than to solely hear about a client's trauma narrative. Perhaps a child welfare worker is more exposed to witnessing direct trauma, rather than secondary traumatic stress, or indirect exposure to trauma, because personally witnessing another's trauma is a requirement for posttraumatic stress disorder, and is not conceptualized as the same as secondary traumatic stress which can lead to compassion fatigue. Studies of child welfare workers have reported high rates of secondary traumatic stress (Conrad & Kellar-Guenther, 2006), and an extensive study found that the experience of the child welfare worker job can pose a significant threat to the physical and emotional well-being of the professional (Griffiths, Royse, Walker, 2018).

One study found that therapists who have limited time, or rather not enough time with their client to proceed through proper psychotherapy, are at an even greater risk for intrusive thoughts and psychological distress from working with their client trauma stories (Way, VanDeusen, Martin, Applegate, & Jandle, 2004). This suggests that perhaps child welfare workers, particularly those who do investigations and do not get to follow their clients through the psychotherapeutic process, but are instead tasked with the honorable and important job of securing safety for children, could be open to more risk of negative emotional and psychological outcomes to their client trauma narratives.

Child welfare workers interact with clients who have experienced recent traumas. Future research could explore if there is a difference in the way secondary traumatic stress impacts a helping professional in working with a clients' recent traumas or working with clients who are processing through traumas that happened further in the past.

The stepwise regression analyses proved that, for this sample, burnout is the strongest predictor of compassion fatigue and compassion satisfaction.

Childhood Psychological Abuse's Impact on Protective Factors to Compassion Fatigue and Burnout Found in This Study

Total childhood psychological abuse was significantly negatively correlated with total social support and family social support. The simple correlation statistics shows that there is a strong negative correlation with family support—possibly accounting for the significant negative relationship with total scores. It would make logical sense that the more that respondents report they were psychologically abused by their families in childhood, the greater the chance of lower reports of family social support.

The component of emotionally abusive threat and humiliation was significantly negatively correlated with total social support, significant other support, and family support. The majority of the correlation appears to come from family support ($r = -.564$, $p < .01$), as compared with significant other support ($r = -.157$, $p < .05$). Again, perhaps suggesting a logical connection with respondents likely reporting lower family support if they experienced emotional abuse and humiliation as children. Of interesting note, is the weak significant correlation between significant other support and this component. Emotionally abusive threat and humiliation was the only component of childhood psychological abuse that, though negative, was statistically significant with significant other support.

Domestic violence exposure was also significantly negatively correlated with total social support and family support. The stronger negative correlation comes from family support, which might again explain the strength of correlation for total social support scores. Those who reported higher viewings of domestic violence in their home were less likely to report higher family support.

The childhood psychological abuse component of neglect was only statistically negatively correlated with family support, and – unique from the other childhood psychological abuse components – was not significantly correlated with total social support. Those who reported higher neglect were more likely to report lower family support.

Other Social Support Findings

Social support and compassion satisfaction were positively correlated. Having a strong support system can increase the likelihood for compassion satisfaction, which agrees with findings from previous studies that investigate the relationship between these variables (Bride, 2004; Iliffe & Steed, 2000; Pearlman & Mac Ian, 1995; Pistorius, Feinauer, Harper, Stahmann & Miller, 2008). There was no correlation between social support and compassion fatigue, perhaps because social support can help protect against compassion fatigue, but through the protective factor of compassion satisfaction.

There was a negative correlation between total social support and burnout and significant other support and burnout. This shows that, for this sample, total social support, and perhaps more specifically, significant other social support can be a protective factor to the difficulty of work-related stress that can come from providing therapy for social workers and allied professionals.

