Acknowledgments

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Abstract

Although many studies have assessed the negative effects of trauma therapy on therapists, little is known about the potentially enriching and/or stress inducing effects of therapy on British psychologists. Also, it remains uncertain whether psychologists' own emotional woundedness and differences in specialist training (i.e., clinical or counselling) may influence such stress and growth outcomes. The current study examined psychologists' Vicarious Posttraumatic Growth (VPTG) and Compassion Fatigue (CF) from therapy and how this was associated and/or predicted by occupational factors (i.e., caseload and experience) and individual factors (i.e., current emotional woundedness; specialist training; sense of coherence; coping; social support). A total of 112 psychologists (50 clinical and 62 counselling) completed a battery of self-report questionnaires. Psychologists' current emotional woundedness, SOC and distractive coping were significant predictors of CF. Also, positive reinterpretation was predictive of VPTG, and counselling psychologists and/or those psychologists who had received their own therapy were significantly more likely to see their clinical work as growth enhancing. Additional correlates of CF and VPTG were also found. This study stresses the importance of clinicians' self awareness, such as attending own personal therapy if currently emotionally wounded, as this could prevent CF, but also prompt VPTG. The findings reaffirm the importance of compulsory therapy in counselling psychology training and its applicability for other specialisations.

Part 1: Introduction

This thesis examines psychologists' stress and personal growth resulting from psychotherapeutic work. The introduction therefore first aims to introduce stress concepts relevant to psychologists and to critically evaluate previous stress research in this population. Thereafter, a discussion on personal growth and whether this applies to psychologists take place. Finally, the introduction assesses how psychologists own woundedness could be related to their stress and personal growth.

1. Is there a cost to caring?

1.1 What is stress?

"People are disturbed not by things, but by their perception of things..."

- Epictetus –

The word "stress" is a highly overused and elusive term and the exact meaning has been disagreed upon among researchers. The popularity of the term has been attributed to the Austro-Hungarian biologist Hans Selye (1951). He saw stress as the physiological responses to any demands made upon it (Selye, 1993). The support for his theory came from studies of laboratory rats, in which he concluded that different physical stressors (e.g., heat, cold or poisons) cause similar responses (e.g., bleeding stomach ulcers) (Selye, 1936). Selye called this response the General Adaption Syndrome (GAS). He thus defined stress as a physiologically based response only, a view which still remains dominant in biomedical sciences today, but not in psychology. The model remains unpopular in psychology because it has been criticised for its extreme biological emphasis that is mainly based upon animal research (Jones & Bright, 2001). On top of this, the model also ignores cognitive and social factors involved in stress (Jones & Bright, 2001).

Other views of stress have therefore been suggested. For example, Holmes & Rahe (1967) put forward the idea that stress should be understood as a *stimulus*, thereby paying attention to the particular characteristics of the stressor (e.g., divorce involving certain demands) that will trigger a particular stress response. This line of research became popular when Sarason, Johnson, & Siegel (1978) constructed a survey called the Life

Experience Survey (LES), which measures stress by assigning numbers, called life change units, to a list of critical life events that are added up to produce an overall score. Some empirical support for this connection between aversive life changes and stress, such as depression, has been found (e.g., Habif and Lahey, 1980).

However, Holmes and Rahe's model has been criticised for not taking into account the individual, cognitive interpretation people make of similar experiences (Jones & Bright, 2001). A third and final suggested broad perspective on stress has thus been the Transactional model of stress and coping, which defines stress as "a particular relationship between the person and the environment that is appraised by the person as taxing or exceeding his or her resources and endangering his or her well-being (Lazarus and Folkman, 1984, p.19). This latter view draws attention to the processes whereby individuals appraise their environment as stressful.

Transactional models of stress and coping have gained high regard by many, particularly because they take into account that stress is more complex than only being either a response (i.e. person reacted to an event in a stressful manner) or a stimulus (i.e. an event was stressful). Instead, stressful experiences are perceived as person-environment transactions. The model further distinguishes between the primary and the secondary evaluation processes. First, the primary evaluation process is an initial evaluation of the situation as challenging or as a threat in relation to his or her well being. If the situation is then seen as a treat, a secondary evaluation comes into play, meaning an evaluation of his or her personal and social resources (e.g. social support) that can be used to cope with the

stressful situation. According to Lazarus and Folkman, stress only becomes distress if the individual evaluates it as such on the basis of deficiencies in her or her resources of coping. A diagram of the transactional model of stress can be seen below in Figure 1.1

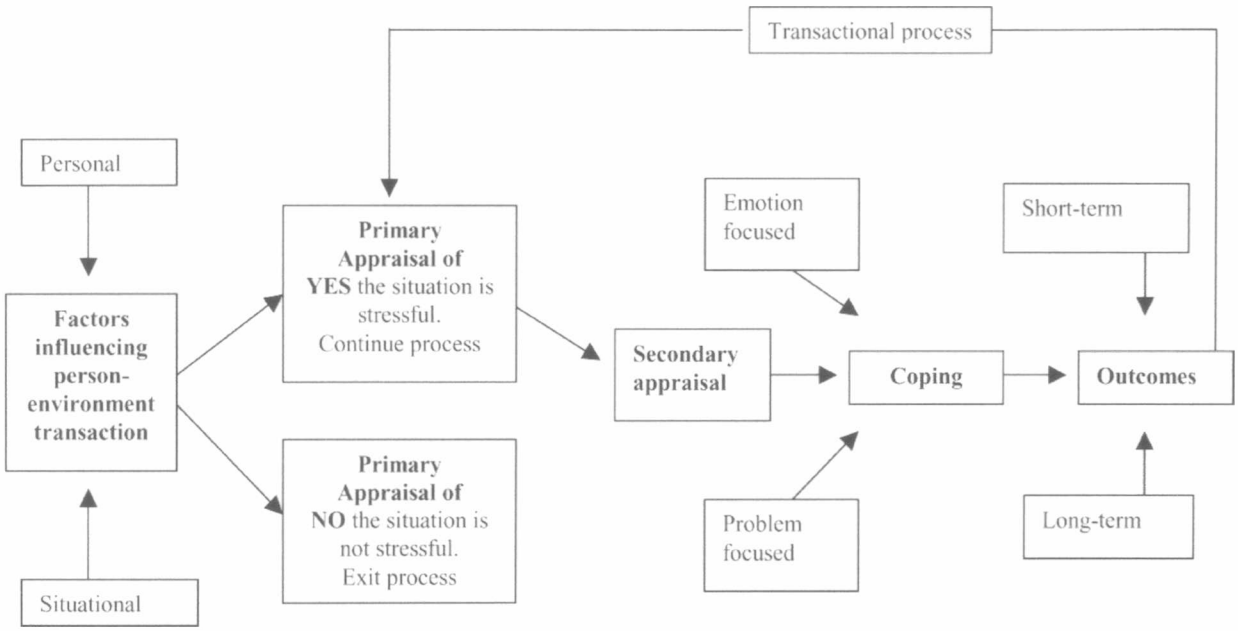


FIGURE 1.1 Transactional Stress/Coping Model by Lazarus and Folkman (1984).

