Secondary traumatic stress in professional caregivers

Thomas Patrick Cashin

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SECONDARY TRAUMATIC STRESS IN
PROFESSIONAL CAREGIVERS

A Project
Presented to the
Faculty Of
California State University,
San Bernardino

In Partial Fulfillment
of the Requirements for the Degree
Master of Social Work

by
Thomas Patrick Cashin
June 1997
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Abstract

Professional caregivers work in an environment which can put them at a significant risk for workplace stress reactions. A new entry into the arena of workplace stress is found in the construct of Secondary Traumatic Stress (STS). This project endeavored to quantify the degree of risk of STS, also known as compassion fatigue, among a sample of professional caregivers in a psychiatric and chemical dependency hospital in Southern California. A survey research design was used with a positivist orientation. Data analysis included the use of univariate, and bivariate methods. A nonparametric test, chi-square, was used as a test of statistical significance. It is hoped that the project might inspire additional research in the area of Secondary Traumatic Stress and lead to assumptions about causes, treatment and prevention of STS.

Further, it is desired that the research might play a part in the evaluation of social work practice by revealing insight into questions such as: Are social workers at particular risk for STS? What is associated with STS in social workers working with trauma victims? And, what should be done about STS in social workers?
# Table of Contents

Abstract ........................................ iii

List of Illustrations ........................... v

Introduction ..................................... 1
    Nature and Scope ........................... 2
    Theoretical Perspective .................... 4
    Problem Focus .............................. 9

Review of the Literature ....................... 10

Research Design and Methods ................. 14

Results ........................................ 18
    Risk of Compassion Fatigue ............... 19
    Risk of Burnout ............................ 19

Discussion .................................... 22

Appendix A: The Compassion Fatigue Self Test 26

Appendix B: Informed Consent .................. 30

Appendix C: Debriefing Statement ............. 31

References .................................... 32
List of Illustrations

Ecomap for Caregiver . . . . . . . . . . . . . . 6
Introduction

Over the past decade considerable attention has been given to the study of psychological trauma in relation to mental disorders. Publication of the American Psychiatric Association's third edition of the Diagnostic and Statistical Manual of Mental Disorders (APA, 1980) broke new ground with the inclusion of the diagnosis of post-traumatic stress disorder. The emphasis in the PTSD literature, however, has been on those who experience traumatic events directly. Until recently, little significance has been given to those who experience trauma indirectly. This study will focus on one segment of that population, healthcare practitioners, or the professional caregivers who place themselves "in harms way."

More specifically, the paper aspires to investigate the phenomena of Secondary Traumatic Stress (STS) among practitioners who treat patients or clients who have experienced trauma. Additionally, the construct of job burnout was addressed as compared with STS as it relates to workplace stress in the helping professions. STS and job burnout share commonalties in symptomatology, however, Figley (1995) indicates burnout emerges gradually as a result of emotional exhaustion, whereas, STS usually emanates with a rapid onset of symptoms and
brings with it a sense of confusion, helplessness and isolation.

Nature and Scope

The construct of STS evolved from the DSM-III (APA, 1980) inclusion of post-traumatic stress disorder as a psychiatric disorder. Other terms for the disorder include vicarious traumatization (McCann & Pearlman, 1990), and contact victimization (Courtois, 1988). Figley (1995) prefers the term compassion fatigue. He defines STS as "the natural behaviors and emotions that arise from knowing about a traumatizing event experienced by a significant other." It is the stress "resulting from helping or wanting to help a traumatized person" (Figley, 1995).

There are four psychodynamic constructs which help to explain why STS can occur. The first one is transference which is defined as a concept that refers to emotional reactions that are assigned to current relations but originated in earlier, often unresolved and unconscious experiences (Barker, 1991). Pines (1986) found that counselors working with traumatized patients and clients frequently experience feelings of loathing and aversion while at the same time deal with thoughts about being oppressors and abusers themselves.
The second psychodynamic concept which can help to understand the etiology of STS is countertransference. It is defined as a set of conscious or unconscious emotional reactions to a client experienced by the social worker or other professional, usually in a clinical setting (Barker, 1991). Newberry (1985) noted how therapists can overvalue or undervalue trauma reported by veterans of the Vietnam conflict because of the unpopularly and rejection of the war and its warriors.