An interesting finding in parceling out the different components of social support, was the relationship, or lack of, that family social support had with other variables in this study. Family social support did not have a significant relationship with compassion satisfaction or with evidence-based training, although significant other and friend social supports did. Apparently, a professional who needs better social support to cope with the stresses of the job can seek out friends and rely upon a significant other to maintain compassion satisfaction. Perhaps the difference in this component of social support lies in the fact that you can choose your significant other and your friends, but you cannot choose your family. One's family is not changed, or discarded for a new set of members, but is static. Families cannot be improved upon easily to provide more support; you

cannot choose a new family to better suit your supportive needs. Families either provide support or they do not. But you can choose your significant other, and you can choose your friends to receive proper social support during difficult times.

Potentially there could be a definitional problem in how the respondents understand who their social support is. For instance, significant other, friends, and family could be understood to include the same person, one's significant other. Additionally, access to family, friends, or significant other could be affected by geography, where the respondent might currently live a distance away from those who he or she wishes to draw support from.

Protective Factors

Higher perceived resilience was significantly negatively correlated with compassion fatigue and burnout in this study's sample. Higher perceived resilience was also significantly correlated with compassion satisfaction and all social support components. In this finding, it could mean that, for this sample, the higher respondents perceived their ability to bounce back after adversity, then the more likely they perceived their personal resource of caring compassionately and environmental resource of social support to be sufficient to fight against burnout and compassion fatigue. This aligns with the Conservation of Resources theory, in that people can navigate difficult times if they perceive that their resources for handling the hardship are adequate to help them through it (Hobfoll, 1989).

Respondents' evidence-based practice training scores were significantly negatively correlated with compassion fatigue and burnout, and significantly positively correlated with compassion satisfaction, all components of social supports excluding

family, and perceived resilience. Education level was also significantly negatively correlated with compassion fatigue and burnout, and significantly positively correlated with perceived resilience. These findings, related to evidence-based practice training and education level, might show that evidence-based training and education help professionals combat against negative costs of caring. Increasing training opportunities to better equip social workers and allied professionals might help to guard against the cost of caring for difficult trauma populations.

Further research should attempt to parcel out the influence that education and evidence-based trainings provide to therapists. For instance, do professionals – after evidence-based trainings – understand the importance of social support and choose their friends and significant others more appropriately? Do professionals utilize their social supports differently after evidence-based trainings? Future longitudinal studies could investigate the impact of training and education of helping professionals, and to measure the influence of education in a professional’s ability to properly navigate the difficult job of caring for trauma populations, self-care, and bolstering environmental and personal resources.

The regression model for predicting compassion satisfaction showed that burnout and caseload only were significant predictors. As burnout increased, compassion satisfaction decreased, and this is consistent with many studies. As caseload increased, compassion satisfaction slightly increased—perhaps more opportunity to work with those who are hurting provides more opportunity to be pleased with the work of caring.

Education and Years of Experience

Education was significantly negatively correlated with the childhood psychological abuse component of neglect. More investigation into the variables surrounding this finding is necessary to draw conclusions, and perhaps further research surrounding adverse childhood experiences could highlight any relationship between childhood neglect and education level.

Those with more years of experience in the field were more educated, better trained, and reported lower compassion fatigue and burnout, but did not significantly report higher compassion satisfaction. In contrast, the Nelson-Gardell and Harris study found no significant correlation between the number of years of experience and secondary traumatic stress among predominantly child welfare workers (2003), while this study of predominantly MSW social workers and allied professionals found that those with more years of experience were more likely to report lower compassion fatigue and burnout. This finding also disagrees with the Craig and Sprang (2015) study that reported no significant correlation between years of clinical experience and compassion fatigue, but did report a significant correlation with years of experience and compassion satisfaction. Even though the sample demographics between the two studies are relatively similar, seventy-three percent of the Craig and Sprang (2015) sample worked in a community mental health setting, while this current study did not inquire about the type of setting where the respondent worked. With such a high percentage of Craig and Sprang's sample coming from community mental health setting, the difference in work experience could be drastic compared to this current study's sample, with 70% of psychological care nationwide provided by such community mental health centers (U.S.