Antonovsky (1979) has further added to the idea that stress does not necessarily result from experiencing stressful incidents per se, but rather from how the individual interprets the event. He formulated the concept of "Sense of Coherence" (SOC), which he defined as the "feeling of confidence that one's internal and external environments are predictable and that there is a high probability that things will work out as well as can reasonably be expected" (Antonovsky, 1979). According to him, SOC is therefore a general orientation towards the world that helps him or her to "see the world as 'making sense' cognitively, instrumentally, and emotionally….Confronted with a stressor, the person ... with a strong

sense of coherence will wish to, be motivated to, cope (meaningfulness); believe that the challenge is understood (comprehensibility); [and] believe that resources to cope are available (manageability)." (p.124). SOC is therefore an overall orientation or attitude towards the world and him/herself that concerns how meaningful, comprehensible and manageable his/her experiences are. The SOC concept and it's relation to health has gained widespread recognition and a recent review of 458 scientific publications on the matter concluded that SOC is strongly related to perceived health, particularly mental health (Erikson & Lindstrom, 2005). SOC thus seems to be a good predictor of stress.

Similarly, this view that people's interpretation of an incident is related to mood, has gained widespread recognition and evidence in the context of Cognitive Behavioural Therapy (CBT). CBT research has found that clients' distress is related to their meaning making (e.g., Beck, Rush, Shaw and Emery, 1979), and that the evaluations and correction of a clients negative thoughts can improve mood (e.g., see Butler, Chapman, Foreman and Beck, 2006 for a review of the effectiveness of CBT). A person's interpretation of an event is thus highly related to perceived stress.

The stress concept itself has however often been criticised for being too vague a definition. Lazarus and Folkman (1984, p.12) has therefore suggested that it may not be helpful to regard the concept of stress as a variable but rather as a "rubric consisting of many variables and processes". Thus, "stress" often needs to be assessed in more specific terms (e.g. burnout). As this doctorate concerns itself with stress in

psychologists, more specific stress-related difficulties in health professionals and thereafter psychologists will therefore be explored.

1.2 Stress in health care professions

Evidence of elevated stress related difficulties has been found in health care professions. For example, occupational stress surveys have found higher levels of minor psychiatric disorders and stress in National Health Service (NHS) staff compared to other occupational groups in the United Kingdom (Borrill et al., 1998; Wall et al., 1997). This is despite the fact that health care professions may not necessarily involve more exposure to traumatic incidents[1] compared to other professions such as police officers and fire fighters. The elevated level of stress found in health care professions therefore suggests that contributing factors, other than direct exposure to extreme traumas at work are involved in these increased mental health difficulties in health care staff. Other possible explanations for this heightened level of stress that has been put forward are: workload (Wheeler, 1998); individual personality characteristics like negative affectivity and neuroticism (Zellars, Perrewe, and Hochwarter, 2000); job role and demands or aspects of the organisations they work in (Borrill et al., 1998). Leary Gallagher, Carson, Fagin, Bartlett and Brown (1995) have further suggested that a combination of occupational factors, such as these noted above, can account for the elevated psychiatric and stress level findings in health care practitioners. Others, such as Figley (1995) have suggested

[1] A traumatic incident has been defined as experiencing, or witnessing or confronting "an event that involved actual or threatened death or serious injury, or a threat to the physical integrity of the self and others, or learning about an unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate....and that the person's response involved intense fear, helplessness and horror" APA, 2000, p. 463.

that it may be specific aspects of health care jobs, such as the listening and talking to very distressed, often traumatised clients, which may increase stress levels in staff.

In fact, many views have been put forward for explaining the high stress related difficulties in health care professionals (e.g., Malan, 1979; Guy, 1987; Bowlby, 1977). Perhaps, the most intriguing argument suggests that health care professionals have themselves often experienced stressful, even traumatic experiences prior to entering the profession, and are therefore attracted to the jobs, because they would like to help others who have suffered like they have (e.g. Malan, 1979). It may be however, that if professionals are treating individuals who have experienced similar traumas to their own, they again will feel more susceptible to be effected by their clients difficulties, as it reminds them of their own issues. To date it however remains unclear whether increased stress related difficulties amongst health professionals are a result of their own vulnerability and/or due to the stress inducing aspects of their jobs. It is questions such as these, and specifically whether psychologists' stress from their therapy work is related to their vulnerability (e.g. whether they have come to terms with their own stressful life experiences or not) and/or the stressful aspect of their job (e.g. of listening to the distressed and often traumatised clients) that will be attempted to be answered from the current research.

1.3 Stress in psychologists working psychotherapeutically

There is a cost to caring. Professionals who listen to clients' stories of fear, pain and suffering may feel similar fear, pain and suffering because they care" (Figley, 1995a, p.1)."

1.3.1 Historical perspective

Historically, a number of references have been made to describe the potentially damaging effects clients can have on their therapists. Jung (1946) for example, described that working with individuals who are mentally ill can lead to "unconscious infection". Likewise, Farber (1985) concluded from his research that clients can transfer their psychopathology to the therapist. English (1976) has explained how this process can take place: "As the emotional needs and distresses of people in difficulty were presented to me, I not only felt them through a process of empathy, but I also found I tended to absorb them within myself, as well" (p.193).

In fact, a wide variety of descriptions have been proposed to describe how psychologists can be effected by their psychotherapeutic work, including, burnout, vicarious traumatisation (VT), secondary traumatic stress (STS) and/or CF. There is of course some overlap when it comes to the meaning of these terms, yet at the same time some distinction. However, there is to date some confusion around these notions and there is therefore a need to clarify their meanings.

1.3.2 Definitions and clarifications of terms

i) Work–Related Burnout

The concept of "burnout" was first used in occupational stress literature to describe the emotional consequences of "people work", i.e. the emotional strain on human service workers of working intensely with people's difficulties (see Maslach, 1976, 1982, 1986). Jenkins and Baird (2002) recently conceptualized burnout as "a defensive response to prolonged occupational exposure to demanding interpersonal situations that produces psychological strain and provides inadequate support" (p. 424). Burnout is thus not limited to individuals working psychotherapeutically, but as Maslach suggests, also applies to other human service workers, and can even occur within families that have traumatised members (Figley, 1997). Maslach and Leiter (1997) state that work-related burnout can be caused by organisational factors such as having an overload of responsibility; being isolated; being in a work environment which is effected by discrimination or lack of respect; and conflicts between organistional related goals/demands and individual values. Moreover, other causal factors can be having little or no emotional and/or financial reward and not feeling like one has any control over the quality of the services provided. Personal characteristics that can contribute to burnout include having high expectations of oneself and a highly idealistic view of helping others (Pines and Aronson, 1988)

Burnout occurs gradually, i.e. takes place through a process rather than being an event, and is "marked by physical, emotional and behavioural indicators than can easily be recognized" (Aguilera, 1995). Physical responses include: headaches; hypertension and

physical exhaustion. Emotional responses include: depression; anxiety and emotional exhaustion (Prosser, Johnson, Kupers, Szmukler, Bebbington, & Thorncroft, 1996). Finally, behavioural responses include: insomnia; boredom; decline in performance; increased addictions and interpersonal problems. Also, cognitive responses can occur, for example: self-doubt; blame; a sense of reduced purpose; as well as negative attitudes towards work and life in general (e.g., Pines and Aronson, 1988).

However, the use of the concept of burnout in relation to the effect of psychotherapeutic work, and specifically the effects of client's trauma material on the counsellor has been criticised for being too vague, i.e., not taking into account all the effects of such work (Salston and Figley, 2003). Daneli (1981) and McCann and Pearlman (1990) support this view, and state that although the burnout literature is of relevance to therapists, the effects of working psychotherapeutically, particularly with trauma clients are distinct from those of working with other difficult populations. This is because the therapist is then exposed to emotionally shocking stories and images of suffering from the traumatised client. The meanings of other related terms to burnout will therefore be explored.

ii) Compassion Fatigue/Secondary traumatic Stress

The use of the term *compassion fatigue (CF)* was first used to describe burnout related difficulties in nurses (Joinson, 1992). Figley (2002) suggested that it was a more user-friendly, less stigmatising description because of its more positive qualification compared to other similar terms noted (e.g., secondary traumatic stress). Through his informal

research of nurses, emergency personnel and other professionals, he found that they in fact favored this description (Figley 2002).