The third psychodynamic construct which can help in understanding how STS comes about is projective identification. It is defined as a process whereby an individual uses projection unto another member of his or her family, group, or organization and then induces that person or the others to behave in accordance with the projected attitudes (Barker, 1991). Catherall (1991) found both client and therapist are adversely effected by projective identification.

The final psychodynamic construct which helps in understanding the emergence of STS is identification. Identification differs from empathy, where the therapist feels with the client without losing distance. A caregiver, when working with traumatized people, can identify with their rage and feelings of revenge, and
thereby increase their feelings as opposed to helping them work through them (Figley, 1995).

Although research on STS is increasing, the construct is still in its infancy stage, so specific morbidity statistics are not readily available, notwithstanding, assumptions can be considered from the prevalence of Posttraumatic Stress Disorder. Lifetime prevalence for PTSD is put from 1% to 14%, however, studies of at-risk individuals such as combat veterans and victims of criminal violence range from 3% to 58%. This researcher believes a strong argument can be made that caregivers are at-risk of STS because of their considerable exposure to trauma victims.

**Theoretical Perspective**

Generally, "Systems Theory" provides a framework which helps to explain STS. General Systems Theory attempts to explain holistically the behavior of people by identifying interacting components of the system and the controls that keep these components stable and in a state of equilibrium. Specifically, the Ecological Perspective explains how STS can take place. Germain (1991) states that the ecological theory promotes a holistic assessment of people and environments as a system whereby neither one can be wholly realized
without consideration of the relationship of the other. The following ecological concepts are useful in explaining STS:

1. Adaptation: A reciprocal process between the individual and the environment in an effort to reach "goodness of fit."

2. Goodness of fit: The level of interface between an individual's needs, abilities and goals and their environment.

3. Transactions: Reciprocal exchanges impacting on relationships.

4. Reciprocal interactions: Mutual responsiveness.

5. Mutuality: Interdependence between subsystems.


(Barker, 1991)

An "ecomap" (Fig. 1, next page) is a diagram depicting reciprocal relationships. When applied to STS it represents the division of reciprocal influences between the professional caregiver and his or her clients. Through flow of energy, and tenuous and stressful relationships, the ecomap suggests reciprocal interactions result in "stressors" which have distributed the existing goodness of fit between caregiver and client. This, in turn, results in the emergence of Secondary Traumatic Stress and Secondary Traumatic Stress Disorder.
Name: Caregiver - IP
Date: 06-01-97

Figure 1
Ecomap for Caregiver
Germain and Gitterman (1995) suggest that "stress" is an internal response to a life stressor and that it results in emotional or physiological turbulence. The authors relate negative feelings such as anxiety, depression, fear, despair and helplessness as possible consequences of stress. It should be noticeable to the reader that the negative feelings related by Germain and Gitterman fall well within the realm of Posttraumatic Stress and Secondary Traumatic Stress disorders.

The ecological viewpoint, then, offers a useful theoretical perspective to explain STS. It suggests that reciprocal transactions, along with social institutions, and environment can result in life stressors which, in turn, disturb a goodness of fit, i.e., therapeutic relationship between caregivers and clients.

Figley (1995) proposed a rearrangement of PTSD as elucidated in the Diagnostic and Statistical Manuals of Mental Disorders III-R & IV (APA, 1987 & 1994.) He advanced the idea that these manuals suggest a relationship exists between Posttraumatic Stress and Posttraumatic Stress Disorder and Secondary Stress and Secondary Stress Disorder. Figley refers to the following as evidence of such a relationship.

1. Posttraumatic Stress Disorder
The essential feature of posttraumatic stress disorder is the development of characteristic symptoms following exposure to an extreme traumatic stressor involving direct personal experience of an event that involves
threatened death, actual or threatened serious injury, or other threats to one's physical integrity; or witnessing an event that involves death, injury, or a threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associates (Criterion A1). Italics added; [p. 424]

Figley points to the italicized phrases as evidence that people can be subject to secondary traumatization. Or, in other words, they can be traumatized by hearing about another person's trauma. The implications of the relationship described by Figley is what has inspired the proposed study.