Department of Health and Human Services, 1999). Additionally, the Craig and Sprang (2015) study was able to collect a randomized sample that could better generalize to trauma treatment specialists. Although the findings from the two studies disagree, “maturity and professional experience may act as buffers against the deleterious effects of secondary trauma exposure” (Craig & Sprang, 2015, p. 335).

Additional Variables

For this study’s sample of MSW social workers and allied professionals, caseload was not significantly correlated with burnout. Perhaps this sample’s high evidence-based training, education, and social support equipped them to handle the work difficulties of a higher caseload. Conceptually, the more interaction with client trauma stories, then the higher chance of exposure to secondary trauma, which can lead to compassion fatigue (Figley, 1995). Yet, for this study, percentage of clients with trauma was not significantly correlated with compassion fatigue, or any other variable, which disagrees with some studies that show that amount of exposure to client trauma can be a risk factor to professional quality of life experiences (Brady, Guy, Poelstra, & Browkaw, 1999; Chrestman, 1999; Kassam-Adams, 1999; Schauben & Frazier, 1995), while there are other studies that have shown no connection to caseload and vicarious trauma (Brady, Guy, Poelstray, & Brokaw, 1999; Lee, 1996). Perhaps the difference in findings is because the majority of this study’s sample worked with high trauma populations, so there was too few of the sample that could help increase the likelihood of that variable producing a significant relationship, potentially not capturing the experience of potential respondents who had more moderate or lesser client trauma.

Implications

This sample of MSW social workers and allied professionals did not have a significant relationship between childhood psychological abuse and compassion fatigue, but a previous study with bachelor's degree child welfare workers did find a correlation between childhood psychological abuse and secondary traumatic stress. Might education level be a protective factor to the cost of caring for trauma populations? Is there something about education and training, or are there other factors that lead to those who are getting educated to be more resilient hears of trauma from their clients? If this is the case, social work programs could attempt to investigate what might be the professional quality of life outcomes from bachelor's level graduates and master's level graduates. Research into this relationship could potentially illuminate what master's level students are gaining that is unique from the bachelor's level experience. Since the Nelson-Gardell and Harris (2004) study collected their data after a training on the problems related to secondary traumatic stress, and this current study did not include educational materials, it would be appropriate for future research on this topic to compare groups that received the training to another group with similar demographics that did not.

An additional question that could be asked: is the experience of a bachelor's level social worker different than a master's level social worker? In many states in the U.S., bachelor's level social workers are not allowed to provide clinical therapy, but master's level social workers are. Is the engagement with client traumas, without providing therapy to help and process through such traumas, a variable that could influence the professional's ability to professionally process their client's trauma narrative? Future studies could attempt to investigate this difference in experience.

Evidence-based trainings are understood as protective factors to burnout (Craig & Sprang, 2015). Is it the acquisition of the skill from evidence-based trainings, or is it the opportunity to be professionally refreshed that can make a difference in a helping professional's professional quality of life? Future studies could attempt to measure the history, or time between evidence-based trainings to see if there is a unique variable that could explain this relationship among therapists. Additionally, studies could focus on the influence of confidence, or self-efficacy, for helping professionals and their ability to protect against compassion fatigue and burnout.

Future studies could attempt to measure more longitudinal data. A longitudinal study that investigates how certain factors change over time, dependent on the ebb and flow of other personal, environmental, and work-related factors, could yield some very intriguing findings into the relationships between professional quality of life variables, the professional's trauma history, and the cost of caring for trauma populations. Could the way agencies support or overlook opportunities to support their therapists be detrimental to the professionals who care the most, and therefore creating more obstacles for quality care for clients? Perhaps support could be conceptualized as more evidence-based training opportunities, more work loan programs for higher education, and increased opportunity for work-related social support; the research is not clear yet on the best route.