Figley (2002) now uses the word CF as a synonym for secondary traumatic stress (STS) and secondary traumatic stress disorder (STSD). He has further suggested that these terms parallels the diagnosis of PTSD (APA, 1994), apart from referring to the effects of a traumatic event of the client on the therapist, rather than the effect of the trauma on the individual who experienced it per se. STS, STSD or CF thus could result in the following main symptoms; re-experiencing the client's traumatic event (e.g., through nightmares), avoidance of reminders, and/or reacting by turning numb in response to reminders, as well as persistent arousal (Jenkins and Baird, 2002). Motta, Joseph, Rose, Suozzi, and Leiderman, L. (1997) have further proposed that CF generally occurs at significantly lower distress intensity when compared to, for example, PTSD (i.e. primary trauma exposure). Instead, CF is suggested to involve medium levels of distress such as intermediate levels of anxiety related symptoms.

Given the similar symptoms of burnout and STS, questions have been posed as to how do these terms really differ in meaning. Figley (1995) has suggested that CF can be sudden and occur after being exposed to a client's trauma just once, whereas "burnout"is a gradual process. Moreover, CF is related to the effects of the client's trauma on the therapist, rather than occupational stress as seen in burnout. In addition, Figley (1995) has pointed out that CF includes a sense of isolation, confusion and helplessness. Nevertheless, he has also noted that individuals affected by CF typically have a faster

recovery rate from symptoms than individuals suffering from work related burnout. There are thus clear conceptual differences between burnout and CF.

iii) Vicarious trauma

Pearlman (1999) has proposed that vicarious trauma, like burnout, is a cumulative process through which the therapists' inner experience is negatively altered through "empathic engagement with trauma survivors" (p. 52). It can occur when therapists listen to graphic descriptions of cruel, horrific events as a part of the therapy session. Moreover, according to Pearlman (1999), such trauma exposure can have an effect on the therapist's world-view, sense of self, affect tolerance, spirituality, interpersonal relationships and memory. For example, changes in the sense of self can incorporate interruptions in the identity of being a parent or a helper, whilst changes in world-view can involve disruptions of moral principles and life philosophy in general. Changes in spirituality could on the other hand, for example involve loss of meaning and hope.

Thus, the concept of VT focuses particularly upon trauma therapy resulting in *cognitive changes* within the trauma therapist, whereas CF focuses more upon trauma therapy resulting in the therapist showing PTSD like *symptoms.* More specifically, VT and CF differ on four major aspects (Jenkins and Baird, 2002). First, CF concerns symptomathology whereas VT concerns theory (i.e., Constructivist Self-Development Theory; McCann and Pearlman, 1990). Second, the nature of the symptoms, with CF focusing on observable symptoms, whereas VT rather involves the covert changes in cognitions. Third, the concepts differ when it comes to what populations they concern.

For example, Figley (1983) first identified CF in combat veterans' and sexually assaulted individual's family members and later expanded the use of the term to also apply to professionals who directly deal with sexually assaulted and other trauma survivors (Figley, 1995). VT on the other hand, has only been applied to mental health professionals, mainly to those who have been working with incest survivors as well as other sexually assaulted individuals (McCann and Pearlman, 1990; Pearlman and Saakvitne, 1995). Finally, whereas Figley (1995) has stated that only one incidence of severe exposure to client's trauma material is needed for the therapist to develop CF, McCann and Pearlman (1990) have asserted that VT can only result from the continuous, cumulative exposure to traumatised clients. All the above points show that there are therefore clear conceptual differences between CF and VT.

1.4 Theoretical Explanations of CF/VT

If there is an occurrence of VT/CF in some therapists as a result of being exposed to clients' trauma material, there is a need to evaluate some of the underlying psychological mechanisms and theories that might explain such a process. It should be noted however, that no actual separate theory of CF has ever been put forward, and so no specific theory has been proposed as an explanation for CF related difficulties. Instead, as previous research and writing about this phenomenon has not adequately distinguished the difference between VT and STS, but rather treated it as a one concept, hypothesised linked processes involved in CF and VT will be described together. Therefore, first underlying proposed processes involved in VT/CF will be evaluated (see part 1.3.2.1), and thereafter a theoretical model of VT will be explored (see part 1.3.2.2). Finally, any

additional factors which may make therapists vulnerable to develop CF/VT will be represented (see part 1.3.2.3).

1.4.1 Proposed underlying processes involved in CF/VT

1.4.1.1 Empathy

One aspect of the therapeutic relationship, which has been linked to CF/VT, is therapist empathy. In fact, as suggested by Pearlman and Saakvitne (1995) VT "refers to a transformation in the therapist's inner experience resulting from *empathic engagement* with client's trauma material" (p. 151). Nevertheless, therapists such as Rogers (1961) have emphasised the importance and necessity of therapist empathy to bring about therapeutic change in the client. He has described such a process of empathy as follows; "when the therapist is sensing the feelings and personal meanings which the client is experiencing in each moment, when he can perceive these from "inside", as they seem to the client, and when he can successfully communicate something of that understanding…..without wanting to analyse or judge, then the client can blossom and grow in that climate" (Rogers, 1961; p. 62;).

While this empathy is seen as a vital part of any therapeutic encounter, sustained empathic inquiry with traumatised clients is generally more necessary and difficult to maintain, than with other client groups (Wilson and Lindy, 1994). This is because such sustained therapist empathy is fundamental for a safe-holding environment, which enables a normalisation of client's difficulties, as well as helping the client to successfully integrate the aftermath of trauma into his/her self-structure (Wilson and

Lindy, 1994). Yet, at the same time, it is by no means easy to maintain a sustained empathic therapist stance, when sessions with traumatised clients involves exposure based therapy, in which therapists must be specifically aware of countertransference processes. For as Figley (1995) notes; "The process of empathising with a traumatised person helps us to understand the person's experience of being traumatised, but in the process we may be traumatised, as well" (p.20). In fact, Wilson and Lindy (1994) stress that working empathically permanently with client's traumatic events can lead to stress called *empathic strain* or defensive countertransference.

1.4.1.2 Traumatic countertransference

A second aspect of the therapeutic relationship, which has been associated with CF/VT, is countertransference. Countertransference has most often been presented as the underlying explanation for why VT/CF may occur (e.g., Pearlman and Saakvitne, 1995). Freud first used the concept of countertranference in psychoanalysis in 1910 to describe 'the analyst's emotional reactions to the patient's transference, influenced by the analysts unconscious needs and conflicts' (Colman, 2003, pp. 173). According to Freud (1914), this unconscious process (i.e., part of the mind that holds repressed instincts such as wishes, ideas and images that are not accessible to direct examination) similarly operates in transference, in which the client unconsciously displaces or redirects emotions and attitudes originated from earlier relationships (e.g., with parents) into the analyst/therapist (Freud, 1914). However, whilst Freud viewed working through the client's transference as a crucial part of the healing power of psychoanalysis, there have been various discussions or even questions put to the usefulness of countertranference. For example,

some analysts, particularly Jungians, view the mutual transformation of both client and therapist, through transference and countertranference as necessary for transformations to take place (Sedgwick, 1994). In fact, even Freud (1913) described how 'everyone possesses in his own unconscious instrument with which he can interpret the utterances of the unconscious in other people' (Standard Edition, XII, pp.317-26).