The research, then, is necessitated by a need to help gain a baseline on the degree of STS and burnout among practitioners who treat clients who have experienced trauma. By establishing a baseline for STS and burnout, assumptions can then be made about such entities as treatment modalities and realistic expectations, goals and objectives for those who suffer from this unique kind of stress reaction. The proposed study also will address gender, age, ethnicity, and educational level. Assessment of these variables may help in establishing specific relationships which could lead to individual programs of intervention and prevention.

When considering the overall significance of the proposed study for social work practice both macro and micro issues should be considered. At a macro level, the
problem addresses practitioner vulnerability to STS and burnout when working with the full range of human service personnel who work with victims of trauma. At a micro level, the problem addresses specific pathologies in particular environments where human service providers are employed. Assessing the magnitude of STS and burnout among professional caregivers may result in new insight which, in turn, could lead to policy changes and programs which address the needs of practitioners working in complex milieus.

Problem Focus

A quantitative positivist approach was used in this research study. Specifically, a survey research design was used to attempt to quantitatively describe specific characteristics of a sample of health care practitioners in a hospital setting.

The survey design used in the study attempted to measure the risk of STS and the risk of a related construct, that of burnout. Burnout is included in the measuring instrument as a means of distinguishing between the two constructs. The positivist approach was best suited to address this task because of its quantitative descriptive capabilities. Causality and evaluation are also better approached through positivism because of its ability to produce numbers to which univariate, bivariate
and multivariate analysis may be applied.

The major social work role being evaluated in this research proposal was direct practice, however, results of the study have implications for administration and policy planning. Continuing education, screening of applicants for work with trauma victims, debriefing and rotation of work assignments might all be considered for reevaluation by administrators as a consequence of STS studies. Further, research findings on STS might ultimately influence policy. By producing data which affects response to natural disasters by agencies such as FEMA and Red Cross execution of national policy might be influenced. Of primary concern in this study, however, are issues of direct clinical practice, specifically, the implications for clinicians who treat trauma one of which may be STS, which in turn, might impact on clinical effectiveness.

Review of the Literature

A review of the literature on workplace stress relative to this study included a look at research on vicarious traumatization, secondary traumatic stress, countertransference and burnout. Early studies in the area of client-clinician trauma transfer centered around warzone veterans. Haley (1974) recorded clinician
responses to trauma survivors which included fear, psychic numbing, and thoughts of retaliation; Margolin (1984) and Blank (1985) documented spiritual and existential therapist responses; Figley (1983) described the impact trauma can have on members of a victim's family; and Scurfield (1985) noted feelings of aggression and judgment, along with rage, grief and vulnerability in caregivers who treat clients who have been traumatized.

An important addition to the literature to Secondary Traumatic Stress was published by McCann and Pearlman in 1990. *Vicarious Traumatization: A Framework for Understanding the Psychological Effects of Working with Victims* detailed experiences of reputable practitioners. The article strengthened the notion that professional caregivers who work with traumatized clients are at risk for secondary stress reactions.

Others have noted the development of PTSD symptoms in caregivers (Herman & Jackson, 1994; Lindy & Wilson, 1994). And still others have contributed to the literature indicating that professional caregivers are especially at risk of STS (Follette, Polusny, & Milbeck, 1994; Gamble, Pearlman, Lucca, & Allen, 1994; Schauben & Frazier, 1995).

Two important works reinforcing the idea of risk of vicarious traumatization in the client-caregiver
relationship were published in 1995. In *Trauma and the Therapist* Pearlman and Saakvitne examine countertransference and vicarious traumatization among caregivers who work with adult survivors of incest and childhood sexual abuse. Figley's contribution *Compassion Fatigue* is a collection of papers on Secondary Traumatic Stress which provide additional testimony that exposure to a client's trauma puts a caregiver at risk for STS. In *Compassion Fatigue* Figley also distinguishes between STS and burnout. Figley postulates burnout emanates progressively as a consequence of emotional exhaustion while STS arises unexpectedly with little notice. Figley adds, unlike burnout STS brings with it a sense of confusion and isolation. Figley's survey instrument, used in this research study, seeks to differentiate between burnout and STS.

Kassam-Adams (1995) reported similar findings in support of the impact of trauma work on practitioners. The primary finding of her study was that "therapists" level of PTSD symptoms was correlated with the level of exposure to sexually traumatized clients." The Impact of Event Scale (IES) used in her study indicated that counselors with a higher number of sexually traumatized
clients in their caseload tended to report higher levels of PTSD symptoms in themselves.