It is commonly conceptualized that the problem may be that "those who do their work well, who use empathy most effectively, are most vulnerable," and that personal backgrounds of the professional might lend some to be at greater risk for compassion fatigue, psychological harm, and potentially dropping out of the profession (Nelson-

Gardell & Harris, 2003, p. 23). But there is hope in the way in which helping professionals can process through the trauma that they are exposed to, and that maybe caring deeply is not a risk factor to compassion fatigue-related symptomology. An exploratory study by Badger, Royse, and Craig (2008) of MSW level hospital social workers found that emotional differentiation during work with patients and families helps protect against secondary traumatic stress, that managing work related stressors can minimize the impact of indirect trauma exposure, and that empathy was not significantly correlated to secondary traumatic stress. This suggests that it could be that practice and experience of managing personal emotions during work with trauma clients and the ability to manage work-related stress is critical to protect against the cost of caring.

Limitations

This study has several methodological limitations. Because the study was interested in professionals who provides therapy to their clients, the study sample relied heavily upon master's level or higher social workers and a few other allied professionals. Therefore, the findings from this study cannot be generalized to all United States psychotherapists.

The method for collecting the data was predominantly a convenience snowball method, which cannot insure that a representative sample of the United States social worker population with a master's degree or higher was collected. The sample was predominantly Caucasian and female, so therefore any findings from this study cannot be generalized to other races or ethnicities, or to other sexes. Additionally, this study relied heavily upon respondents from the Commonwealth of Kentucky, and therefore might not represent MSW therapists from other states because each state has their own unique laws

and structure for providing therapeutic care. The size of the sample was not large enough to provide a strong statistical power in the analyses used in this study. Some variables, such as respondent's current personal psychotherapy utilization, were not measured and could have influenced the relationship between the study findings. Lastly, this data was collected cross-sectionally, so any findings from this study cannot speak to causality, and is limited by the year in which it was collected in 2016.

Appendices

Professional Quality of Life Scale (ProQOL) Compassion Satisfaction and Compassion Fatigue (ProQOL) Version 5 (Stamm, 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. For each item, indicate whether you *Never* (1), *Rarely* (2), *Sometimes* (3), *Often* (4), or *Very Often* (5) experience the item for each question.

	Never	Rarely	Sometimes	Often	Very Often
1. I am happy	1	2	3	4	5
2. I am preoccupied with more than one person I help	1	2	3	4	5
3. I get satisfaction from being able to help people	1	2	3	4	5
4. I feel connected to others	1	2	3	4	5
5. I jump or am startled by unexpected sounds	1	2	3	4	5
6. I feel invigorated after working with those I help	1	2	3	4	5
7. I find it difficult to separate my personal life from my life as a helper	1	2	3	4	5
8. I am not as productive at work because I am losing sleep over traumatic experiences of a person I help	1	2	3	4	5
9. I think that I might have been affected by the traumatic stress of those I help	1	2	3	4	5
10. I feel trapped by my job as a helper	1	2	3	4	5
11. Because of my helping, I have felt "on edge" about various things	1	2	3	4	5
12. I like my work as a helper	1	2	3	4	5
13. I feel depressed because of the traumatic experiences of the people I help	1	2	3	4	5
14. I feel as though I am experiencing the trauma of someone I have helped	1	2	3	4	5
15. I have beliefs that sustain me	1	2	3	4	5
16. I am pleased with how I am able to keep up with helping techniques and protocols	1	2	3	4	5
17. I am the person I always wanted to be	1	2	3	4	5
18. My work makes me feel satisfied	1	2	3	4	5

19. I feel worn out because of my work as a helper	1	2	3	4	5
20. I have happy thoughts and feelings about those I help and how I could help them	1	2	3	4	5
21. I feel overwhelmed because my case work load seems endless	1	2	3	4	5
22. I believe I can make a difference to my work	1	2	3	4	5
23. I avoid certain activities or situations because they remind me of frightening experiences of the people I help	1	2	3	4	5
24. I am proud of what I can do to help	1	2	3	4	5
25. As a result of my helping, I have intrusive, frightening thoughts	1	2	3	4	5
26. I feel “bogged down” by the system	1	2	3	4	5
27. I have thoughts that I am a “success” as a helper	1	2	3	4	5
28. I can’t recall important parts of my work with trauma victims	1	2	3	4	5
29. I am a very caring person	1	2	3	4	5
30. I am happy that I chose to do this work	1	2	3	4	5

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Brief Resilience Scale (BRS)
(Smith et al, 2008)

Instructions: Use the following scale and choose one number for each statement to indicate how much you disagree or agree with each of the statements.