A lot has nevertheless been written about 'the shadow side' of countertransference, or what is typically named 'neurotic countertransference. Sedgwick (1994), for example has described how countertransference work can result in pathology in the analyst/therapist. Indeed, Freud (1913) even admitted that his neutral, blank-screen stance was a way of protecting himself against the pitfalls of countertransference. Jung (1946) however criticised Freud for this, again suggesting that the analyst must bring the whole self to their work (thereby also using countertransference as a treatment tool). Various discussions thus still remain about the usefulness and necessity of the usage of countertranference in therapy.

In relation to this thesis, countertransference will be viewed as *all* the emotional reactions the therapist has towards the client (Figley, 1995). Interpreted this way, sources of countertransference do for example not only include past and present stressful life events of the therapist, but also the traumatic material shared by clients and absorbed by the therapist. It is this latter source of countertransference, which will be the focus here. It is within this context that Pearlman and Saakvitne (1995) conceptualised countertransference as "1) the affective, ideational, physical responses a therapist has to a

client, his clinical material, transference and re-enactments, and 2) the therapist's conscious and unconscious defences against effects, intra-psychic conflicts and associations aroused in the former". In other words, trauma counter transference is "the unconscious attunement to and absorption of clients' stresses and traumas…often expressed nonverbally, such as through gestures and enactments" (Valent, 2002, p.19). Thus, such nonverbal body language can be seen as "vehicles" for transferring emotional information. This is called *transference* (Figley, 2002). For the purpose of this doctorate, however, the focus will remain on *traumatic countertransference*, meaning the therapist's emotional responses towards the client's trauma material. Herman (1992) states that such traumatic countertransference can include a number of emotional reactions towards trauma survivors; including identifying with the feelings of helplessness, anger, grief and personal vulnerability. Others, report that it can include conscious and unconscious emotional and/or behavioural reactions towards the client, reenactments, the transference and the trauma material (Gabbard, 2001).

The above draw on similarities between the concepts of VT/CF and countertransference. Yet, at the same time, differences between these concepts have been noted. Wilson and Lindy (1994) for example, have suggested that whereas countertransference is a description of something that takes place within the therapeutic relationship, VT/CF refers to changes taking place in the whole of the therapist's life. Nevertheless, taking these differences into consideration, it is acknowledged that these concepts do interact. For example, if negative countertransference reactions are not understood and the therapist does not manage to contain these feelings, it can lead to long term difficulties

for the therapist, including personal, professional and therapeutic effects such as VT/CF (Sabin-Farrell and Turpin, 2003).

Wilson and Lindy (1994) has reported the various countertansference *positions* under which such difficulties can occur. Such countertransference positions involve the therapist feeling like she/he has entered a particular role as a part of the client's reenactments of their traumatic experiences. These reenactment positions can range from being positive, such as for example, the therapist being seen as a fellow survivor or a helpful rescuer, to negative, in which the therapist for example can be seen as a hostile judge. At the worst end of the spectrum, however, is the countertransference position of the therapist being seen as the perpetrator in the role reenactment of the traumatic situation (Wilson and Lindy, 1994).

Wilson and Lindy (1994) have further stated that such negative traumatic countertransferenece positions in which the therapists enacts as a negative figure in the traumatic situation can be evoked by failures in therapist empathy called *empathic strain* or defensive coutertransference. They have divided such empathic strain or defensive countertransference in therapists into two categories. First, intrusive type countertransference strain includes therapists': loss of boundaries; reciprocal dependency; over involvement; and pathological bonding. Second, avoidance type countertansference strain in therapists includes: numbness; withdrawal; intellectualization and denial. According to Wilson and Lindy (1994), such emphatic strain in the therapeutic relationship can be caused by therapist affective processes, such as for example, guilt,

shame, anxiety and tension towards the trauma-specific transference reactions (i.e. unconscious related reactions towards the therapist that involves unresolved, unassimilated, and ego-alien aspects of the traumatic experience) in the client. If such therapist affective reactions are intense they can lead to negative, defensive countertransference reactions by withdrawing the capacity for sustained empathic inquiry, and thereby producing a temporary rupture in the therapeutic relationship (Wilson and Lindy, 1994). It is thus vital to the therapist, that he/she seeks to understand their countertransference tendencies, as they are a common part of trauma treatment, yet also a source of empathic strain. Given the importance of therapist empathy for the successful treatment of particularly traumatised clients, it is thus fundamental that the therapist develops an understanding of their countertransference reactions. Moreover, such an understanding is also essential for the therapist's individual, therapeutic and professional wellbeing and can thus counter the negative effects of CF/VT. For as Pearlman and Saakvitne (1995) suggest; unacknowledged countertransference can make the therapist become vulnerable to VT, whereas at the same time, VT can leave the therapist vulnerable to stronger countertranference reactions.

1.4.1.3 Vicarious Trauma (VT) from a Cognitive – Constructivist Self-Development Perspective

As stated previously VT has been suggested to involve "the transformation in the therapist's inner experience resulting from empathic engagement with clients trauma material" (Pearlman and Saakvitne, 1995, p. 151). The concept has derived from Constructive Self Development Theory (CSDT) (McCann and Pearlman, 1990), an

interpersonal, developmental theory which attempts to explain the effect of trauma on the therapist's identity, adaptation and psychological development. The underlying premise is that in line with Cognitive Behavioural Theory (e.g., Beck, Rush, Shaw and Emery, 1979) individuals construct their own reality through complex cognitive structures or basic assumptions about self, others and the world (i.e., schemas) which are used to interpret events (e.g., Janoff-Bulmn, 1985). More specifically, it is suggested that trauma therapists may experience disruptions in frame of reference such as world view (e.g., changes from thinking the world is safe to it is dangerous), spiritual beliefs (e.g., start questioning one's long standing commitment to a religion) and sense of identity (e.g., start questioning whether he/she is an abusive parent) (Rosenbloom, Pratt and Pearlman, 1995). Furthermore, there can occur changes in therapists' schemas in relation to psychological needs including; dependency/trust, safety, control, esteem and intimacy (McCann and Pearlman, 1990). Everyone possesses such needs, however, specific areas are more important for each individual, and can thus consequently be more disrupted (Rosenbloom, Pratt, Pearlman, 1995). These possible changes do not only originate from one therapeutic relationship, but has rather been proposed to happen after cumulative work across both time and therapeutic relationships (Pearlman and MacIan, 1995). An exploration of these various possible areas of disruptions in trauma therapist's schemas follows.

Firsts, therapist's exposure to clients who have been victims of horrific, cruel ways of betrayal, deception and violation of their trust, may disrupt the therapist's own schemas about trust (McCann and Pearlman, 1990). Consequently, such therapists may become

more cynical and/or distrustful, as well as becoming more suspicious about people intentions or motives. For example, a therapist who regularly works with incest survivors may start questioning other parent's motives towards their children when in the playground with her own daughter.

Second, listening to victims' stories of loss of safety such as threats or physical, sexual abuse or harm may challenge therapists' sense of own and/or of others safety (McCann and Pearlman, 1990). In particular, therapists who work with victims of sudden, random violent acts or accidents may feel a heightened sense of the fragility of life and thus may feel more vulnerable. For example, a therapist may experience increased thoughts of self or loved ones being in a car crash.