In the Kassam-Adams sample, women reported a greater history of personal trauma and also a larger clientele reporting sexual trauma. It should be noted, however, Kassam-Adams states that women are not necessarily at higher risk of STS. In further support of this hypothesis, Munroe (1990) conducted a study of men therapists at the Department of Veterans Affairs which suggested that exposure is the key variable. Munroe's findings were analogous to those of Kassam-Adams, specifically, the male subjects who had more exposure to combat Post-Traumatic Stress Disorder clients reported more STS symptoms.

Although it can be argued that the literature remains sparse on the construct of STS, it can also be asserted that the recent works by Figley, Kassam-Adams, and Pearlman and Saakvitne continue to build empirical evidence that caregivers who work with traumatized clients are at risk for Secondary Traumatic Stress.

The construct of countertransference offers another theory which could account for the transfer of PTSD symptoms from client to counselor. Countertransference emanates from psychodynamic theory and postulates conscious or unconscious reactions to clients originating in the caregiver own developmental conflicts. Johnson
(1993), however, takes the notion of countertransference a bit further by suggesting it is all of the emotional reactions of a caregivers toward the client without respect to the origin. This sentiment, then, would include the traumatic episodes in a clients life which could be assimilated by the caregiver.

Few empirical studies could be found on countertransference in the treatment of trauma. One study, Daniel (1982) looked at clinician responses to Nazi Holocaust survivors and their children. Daniel identified responses such as guilt, rage, denial, avoidance and numbing. These responses match DSM-IV criteria for Post-traumatic Stress Disorder. The study, then, makes an early statement for the notion of Secondary Traumatic Stress. In another work, Gold and Nemiah (1993) pointed out how clients as opposed to the personal experiences of practitioners are troublesome and painful for therapists to deal with. This finding implies that trauma, indeed, can be transmitted from client to caregiver.

Research Design and Methods

The research question was stated as:

Are some individuals who work with clients who have experienced trauma at higher risk for workplace stress?
The following hypotheses were tested:

Hyp.#1: Women caregivers are at higher risk for STS.

Hyp.#2: Ethnic minority caregivers are at higher risk for STS.

Hyp.#3: The higher the education level the lower the risk of STS.

Hyp.#4: The more direct contact with clients the higher the risk will exist for STS.

The Compassion Fatigue Self-Test for Practitioners (See Appendix A) designed by Charles Figley (1993) was used as the instrument to collect the data. This instrument was designed to help therapists distinguish between job burnout and secondary traumatic stress. Burnout is a workplace stress construct which shares commonalties with STS. Pines and Aronson (1988, 1989) indicate job burnout is "a state of physical, emotional, and mental exhaustion caused by long term involvement in emotionally demanding situations."

The Compassion Fatigue Self Test used in this study is comprised of forty questions which request a respondents degree of agreement or disagreement on a five-point Likert scale. Scores suggest the degree of risk for Compassion Fatigue (STS) and burnout. Figley (1993) states the following about his test instrument:
Scores for the instrument emerged using a sample of 142 psychotherapy practitioners attending workshops on the topic during 1992 and 1993. Psychometric properties of the scale are reported by Stamm and Vara (1993). Alpha reliability scores ranged from 94 to 86; structural analysis yielded at least one stable factor which is characterized by depressed mood in relationship to work accompanied by feelings of fatigue, disillusionment, and worthlessness. Structural Reliability (stability) of this factor, as indicated by Tucker’s Coefficient of Congruence (cc), is .91.

The Compassion Fatigue Self-Test was distributed among professional caregivers at a psychiatric and chemical dependency hospital in Southern California. An intent of this research was to extend the study beyond therapists to the larger arena of professional caregivers working in a mental health setting. Fifty-five surveys were handed out to a staff which included nurses, psych techs, social workers, psychologists, physicians, psychiatrists, marriage and family trained counselors, substance abuse counselors, and uncredentialed intake and front-line health care workers and support staff. The surveys were collected over a 30 day period.
Strengths of using the self-administered questionnaire included more anonymity, a lack of interview bias, speed and economy. An attempt at offsetting a potential weakness of using the self-administered questionnaire, a low response rate, was done by making follow-up contacts which offered additional copies of the survey for individuals who had not filled out the initial survey given to them. These follow-up contacts were made on a weekly and sometimes daily basis by the researcher who made himself available to staff throughout the day.