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

Multidimensional Scale of Perceived Social Support (Zimet, Dahlem, Zimet & Farley, 1988)

Instructions: We are interested in how you feel about the following statements. Read each statement carefully. Indicate how you feel about each statement.

Circle the "1" if you **Very Strongly Disagree**
 Circle the "2" if you **Strongly Disagree**
 Circle the "3" if you **Mildly Disagree**
 Circle the "4" if you are **Neutral**
 Circle the "5" if you **Mildly Agree**
 Circle the "6" if you **Strongly Agree**
 Circle the "7" if you **Very Strongly Agree**

1.	There is a special person who is around when I am in need.	1	2	3	4	5	6	7	SO
2.	There is a special person with whom I can share my joys and sorrows.	1	2	3	4	5	6	7	SO
3.	My family really tries to help me.	1	2	3	4	5	6	7	Fam
4.	I get the emotional help and support I need from my family.	1	2	3	4	5	6	7	Fam
5.	I have a special person who is a real source of comfort to me.	1	2	3	4	5	6	7	SO
6.	My friends really try to help me.	1	2	3	4	5	6	7	Fri
7.	I can count on my friends when things go wrong.	1	2	3	4	5	6	7	Fri
8.	I can talk about my problems with my family.	1	2	3	4	5	6	7	Fam
9.	I have friends with whom I can share my joys and sorrows.	1	2	3	4	5	6	7	Fri
10.	There is a special person in my life who cares about my feelings.	1	2	3	4	5	6	7	SO
11.	My family is willing to help me make decisions.	1	2	3	4	5	6	7	Fam
12.	I can talk about my problems with my friends.	1	2	3	4	5	6	7	Fri

The items tended to divide into factor groups relating to the source of the social support, namely family (Fam), friends (Fri) or significant other (SO).

MPAI

Gender: M F Transgender **Age in Years:** _____ **Total Annual Household Income:** _____
 (circle one)

Race: Caucasian African American Hispanic American Native American Asian American Biracial Other _____
 (circle one) Please specify

Sexual Preference: I prefer sex with the same gender I prefer sex with both genders I prefer sex with the opposite gender
 (Circle one)

The following are descriptions of situations that can happen to a person in childhood. Please read each item below and place the number 0 through 6 located in the boxes below that best describes the frequency for which each of those situations happened to you.

Never	Rarely	Occasionally	Sometimes	Often	Almost Always	Always
0	1	2	3	4	5	6
0% of the time	1-15% of the time	16-30% of the time	31-45% of the time	46-60% of the time	61-85% of the time	86-100% of the time

- 1) ____ My parent(s)/primary caregivers humiliated me as a way to punishment me.
- 2) ____ Threats to harm someone I loved were heard in my childhood home.
- 3) ____ My parent(s)/primary caregivers lied to me as a means to keep me confused about household rules and other expectations in the home.
- 4) ____ As a child, I felt my parent(s)/primary caregivers ignored my basic emotional needs.
- 5) ____ My parent(s)/primary caregivers got rid of things such as stuffed animals, toys, clothes, souvenirs that I valued as a means to punish or hurt me.
- 6) ____ My parent(s)/primary caregivers said things like, I wish you were never born.
- 7) ____ My home was an emotionally chaotic place to live.
- 8) ____ My parent(s)/primary caregivers encouraged me to break the law.
- 9) ____ My parent(s)/primary caregivers called me hurtful names.
- 10) ____ My parent(s)/primary caregivers would isolate me from the rest of the family as a child.
- 11) ____ My parent(s)/caregivers acted as if they did not care what happened to me.
- 12) ____ I had to take care of a parent's/caregiver's emotional needs when I was a child.
- 13) ____ My parent(s)/primary caregivers did things that would cause me to lose my friends.
- 14) ____ I witnessed my parents/primary caregivers arguing and screaming at each other.
- 15) ____ When I became ill as a child, I was ignored.