Third, victims' talk of loss of control of one's own thought, affect and behaviours when for example being sexually abused, may evoke concerns in the therapist about his/her own sense of control (Pearlman and Saakvitne, 1995). Issues of control can become dysfunctional if it leads to inappropriate ways of attempting to control other individuals (e.g., through anger) or attempts to try to control and avoid one's own difficult thoughts and connected emotions.

Fourth, McCann and Pearlman (1990) have defined esteem as "the need to perceive oneself and others as benevolent and worthy of respect" (p. 140). Victims of intentional cruel, malicious acts may experience diminished esteem towards other people. This view may further influence the therapist into becoming cynical and pessimistic about human

nature in general. For example, a therapist with an initial ideal view of humans may experience a shattering of these assumptions after working with individuals who have had terrible abuse perpetuated towards them.

Finally, trauma victims who have been exposed to cruel, horrific incidences may commonly feel a sense of alienation towards others and the world. Trauma therapists' exposure to such stories may equally result in a sense of separateness from friends, family and co-workers, which could result in withdrawal and isolation (McCann and Pearlman, 1995). This sense of alienation can be compounded by confidentiality requirements and feelings of being stigmatised for choosing this field of work (e.g., of "freely wanting to listen" to traumatising stories).

1.4.2 Additional factors which make therapists vulnerable to CF/VT

Various other factors have been suggested to make trauma therapists more vulnerable to develop CF/VT. Perhaps one of the most frequently cited factors is the therapist's previous trauma history. For example, Pearlman and Sakvitne (1995) have suggested that a client's trauma material can not only prompt empathy, but also personal memories and pain in the therapist. Moreover, this can become problematic if the therapist has not been in extensive therapy for his/her own traumas. It may become a disruptive part of the therapeutic relationship with his/her trauma clients. The therapist may then employ defensive strategies in their sessions, which may traumatise him/her further (e.g., dissociation), as well as be of limited help or even damaging to the client. The therapist's own trauma history may therefore make him/her more vulnerable to develop VT/CF.

Additional characteristics of the therapist, which also may make him/her more susceptible to such effects, are having high ideals and client rescue fantasies, inadequate psychotherapy training, and inadequate trauma therapy training (Pearlman and Saakvitne, 1995).

Other suggested additional factors that can potentially contribute to CF/VT are work factors such as amount of supervision/colleague support, size of traumatised client load, and working with clients who's abuse histories are stigmatised and not generally understood nor accepted (e.g., childhood incest, cult abuse) (Pearlman & Saakvitne, 1995).

1.5 Research evidence for Compassion Fatigue (CF) in psychologists

1.5.1 Does CF occur, and if so, who is affected?

To date, research evidence for VT/CF remains inconsistent, due to the various discrepancies in findings between studies. Even the evidence for the existence of VT/CF has been questioned, with some researchers having put forward that "the negative effects of trauma work reported in previous studies may have been overestimated" (Minnen and Keijsers, 2000). Altogether this suggests a need to critically review the CF/VT empirical literature. First, quantitative research relating to the existence of VT/CF will be evaluated (see part 1.4.1.1) and then potential risk factors (see part 1.4.1.2). Next, qualitative research will be reviewed (see part 1.4.2.3), and finally, a summary of the limitations of previous CF/VT research and future directions will be discussed (see part 1.4.2.4).

1.5.1.1 Quantitative research; does VT and/or CF occur?

Perhaps the two most classical studies reporting the existences of CF/VT in therapists are those of Pearlman and MacIan, (1995) and Schauben and Frazier (1995). Pearlman and MacIan (1995) performed a study of 188 self-identified American trauma therapists. They discovered that inexperienced therapists had significantly higher symptom levels (CF) and more disrupted beliefs (VT) when it came to self-trust, self-intimacy and self-esteem. In addition, those trauma therapists with a personal history of trauma, particularly inexperienced therapists, had a significantly higher level of distress (e.g., intrusion) and disruptions in beliefs (e.g., safety). Furthermore, in a comparable study, Schauben and Frazier (1995) found that American sexual violence counselors who had higher caseloads; self-reported VT and showed more PTSD related symptoms (CF), as well as a greater disruption in beliefs (particularly about esteem in others; VT). On the contrary to Pearlman and MacIan (1995), however, they did not find VT/CF to be related to therapist's own trauma history. Moreover, Sabin-Farrell and Turpin (2003) have criticised both studies' findings for being based upon weak correlations (i.e., ranging from 0.16 to 0.27 [Schauben and Frazier] and -0.14 to -0.20 [Pearlaman and MacIan]). In addition, Schauben and Frazier used non-standardised measures of VT (i.e., self-rated VT on 5-point scale). Therefore, on such bases it is difficult to make conclusions about the findings of these studies.

Nevertheless, other studies have also found evidence of CF and/or VT. In fact, some studies have even found the level of CF in a large amount of their sample of therapists to be within the clinical range. For example, Kassam-Adams, (1995) reported that almost half of the 100 American, sexual trauma psychotherapists in her sample scored in the

"high" range on the Impact of Events Scale (IES; Horowitz, Wilner, & Alvarez, 1979). Regression analyses further revealed that being female, having a personal trauma history (particularly childhood) and higher amount of exposure to clients altogether predicted avoidant and intrusive symptoms on the IES. Kassam-Adams suggested that if such high overall IES levels of traumatisation were found in primary trauma victims, they would typically be referred for clinical intervention. Such "high" levels, however, were never defined, and so the result remains impossible to interpret.

Another, more recent American study by Way, VanDeusen, Martin, Applegate and Jandle, (2004) found that 52% of their 347 clinicians treating either sexually abused or sexual offenders scored in the *clinical range* on the IES (according to patient norms). Additional findings revealed that therapist's own childhood trauma history was not associated with these IES scores of intrusion and avoidance, thereby supporting Schauben and Frazier's (1995) findings, although contradicting others (e.g., Pearlman and MacIan, 1995, Kassam-Adams, 1995). Moreover, in line with Way et al., (2004) Steed and Bicknell (2001) also found that almost half (46.2%) of their Australian sexual offenders therapists sample was at moderate or higher risk of CF. These findings thus suggested that approximately half of therapists treating sexually abused or sexual offenders are at a great risk for developing STS, thereby supporting earlier claims of the widespread affect of such work (e.g., Stamm, 1995, Figley, 1995, and Pearlman and MacIan, 1995).

However, other research has implied that earlier findings (e.g., Pearlman and MacIan, 1995) and theories (e.g., Figley, 1995, Stamm, 1995) of VT/CF possibly have

exaggerated the effects of such work. For example, Brady, Guy, Poelstra and Brokaw (1999) found little evidence for VT, although some evidence for CF in their sample of 446 American, female sexual abuse psychotherapists. The psychotherapists with greater current and cumulative exposure to abuse material reported significantly more trauma symptoms, as measured by the IES. However, they did not demonstrate significant disruptions to their cognitive schemas, as measured by the TSI Belief scale (Pearlman and MacIan, 1994).