Confidentiality and anonymity of respondents was protected by avoiding the use of names. Actual instruments were coded with numbers and each respondent was reminded at end of the survey to remember his or her number if he or she would like to know his or her risk for STS or burnout according to the survey. Informed consent and debriefing statements were included with the surveys to address any questions or the unlikely event of an adverse reaction to completing the survey. As indicated in the research question and hypotheses the variables addressed in the research were risk (severity), gender, ethnicity, educational level, and health care specialty. As a result of confusion over how to answer the survey identifying data which would have earmarked
health care specialty," this variable could not be analyzed because of inadequate responses. Consequently, hypothesis #4 "The more direct contact with clients the higher the risk exists for STS," was eliminated from the research analysis.

The method used for interpreting the distribution of individual cases at risk for STS was univariate analysis. To interpret on subgroups bivariate analysis was used for descriptive and comparison purposes and especially to consider possible relationships between variables. As a test of statistical significance among variables a nonparametric test, chi-square, was used. Chi-square values were calculated for significance with one degree of freedom.

Results

Of the 55 surveys handed out in the study 28 were collected for a return rate of 51%. Of the respondents, 17 were women and 11 were men; 18 were Caucasian and 10 were people of color. There were no Native Americans or Pacific Islanders represented in this study. Ages of participants ranged from 23 to 69 years old. It should be noted that significant administrative changes were occurring at the agency while the sample was being taken and this may have had an impact on the return rate. The key for scoring is as follows:
Risk of Compassion Fatigue

26 or less = Extremely low risk; 27 to 30 = Low risk; 31 to 35 = Moderate risk; 36 to 40 = High risk; 41 or more = Extremely high risk.

Scores ranged from a high of 67 to a low of 23 with a mean score of 34.8, a medium of 32 and bimodal distribution scores of 35 and 32. There were 4 respondents in the extremely high risk range, 2 at high risk, and 10 in the moderate risk range. This put 16 of the 28 respondents or 57% at moderate or above risk for STS.

As indicated earlier the Compassion Fatigue Self-Test for Practitioners differentiates between STS and job burnout and although the focus of this paper is STS and not burnout, the following key and scores are offered for comparison.

Risk of Burnout

17-36 or less = Extremely low risk; 37-50 = Moderate risk; 51-75 = High risk; 76-85 = Extremely high risk.

Scores at risk of burnout ranged from a high of 50 to a low of 21 with a mean score of 29, a medium score of 25 and a mode also of 25. Of the respondents, 4 scored in the moderate range while the remaining 24 all scored in the extremely low risk range of the distribution.
How, then, do the data address the research question: Are some individuals who work with clients who have experienced trauma at higher risk for workplace stress? With 57% of the respondents scoring in the moderate or above category, the data suggest that the risk of STS in the population surveyed is notable. Conversely, with only 4 respondents in the moderate range and 24 in the extremely low risk range, the data suggest that the risk of burnout is nonessential. Although the sample was small, the results present additional questions which will be addressed in the discussion section of this paper.

A Chi-square test was used for formal hypothesis testing. The first hypothesis tested was: Women caregivers are at higher risk for STS. Among the 28 respondents 11 women scored in the moderate or above risk range while 5 men scored in this risk range; 6 women and 6 men scored in the under moderate risk range.

\[
\text{Chi-Square} = 2.17 \\
\text{P-value} = .15
\]

The second hypothesis tested was: Ethnic minority caregivers are at higher risk for STS. Of the 27 respondents to the survey, 12 were Ethnic minorities and 15 were Caucasians; 9 minorities were in the moderate or
above severity range and 3 were in the moderate or below range; 9 Caucasians were also in the moderate or above range and 6 were in the moderate or below range.

Chi-Square = 0.68
P-value = 0.41

The third hypothesis tested was: The higher the education level the lower the risk of STS. Of the 27 respondents 18 had a 4-year college degree or more; 9 respondents had less than a 4-year college degree. Of the college educated or above respondents, 12 were in the moderate or above severity range; 6 were below.