- 16) ____ My parent(s)/primary caregiver's expectations of me were unrealistic.
- 17) ____ My parent(s)/primary caregivers would threaten to harm someone I loved if I did not obey their wishes.
- 18) ____ My parent(s)/primary caregivers used to physically beat me and then threaten to hurt other family members or friends if I told anyone.
- 19) ____ I often felt embarrassed or degraded after my parent(s)/primary caregivers punished me.
- 20) ____ My parent(s)/primary caregivers purposely hurt my childhood pet in front of me as a punishment.
- 21) ____ My parent(s)/primary caregivers liked to change the rules to trick me and I would get in trouble as a result.
- 22) ____ I was able to get adequate sleep in my home at night as a child.
- 23) ____ If my parent(s)/primary caregivers found out that I liked a toy they would take it away or destroy it.
- 24) ____ My parent(s)/primary caregivers threatened to kick me out of the house when I was a child.
- 25) ____ My home environment was a warm, safe, and loving place to live as a child.
- 26) ____ I was forced to say hurtful things to others by a parent or caregiver.
- 27) ____ One of my parents/primary caregivers used me as an excuse so that he/she could get out of the house to engage in negative behaviors such as drug use, alcohol use, marital affairs.
- 28) ____ My parent(s)/primary caregivers cursed at me.
- 29) ____ I spent most of my childhood alone as a way to cope with my family issues.
- 30) ____ I felt emotionally close to my parent(s)/caregivers.
- 31) ____ My parent(s)/caregivers made sure I had adequate health care.
- 32) ____ I was forced by my parent(s)/primary caregivers to be an adult at too early an age.
- 33) ____ I often felt like an intruder in my family.
- 34) ____ As a child, my parent(s)/primary caregivers taught me the skills I needed to make friends and get along with others.
- 35) ____ I witnessed my parents/primary caregivers physically hurting each other.
- 36) ____ I was purposely burned by a parent/primary caregiver and he or she threatened further harm if I told anyone.
- 37) ____ My parents/primary caregivers would punish me in a way that publicly humiliated me.
- 38) ____ I felt intense fear in my childhood home due to things my parent(s)/primary caregivers would say or do.
- 39) ____ Growing up, just when I thought I knew the rules in my home, they would change.
- 40) ____ I was deprived of food for long periods of time as a punishment for minor misbehaviors.

- 41) _____ My parent(s)/ primary caregivers would threaten things or people that I loved as a way of getting me to listen or obey.
- 42) _____ As a child, I was locked out of my home for long periods of time.
- 43) _____ I was used as a bargaining object in my parent's/ primary caregiver's arguments or during their divorce.
- 44) _____ I had secrets to carry as a child due to being threatened by a caregiver/parent.
- 45) _____ My parent(s)/primary caregivers use to say things like, you are good for nothing!
- 46) _____ My parent(s)/primary caregivers would leave me with distant relatives or friends without me knowing of their expected return.
- 47) _____ My parent(s)/primary caregivers missed scheduled visits with me which caused disappointment and emotional upset.
- 48) _____ When I became ill as a child, I felt loved less.
- 49) _____ I felt criticized or blamed for problems within our family.
- 50) _____ My parent(s)/ primary caregivers did show interest in what I was doing as a child.
- 51) _____ My parent(s)/ primary caregivers attended events like school activities and sporting functions that were important to me.
- 52) _____ I use to listen in fear to my parents/primary caregivers arguing and screaming.
- 53) _____ A parent/primary caregiver or other family member threatened to hurt me if I told anyone about how they had touched me in a sexually inappropriate manner.
- 54) _____ My parent(s)/ primary caregivers made me do things as a form of punishment that made me feel much younger than I was at the time of punishment such as wear baby clothes, forcibly pin a diaper on, or force a pacifier in your mouth).
- 55) _____ A parent/primary caregiver grabbed me by the throat or other part of the body in a threatening manner but stopped short of physically hurting me.
- 56) _____ I wished that there would have been more consistent expectations during my childhood.
- 57) _____ When I expressed emotional affection to my parent(s)/primary caregivers they would ignore me.
- 58) _____ There was constant yelling and arguing in my home.
- 59) _____ My parent(s) got rid of a childhood pets as a means to punish or hurt me.
- 60) _____ My parent(s)/primary caregivers faked being ill as means to get benefits and made me participate.
- 61) _____ Other relatives other than my parent(s) /primary caregivers often criticized me, called me names, and belittled me (e.g., brother, sister, cousins, aunts, uncles).
- 62) _____ I was locked away in closets, cabinets, attics as means of punishment by my parent(s)/primary caregivers.