In addition, Minnen and Keijsers (2000) study of the effects of exposure treatment on 20 Dutch trauma therapists found no enhanced symptoms of CF, nor distorted cognitive schemas (VT). Trauma therapist's scores were compared with both norm-standards and non-trauma therapists (N=19) using the TSI belief scale (Pearlman and MacIan, 1994), the World assumption Scale (WAS; Janoff-Bulman, 1989) and Symptom checklist-90-Revised (SCL-90; Dutch version). The findings remain questionable, however, as the power of the study remained poor due to a small sample. Moreover, Minnen and Keijsers (2000) also noted through their semi-structured interviews that trauma therapists reported having significantly more negative cognitive changes ($p<0.001$) [e.g., suspicion such as " maybe that man over there abused his little daughter"] than non trauma therapists. Such discrepancies between quantitative and qualitative findings may suggest that the current questionnaires are not sensitive enough when it comes to detecting VT. This will be further discussed in the qualitative part. Nevertheless, both Brady et al.'s (1999) and Minnen and Kaijsers's (2000) studies highlight the fact that research evidence for CF/VT is inconsistent and with a number of discrepancies in findings.

Additional studies such as those of Ortlepp and Friedman (2002) and Ennis and Horne (2003) have also put some of the earlier findings of VT/CF into question. Ortlepp and Friedman (2002) for example, found that generally their group of 130 South African non-professional trauma counsellors were not experiencing significant CF. In fact, using the Compassion Satisfaction/Fatigue test (Figley and Stamm, 1996) the majority of the respondents reported to be at extremely low risk (69%) and low risk (10%), whereas 11 % were at moderate risk, 2 % high risk and, only 8% at an extremely high risk of experiencing CF. Ortlepp and Friedman (2002) did point out, however, that the cousellors included in the study were only doing so on volunteer basis, thereby suggesting that the participants were typically not exposing themselves to trauma material on as frequent basis as full-time trauma counsellors included in other comparable studies. This may therefore have prevented the South African counsellors from developing more severe symptoms of CF.

Nevertheless, using the Los Angeles Symptom Checklist (LASC; King, King, Leskin, and Foy, 1995) Ennis and Horne (2003) found that their sample of 59 American sexual offender therapists reported generally low levels of distress and PTSD related symptomatology (CF). However, when investigated closer, about 20% of the group reported having moderately, seriously or extremely problematic PTSD related difficulties; with 22% reporting restlessness, 34% irritability, 24 % easily fatigued, 32% tension and anxiety, 20% difficulty with memory, 25% waking easily during the night, and 22% having problems with authority. No relationship was found between numbers of hours spent working with sex offenders and CF symptomatology. Greater levels of perceived social support from peers was however significantly predictive of lower levels

of CF symptoms. Altogether these studies suggest that the levels of CF may not be as high as suggested by initial CF/VT studies.

In fact, a more recent study actually put into question whether VT/CF is specific to trauma work at all. Kadambi and Truscott (2004) studied VT, CF and burnout among therapist groups working with sexual violence, cancer or general practice and indeed found no differences in symptoms between the groups. These findings therefore may suggest that VT and CF may not be specific effects of trauma work, as has been previously suggested by theorists (e.g., Stamm, 1999; Pearlman, 1995). This may mean that psychologists with a more general case load (e.g., occasional trauma clients) may also be affected by CF and VT. Further research is however needed to confirm whether CF/VT is specific to trauma work only, or whether other more general practitioners such as psychologists (that are not trauma specialists) may also be affected by CF/VT.

Altogether the above review has thus shown inconsistencies in findings in relation to the extent to which VT/CF occurs. Overall, these quantitative studies seem to provide part support for the existence of some level of CF, although the prevalence appears to be of lower levels than was initially suggested by some researchers (e.g., Stamm, 1995; Sexton, 1999) The overall support of the existence of VT does however remain less convincing. In addition, newer findings question whether CF and VT symptoms are specific to trauma work (e.g., Kadambi and Truscott, 2004). To conclude, as there remains little evidence for the occurrence of VT, the prevalence of specifically CF in general practitioners such as psychologists warrants further research.

1.5.1.2 Risk factors; which personal and/or work characteristics are associated with VT and CF?

Although studies have revealed mixed findings as to whether CF/VT is actually a common occurrence for therapists, some studies have still attempted to work out what therapist characteristics and /or what work characteristics make practitioners at risk for developing VT/CF. While some of these issues were discussed above, a summarised, more easily comparable version of characteristics associated with VT/CF will now be described.

i) Personal characteristics

Perhaps the most commonly studied personal characteristic which has been quoted in relation to VT/CF, has been personal trauma history. In short, it has been put forward that practitioners with a trauma history may be reminded of their own trauma(s) when encountering client's trauma material, and therefore may be at higher risk for developing CF/VT. The research however, remains ambiguous. For example, whereas some studies have found the therapist's personal trauma history, and particularly childhood traumas to be a factor in the development of CF/VT (e.g., Pearlman, and MacIan, 1995: Kassam-Adams, 1995; Jenkins and Baird, 2002), others have found no such associations (e.g., Schauben and Frazier, 1995, Way et al., 2004). Such discrepancies in findings may relate to the extent to which the practitioner has dealt with his/her own trauma or not (e.g., through personal therapy). Further research is thus needed to gain a better understanding of how a potentially previous trauma history can affect clinician's trauma work.

Unfortunately, to date, the research on additional personal characteristics, which may predict CF/VT is no less ambiguous. For example, some studies have found that therapists with a lot of experience suffer from more CF like symptoms (e.g., Steed and Bicknell, 2001), whereas others have found the opposite; i.e., inexperience (shorter length of time providing trauma counselling) to be predictive of CF/VT (Way et al., 2004; Pearlman and MacIan, 1995). This latter relationship seems to be somewhat confusing. Steed and Bicknell (2001) thus studied this in more detail and found that typically there appeared to be a common experience of being at greater risk of CF when beginning therapy work. Moreover, such risk reduced somewhat by year two to four of working, and thereafter increased again. They concluded that fluctuating levels of CF across work experience appears to be a shared phenomenon, and that on the contrary to what was previously believed by some, more therapist experience does not provide "resistance" against CF. Thus, although the research related to therapist experience remains somewhat unclear, it does appear to date that both inexperienced and experienced therapists are at higher risk for developing CF.

Negative individual coping styles have on the other hand been mostly supported as a risk factor for the development of CF/VT in similar ways as to PTSD. For example, Way et al., (2004) found that negative personal strategies were associated with greater CF. Similarly, Schauben and Frazier (1995) reported positive coping styles, including active coping, emotional support, planning, instrumental support and humor all to be associated with lower symptom levels of both VT and CF. However, contrary to this, coping by behavioural disengagement correlated with higher symptom levels. Moreover, Ortlepp

and Friedman's (2002) and Linley and Joseph (2007) also found more adaptive personal coping styles, as indicated by counsellors' higher levels of sense of coherence (as measured by Antonovsky's sense of coherence construct) to be associated with lower levels of CF and higher levels of role satisfaction. Also, Ennis & Horne (2003) found a negative association between peer social support and CF. These finding were thus consistent with mainstream psychological theory (e.g., Lazarus and Folkman, 1984) and research which has found an association between social support and psychological distress (e.g., Grassi, Rasconi, Corridoni, Bevilacqua and Ferrara, 2000). Altogether this suggests that more negative coping styles (i.e., SOC, negative coping strategies and social support) may be predictive of CF like symptoms. Further studies are thus needed to confirm this potential association between coping styles, strategies, social support and CF/VT.