Of the respondents with less than Bachelors degrees, 3 were in the moderate or above severity range; 6 were in the below moderate severity range.

Chi-Square = 2.70
P-value = 0.100

The final hypothesis: The more direct contact with clients the higher the risk will exist for STS, unfortunately could not be tested. Although the means of collecting information to test this hypothesis was discussed thoroughly for effectiveness, confusion was evident in the collection of the data and the hypothesis had to be excluded from the findings. Additional comments of the need to test for exposure levels will be
made in the discussion section of this paper.

Discussion

The concept of Secondary Traumatic Stress implies that trauma can be contagious. Professional caregivers need to consider that there is, indeed, “a cost to caring” and that they may be at risk for STS. The findings of this study offer support for the notion of the development of Secondary Traumatic Stress in professional caregivers. Further, the results offer additional strength for the assumption that STS is a construct apart from job burnout.

The study indicated 16 of the 28 respondents, or 57%, were at moderate or above risk for STS. These results support the growing body of empirical data in support of the concept of STS. Recent studies have reported similar findings in support of the impact of trauma work on practitioners (Kassam-Adams, 1995; Chrestman, 1995).

The idea that women caregivers are at higher risk for STS should be looked at closely. Of the 28 respondents in this study 11 women scored in the moderate or above risk range while 5 men scored in this risk range. In general terms roughly one-half of the men and two-thirds of the women scored in the moderate or above risk range. Although the P-value did not reach statistical
significance of .05 it does, however, approach statistical significance. It could be argued that the small sample precluded the findings from reaching statistical significance. To confirm this notion the study needs to be repeated with a larger sample.

Nevertheless, it should be pointed out, it can not necessarily be deduced from the findings that women are at higher risk for STS. Regression analyses indicated women were more likely to relate a personal history of trauma and this may influence the findings. Again, because of the small sample interpretation of this finding was limited.

It should be noted also that a study by Munroe (1990) of male Veteran Administration therapists found that higher exposure to warzone PTSD clients was related to STS in the men clinicians. Munroe's study would confirm the assumption that higher exposure to vicarious trauma and not gender may be a greater factor in the development of STS.

Likewise, the notion that ethnic minority caregivers are at higher risk for STS should be viewed with prudence. This study produced a P-value which did not reach statistical significance, so it could be maintained that even with a larger sample statistical significance as regards ethnicity would not be reached. However,
because of the sensitivity to ethnic minorities needed in social work research, repeating the study with a larger sample would be helpful in confirming the findings of this study.

The assumption that the higher the education level the lower the risk of STS revealed an intriguing result. 67% of the respondents in the moderate or above severity range had a 4-year college degree or a graduate degree. This suggests the hypothesis does not hold that, indeed, caregivers with less education may be less vulnerable to STS. The P-value of .10 certainly approaches the level of statistical significance. The findings here strongly indicate a need to repeat this study with a larger population of professional caregivers. Regression analysis of the data would be important to determine possible correlation's and causes and effects.

As indicated earlier, the hypothesis regarding direct client contact and risk for STS could not be tested because of inadequate data. This hypothesis attempted to test the degree and intensity of contact caregivers have with clients. Specifically, the notion was that social workers, nurses, and psych techs have more and longer contact with clients and therefore might be at higher risk for STS. This hypothesis offers substance for additional study.
The construct of Secondary Traumatic Stress suggests a casual relationship between working with clients with traumatic stress symptoms and acquiring some of these symptoms as their caregiver. Again, STS may be contagious and that, in fact, there may be "a cost to caring." The results of this research along with a growing foundation of empirical studies suggest that professional caregivers are vulnerable to STS.

The need for further examination of variables such as gender, ethnicity, education level and professional discipline are brought forward as a result of this study. Additionally, it should be noted that there is an ethical duty to warn clients, as well as professional caregivers, about the potential peril of working in the arena of trauma.