- 63) ____ My parent(s)/primary caregivers often forgot my birthdays and other important events in my life.
- 64) ____ My parent(s)/primary caregivers did not care about whether I did well in school.
- 65) ____ Expectations of children in my home were always fair and consistent.
- 66) ____ My parent(s)/primary caregivers supervised me as a child.
- 67) ____ As a child, my parent(s)/primary caregivers taught me the skills I needed to make friends and get along with others.
- 68) ____ I was physically injured as a result of trying to prevent one parent/caregiver from hurting the other during one of their fights.
- 69) ____ I was threatened with a weapon by my parent(s)/primary caregivers by them demonstrating on a valued object such as a stuffed animal or pet what would happen to me if I did not obey.
- 70) ____ I use to lay awake at night hearing my parents/caregivers hitting each other.
- 71) ____ I use to lay awake at night hearing my parents breaking things while they were yelling and screaming.
- 72) ____ I witnessed my parents/primary caregivers sexually hurting each other.
- 73) ____ My parent(s)/primary caregivers left me with total strangers for periods of time such as days, weeks, or months without me knowing when they would return.
- 74) ____ As a young child, my parents use to do things like pull my pants down and spank my bare bottom.
- 75) ____ I felt like a burden to my entire family throughout my childhood.

1) Do you have anything else to report that is similar to the items above but was not asked?

2) If you feel that you were emotionally abused, do you feel the majority of the abuse was done by a brother or sister including step brother and sisters instead of a primary caregiver? **Yes No**
(feel free to describe your experience)

3) Were you ever bullied or emotionally, physically, or sexually abused because of your sexual preference/orientation? **Yes No** (feel free to describe what happen below)

Demographics Questionnaire

1. What is your current age?
 - a. 18-24
 - b. 25-34
 - c. 35-44
 - d. 45-54
 - e. 55-64
 - f. 65-74
 - g. 75 or older
2. What is your gender?
 - a. Male
 - b. Female
 - c. Transgender
3. What is your race/ethnicity? (Please select all that apply)
 - a. American Indian or Alaskan Native
 - b. Asian or Pacific Islander
 - c. Black or African American
 - d. Hispanic or Latino
 - e. White / Caucasian
 - f. Other (please specify): _____
 - g. Biracial (please specify): _____
4. Sexual preference:
 - a. I prefer sex with the same gender
 - b. I prefer sex with both genders
 - c. I prefer sex with the opposite gender
5. In which country do you currently reside?

- a. United States
 - b. Other (please specify): _____
6. If you reside in the U.S., in what state or U.S. territory do you live?
- a. _____
7. If you reside in the U.S., in what county do you live?
- a. _____
8. Estimated total annual household income: _____
9. How many times in your life would you estimate that you've moved geographical regions?
- a. _____ times
10. To which professional field do you belong?
- a. Social Work
 - b. Psychology
 - c. Counseling
 - d. Psychiatry
 - e. Other (please specify): _____
11. What is the highest level of education you have completed?
- a. Graduated from High School
 - b. Associates Degree
 - c. Bachelor's Degree
 - d. Master's Degree
 - e. PhD or Doctorate
12. My work title is equivalent to:
- a. Case Manager
 - b. Therapist