Furthermore, a few studies have also found that women have been more likely than men to report CF like symptoms (e.g., Cornille and Mayers, 2002; Kassam-Adams, 1995). Cornille and Mayers (2002), for example, found that female workers reported significantly more symptoms of anger, irritability, jumpiness, hypervigilance, trouble concentrating and nightmares than when compared to men (84% female[n=303], 16% male[n=57]). These studies did however stress that CF/VT should not necessarily only be seen as a risk for female practitioners, and that such discrepancies between men and women may be due to sex role socialisation, i.e., women may be more likely to disclose such emotional discomfort as opposed to men (Cornille and Mayers, 2002). More importantly, most other studies have not found any differences in report of CF/VT

between men and women (e.g., Way et al., 1999; Linley & Jospeh, 2007), thereby suggesting that men are by no means unsusceptible to CF/VT, and that in fact, woman may not even be at any further risk than men for developing such difficulties. In addition, it remains unknown whether the few studies reporting gender differences in CF/VT report have included female samples with a higher abuse history than their male sample, thereby suggesting that these gender differences may be due to higher abuse history rather than being female per se. Gender differences findings must thus be interpreted with caution.

Altogether, the above research suggests that personal characteristics such as type of coping strategies, as well as experience can be predictive of CF. These areas do however need further research to verify such findings. In addition, the predictive value of trauma history of CF remains vague and needs to be further evaluated. Finally, this review has revealed that the relationship between personal characteristics as predictors of VT remain even more ambiguous than CF predictors.

ii) Work characteristics

Shauben and Frazier (1995) found that counsellors with a higher percentage of sexually traumatised client caseload reported significantly more schema disruptions (VT) and symptoms of CF. Similarly, Kassam-Adams (1995) also found cumulative career exposure to trauma clients and percentage of traumatised clients in caseload over the last year to be positively correlated with symptoms of STS. In other words, therapists with higher percentage of trauma clients in caseload and more lifetime cumulative exposure reported more CF symptoms. Chrestman (1995) further reported that higher percentage of

trauma clients in caseload was associated with increased levels of anxiety, dissociation and intrusion. Brady et al, (1999) also found greater current and cumulative exposure to sexual abuse clients to be significantly related to higher PTSD-like symptoms, as measured by the IES. They did however, not find any connection between such higher exposure and disrupted beliefs (VT). Altogether, these studies thus consistently suggest that CF is associated with higher exposure to trauma clients. However, again, associations between VT and higher trauma caseloads remain unconvincing.

1.5.1.3 Qualitative Research; Does VT/CF occur in therapists?

In an Australian phenomenological study, Steed and Downing's (1998) interviewed 12 female sexual assault/abuse therapists and analysed these through thematic code analysis. They found a number of negative and positive effects of working with sexually traumatised clients. Steed and Downing (1998) also reported negative effects included responses such as pain, frustration, anger, sadness, shock, horror and distress. Physiological effects included reduced energy levels, somatic complaints and sleep disturbances. In addition, 7/12 participants described experiencing distressing dreams, imagery and intrusive thoughts. Moreover, 8/12 reported increased vigilance in relation to their own and others safety, and 6/12 described a decrease in trust towards others, particularly men/partners. Also, some participants reported a loss of trust in their own ability of working effectively. In fact, all therapists reported changes in cognitive schemata, often related to a "loss of faith in human beings", an increased sense of vulnerability, as well as changes in their sense of identity. To prevent such negative effects of their work, the therapists stressed the need for a personal awareness of their

own stress reactions and vulnerabilities, as well as a need for education and training in how to work with trauma victims and the potential effects of such work.

In addition, Steed and Downing's (1998) therapists reported negative coping strategies such as drinking too much coffee or alcohol, risk-taking behaviour (e.g., speeding), or withdrawing from family and/or friends. Altogether, this qualitative study thus highlighted a range of coping strategies and a number of negative effects of trauma work, thereby broadening previous VT/CF research findings.

A further qualitative study by Iliffe and Steed (2000) made use of semi-structured interviews with domestic violence counsellors. They reported VT like changes in schemas including, feeling less safe, having more difficulties trusting and generally having a changed world view of issues related to power (e.g. increased sensitivity to gender power issues). Moreover, the counsellors described symptoms, such as anger, shock and horror during sessions, on top of CF-like physical reactions/ symptoms after sessions (e.g., sleep disturbances). This study thus supported Steed and Downing's (1998) study above, thereby suggesting that trauma work can result in both schema like VT effects, as well as CF like symptoms. Both studies thus contradict a lot of quantitative findings, which have mainly supported the existence of CF, although not VT as an effect of trauma work.

Ortlepp and Friedman's (2002) qualitative part of their analysis of CF/VT in part time trauma counsellors further supported the existence of CF and VT-like changes. The

counsellors did in fact report long lasting changes in cognitive schema in regards to their world view of self and others (e.g., more aware of own and others' vulnerability) and their affect tolerance (e.g., heightened sensitivity to suffering). CF-like symptoms, including increased emotional arousal and dreaming of the incident, was on the other hand only reported to last for up to a week, thereby perhaps suggesting Acute Stress Syndrome like changes rather than lasting PTSD or CF like changes. Nevertheless, yet again these qualitative findings contradicted most quantitative research, and rather suggested that trauma work can result in both VT and CF.

1.5.2 Summary of CF/VT research

This review has shown that most quantitative research has found a non-existent relationship between VT and trauma counselling, whilst qualitative studies have reported both CF and VT. More specifically, qualitative studies have found accounts of VT including changes in schemas (e.g., from feeling like the world is safe to feeling like it is dangerous), and CF like symptoms such as increased emotional arousal and sleep disturbances. Quantitative studies have on the other hand, only provided partial support for the existence of some level of CF (although this prevalence seems to be less than what was initially put forward) and little evidence for the existence of VT. The qualitative studies therefore starkly contrast quantitative findings, which mostly lack support for VT. This thus brings into question the research methods and specifically the questionnaires used to measure VT (i.e., The TSI belief scale). It is uncertain whether this questionnaire is sensitive enough in detecting VT.

Moreover, the CF empirical literature has shown that many areas of the research remains inconsistent and inconclusive. In particular, the most disputed factor is whether therapist's own trauma is associated with the development of CF. This inconclusive finding may be due to not assessing the potential link between own current woundedness (i.e., the extent to which practitioners have come to terms with their trauma) and CF. Moreover, further studies are needed to confirm whether differing coping strategies and social support are related to the development of CF. Such inconclusive and inconsistent findings therefore suggest that CF merits further investigation. Finally, most of the CF/VT research has largely focused upon American and Australian therapists working solely with traumatised, often sexually abused clients, despite newer findings suggesting that more general therapists can also suffer from STS (Kadambi & Truscott, 2004). The potential level of CF in British clinical and counselling psychologists, with a more general case load thus remains unknown and therefore warrants further research.

2. Positive effects of caring; are clinicians' client work personally growth enhancing?

2. Personal growth and stress-related growth

2.1 A historical look at stress-related growth and personal growth

"But we also boast in our sufferings, knowing that suffering produces endurance, and endurance produces character, and character produces hope, and hope does not disappoint us." (Romans 5:5)

Stress does not have to cause psychological difficulties. In fact, a recent rush of psychological research suggests that there can be personal gain, in other words, personal growth following adversity and suffering (e.g., see Zoellner and Maercker, 2006 for a review). For example, some survivors of traumatic events have reported increased personal strength, self-reliance and positive changes in their personal relationships (e.g. Linley & Joseph, 2004). And this is certainly not a new idea; such stress-related growth has been recognised since ancient times through various writings in philosophy (e.g., Kierkegaard, 1983; Nietzsche, 1955) and religion (e.g., see extract from the bible above). Even everyday sayings such as the commonly known "what does not kill you only makes you stronger" (Nietzche, 1955) supports this idea. Despite this well known general knowledge on the matter, surprisingly little attention has been devoted to the concept of stress related growth in psychology. In particular, it is only in the last few years, that there has been an increase in growth related psychology research. In this period there has been a growth in positive related psychology in general, with psychological theories such as Cognitive Behavioural Therapy (CBT) now developing therapies that focus on

increasing strength, resilience (e.g., Padesky & Mooney, 2006) and self compassion (e.g., Gilbert & Proctor, 2006) in clients, in order to combat psychological difficulties.