Finally, the importance of self care is intensified as a result of this study. Considerations such as caregiver workload, use of clinical supervision, personal and professional support systems and the significance of one's own trauma are all weighty factors in insuring the delivery of quality care to clients and meaningful healthcare experiences to clinicians.
Appendix A
The Compassion Fatigue Self Test

*****************************************************************************
1=Rarely/Never    2=At times     3=Not sure     4=Often
5=Very often
*****************************************************************************

Please answer all items

Items About You:
1.    ___ I force myself to avoid certain thoughts or feelings that remind me of a frightening experience.
2.    ___ I find myself avoiding certain activities or situations because they remind me of a frightening experience.
3.    ___ I have gaps in my memory about frightening experience.
4.    ___ I feel estranged from others.
5.    ___ I have difficulty falling or staying asleep.
6.    ___ I have outbursts of anger or irritability with little provocation.
7.    ___ I startle easily.
8.    ___ While working with a victim I thought about violence against the perpetrator.
9.    ___ I am a sensitive person
10. ___ I have had flashbacks connected to my clients.
11. ___ I have had first-hand experience with traumatic events in my adult life.
12. ___ I have had first-hand experience with traumatic events in my childhood.
13. ___ I have thought that I need to "work through" a traumatic experience in my life.
14. ___ I have thought that I need more close friends.
15. ___ I have thought that there is no one to talk with about highly stressful experiences.
16. ___ I have concluded that I work too hard for my own good.
17. ___ I am frightened of things a patient has said or done to me.
18. ___ I experience troubling dreams similar to those of a patient I have treated.
19. ___ I have experienced intrusive thoughts of sessions with especially difficult patients.
20. ___ I have suddenly and involuntarily recalled a frightening experience with a patient.
21. ___ I am preoccupied with more than one patient.
22. ___ I am losing sleep over a patient's traumatic experiences.
23. ___ I have thoughts that I might have been "infected" by the traumatic stress of my patients.
24. ___ I remind myself to be less concerned about
the well-being of my patients.

25. ___ I have felt trapped by my work as a caregiver.
26. ___ I have felt a sense of hopelessness associated with working with patients.
27. ___ I have felt "on edge" about various things and I attribute this to working with certain patients.
28. ___ I have wished that I could avoid working with some patients.
29. ___ I have been in danger working with patients.
30. ___ I have felt that my patients dislike me personally.

Items About being a caregiver and Your Environment

31. ___ I have felt weak, tired, rundown as a result of my work as a caregiver.
32. ___ I have felt depressed as a result of my work as a caregiver.
33. ___ I am unsuccessful at separating work from personal life.
34. ___ I feel little compassion toward most of my coworkers.
35. ___ I feel I am working more for the money than for personal fulfillment.
36. ____ I find it difficult separating my personal life from my work life.
37. ____ I have a sense of worthlessness, disillusionment, and resentment associated with my work.
38. ____ I have thoughts that I am a "failure" as a caregiver.
39. ____ I have thoughts that I am not succeeding at achieving my life goals.
40. ____ I have to deal with bureaucratic, unimportant tasks in my work life.
Appendix B

Informed Consent

This research is being conducted by Thomas P. Cashin, in cooperation with Knollwood Psychiatric and Chemical Dependency Hospital, as a graduate project in Social Work at California State University, San Bernardino. The purpose of the study is to identify the risk of "secondary traumatic stress" (compassion fatigue) and "burnout" in "caregivers." In this study the term "caregiver" is being defined as "a mental healthcare practitioner or worker." A survey design is being distributed to a randomly selected group of health care workers at Knollwood Psychiatric and Chemical Dependency Hospital in Riverside, California. Your participation is voluntary and will be limited to completion and returning of the survey.

If you choose to participate total anonymity and complete confidentiality will be observed. Participants names will not be used in the research and only the primary researcher will have access to the actual surveys. At any time you may withdraw your participation and data from the study. In the very unlikely chance the questions in the survey cause psychological discomfort, please contact:

Department of Social Work
Mr. Steve Petty, LCSW
Cal State University, 5500 University Parkway
San Bernardino, CA 92407 (909) 880-5501
Appendix C
Debriefing Statement

This research is being conducted to help identify the risk of secondary traumatic stress---also known as compassion fatigue---and burnout in mental health caregivers. General results of this research will be placed on file in the professional library at Knollwood upon completion of the project. If you experience emotional unpleasantness as a result of this survey or if you have questions or other concerns please address them to:

Mr. Steve Petty, LCSW
Department of Social Work
Cal State University
5500 University Parkway
San Bernardino, CA 92407
(909) 880-5501
THANK YOU FOR YOUR PARTICIPATION
References