- c. Administrator
- d. Psychiatrist
- e. Other (please specify): _____

13. How many years have you currently worked in this field? _____ years

14. How many years have you been employed by your current employer? _____
years

15. My work setting provides me with experience in (check all that apply):

- a. Mental Health
- b. Medical
- c. Hospice
- d. Government
- e. Children
- f. Elderly
- g. Criminal Justice
- h. Employee Assistance
- i. HIV/AIDS
- j. Fund Raising
- k. Adolescents
- l. Adults
- m. Disabilities
- n. Schools
- o. Residential Treatment
- p. Substance Abuse

- q. Lobbying/Advocacy/Organizing
- r. Physical disabilities/emotional disabilities
- s. Other

16. Do you work primarily for an agency/organization or independently?

- a. Agency/Organization
- b. Independent

17. I work with (check all that apply):

- a. Individuals
- b. Couples
- c. Families
- d. Groups
- e. Organizations
- f. Community Groups

18. Is your work considered a mobile unit?

- a. Yes
- b. No

19. I meet with my clients in:

- a. My office
- b. Their home/residence
- c. Both my office and their home/residence

20. How many co-workers would you estimate that you have social interactions with in a given day? (Number of different co-workers, not total number of conversations) _____

21. How many co-workers would you say you're close friends with? _____
22. On average, how many quality social interactions in a week would you say you have with family and friends?
- a. _____ interactions
23. I feel connected to family or friends that help me deal with my stressful work
- a. Never
- b. Rarely
- c. Occasionally
- d. Sometimes
- e. Often
- f. Almost Always
- g. Always
24. There is open professional communication in my agency
- a. Strongly Agree
- b. Agree
- c. Neither Agree nor Disagree
- d. Disagree
- e. Strongly Disagree
- f. I primarily work independently
25. My opinions matter to my agency/organization
- a. Strongly Agree
- b. Agree
- c. Disagree

- d. Strongly Disagree
- e. I work independently

26. My current case-load number is (just provide number of clients you're primarily responsible for)_____

27. What percentage of your clients would you estimate to have experience psychological trauma? _____%

28. I have received, and am receiving, proper training to work with the clients I currently work with:

- a. Strongly Agree
- b. Agree
- c. Disagree
- d. Strongly Disagree

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Professor of Social Work, Full-Time Assistant Professor 2016-2019

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Director of BSW Field Education, Part-Time Assistant Professor 2014-2016

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Therapist/Owner 2016-2017

University of Kentucky

RA, Integrative Behavioral Health Grant – University of Kentucky 2015-2016

RA, Geographical Management of Cancer Health Disparities Program – University of Kentucky 2016

TA, College of Social Work – University of Kentucky 2014-2015

Child and Family Therapist (Part-time) 2013-2014

David P. Cecil, PhD, LCSW- Individual and Family Counseling

Intensive Child, Adolescent, and Family Therapist 2011- 2013

Intensive Treatment Team South (Bluegrass.org) formerly known as Pathfinders

Afterschool Children's Program,

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Awards & Professional Organization Memberships:

Council on Social Work Education (CSWE)
National Association of Christians in Social Work (NACSW)
Excellence in Student Investment Finalist - 2017-2018 AY Asbury University
The faculty honorary member of Asbury University's 2018 graduating class
Submitted to the Dumas Scholarship – University of Kentucky CoSW
Awarded presentation grant funding – University of Kentucky 2014

Presentations and Trainings:

Clifton, L., Wells, M., & **Reynolds, A.** (2016). Comparison of 2008 & 2015 EPAS for Field Evaluation. *Annual Program Meeting: Advancing Collaborative Practice Through Social Work Education.*

Reynolds, A. (2015). A graduate student's guide to data collection and research: How to get your foot in the door. *NACSW Annual Conference: Pursuing Shalom.*

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