Stress-related growth in psychology has however mostly gone unexamined until a few years ago. This is probably largely due to psychology having adapted the medical model of disease, meaning that the focus has remained on psychopathology, rather than resilience or psychological strength and growth. This view of psychology only emphasising disease remains, however, alien to counselling psychology; a discipline that also stresses the importance of how individuals' can maximise their health, as well as areas of growth.

Despite this general lack of psychological focus on the matter, there have nevertheless been a few highly noteworthy contributors towards the psychology of personal growth and stress related growth. This has mainly come from existential psychologists. For example, Rogers (e.g., 1961) was one of the first psychological researchers to propose that we should focus less of our research efforts on psychopathology and more on healthy or "fully functioning" persons. In fact, Rogers' entire client-centered therapy was based on the philosophy that humans have an inherent drive to become "fully functioning", meaning to actualize their potential. Moreover, Frankl (1964; 1961) did not see psychological despair as the direct product of experiencing difficult situations. Instead, he suggested that despair was a consequence of experiencing suffering that was seen as having no meaning (Frankl, 1964). And indeed, having himself been one of the only survivors of his family in a Nazi concentration camps during the second world war,

Frankel was highly qualified for commenting on how his and other prisoners meaning making had kept them going, despite the horrendous life circumstances. Such meaning making, Frankl later claimed, can only occur through confronting what he called "primordial facts" of existence. By these he meant that humans can only find meaning through confronting their guilt, suffering and impermanence, and thereby grow and develop as individuals.

Others in existential psychology have further elaborated on how growth, or often what they call individuation or self actualization (e.g., Maslow, 1970) occurs if our inherent life difficulties are faced up to. For example, Sanford (1977) stated; "Individuation is a work, a life opus, a task that calls upon not avoiding life's difficulties and dangers, but to perceive the meaning in the pattern of events that form our lives.....It does not necessarily mean happiness, but growth. It is often painful. It is not getting out of life what we think we want, but it is the development and the purification of the soul" (Sanford, 1977, p.20). Shoestrom (1976), the originator of the Personal Orientation Inventory, the scale that measures the concept of self actualization, even went as far as suggesting that suffering is necessary to achieve growth; " most people who become self-actualizing do so as a result of a struggle to overcome problems in their lives" (p.311). Even Jung (1951), through his alchemical models, suggested that negative experiences are necessary for a change towards something positive can occur. Altogether, these historical accounts show that an emphasis on personal growth and stress-related growth have long existed among existentially orientated psychologists, despite the lack of psychological empirical research on this areas.

2.2 What is stress-related growth and is it really a valid concept?

Posttraumatic growth has been defined as "the subjective experience of positive psychological change reported by an individual as a result of the struggle with trauma" (Zoellener and Maercker, 2006, p. 628). These positive outcomes following stressful experiences occurs either as direct result of the event itself, or through the effort of trying to cope with the experience. For example, going through the traumatic experience of the sudden death of one's partner may itself lead to a discovery of having more personal strength, such as being able to handle more things thereafter, compared to what he/she was able to deal with prior to the incident (Davis, Nolen-Hoeksema & Larson, 1998). Various terms have been suggested to explain this phenomenon, for example, adversarial growth (Linley and Joseph, 2004), stress-related growth (Park, Cohen, & Murch, 1996), heightened existential awareness (Yalom & Lieberman, 1991), post-traumatic growth (PTG: Tedeschi & Colhoun, 1996) and many others terms have been put forward (see Joseph and Linley, 2006 for a review). Perhaps the best known term however, is the latter; post-traumatic growth (PTG), which has been defined as "the experience of significant positive change arising from the struggle with a major life crisis" (Calhoun, Cann, Tedeschi, and McMillan, 2000, p. 521). It is thus suggested that the individual concerned develops beyond how they were prior to the stressful incident (i.e. better themselves). As there is no agreement on what term best describes this phenomenon, these differing terms will be used interchangeably throughout this doctorate to describe the same phenomenon. However, mostly, the abbreviated version of posttraumatic growth; i.e., PTG will be used to describe the occurrence of growth as a whole.

Three broad areas of growth following stressful life events have been described throughout the literature (Joseph and Linley, 2006). These are enhancements in relationships (e.g. appreciate and value family and friends more), changes in self-perception (e.g. see self as having a greater sense of wisdom, strength resilience and self-acceptance), and changes in life philosophy (e.g. appreciate each day more and perhaps experience changes in spiritual beliefs) (e.g. Calhoun and Tedechi, 1998, 2006; Shaw, Joseph & Linley, 2005). These three areas are assessed by recent measurement scales of growth (e.g., the Posttraumatic Growth Inventory (PTGI), Tedeschi & Coloun, 1996). It to date however remains uncertain whether these three suggested dimensions of growth reflect the true structure of growth. In fact, some have proposed that these factors are highly related and that growth rather involves one higher order factor (Joseph, Linley and Andrews, Harris, Howle, Woodward, & Shevlin, 2005). In addition, there are other concerns in relation to the measurement of the phenomenon. For example, a variety of scales have been designed to measure growth, yet there is sparse evidence for their inter-correlations (Joseph et al., 2005). This may suggest that they are not measuring the same concept of personal growth, thereby putting the validity of these scales into question. Thus, further theory development, research and scale development is needed to fully get an understanding of the concept of stress-related growth. Meanwhile, the whole growth concept is thus mostly taken into account (instead of the three individual dimensions of growth).

Despite these clear weaknesses in our understanding of stress related growth, many studies have found that stressful events can be followed by growth. For example, a

number of studies have reported growth following a wide variety of differing direct stressful situations including: cancer (e.g. Weiss, 2002); HIV and AIDS (Siegel & Schrimshaw, 2000); accidents and disasters (e.g., Joseph, William and Yule, 1993); bereavement (Polatinsky and Esprey, 2000; Davis, Noel-Hoekesama, and Larson, 1998); sexual abuse (e.g., Woodward and Joseph, 2003); illness (e.g. Maercker and Langner, 2001) and war and conflict (e.g. Waysman, Schwarzwald, and Salomon, 2001) (see Linley and Joseph, 2004,or Zoellner and Maerker, 2006 for a fuller review).

Altogether, these studies advocate that some sort of stress-related growth is evident after experiencing many differing traumas. Thus, previous debates about the validity of the stress-related growth concept, with some suggesting it is nothing more than a positive illusion, seem to be dismissed. Nevertheless, the exact structure of the PTG concept remains unclear as stated above.

This unclear structure of PTG may be due to seeing the phenomenon as adaptive only. In their recent review of post-traumatic growth literature, Zoellner and Maerker (2006) put forward that stress related growth can *at times* be maladaptive or even an avoidance strategy, whereas other times it can be adaptive. Their conclusion is based on their review which found no conclusive relationship between PTG and adjustment. In fact, many studies have found a positive relationship between PTG and psychological distress, whereas other studies, particularly the long term studies, found a mild positive relationship between adjustment and PTG (e.g. see Zoellner and Maerker, 2006). On the basis of such observations, they therefore proposed that apart from a functional side to

PTG, there also may be a possible maladaptive side to it, an illusionary, avoiding side. And indeed, some preliminary evidence for this two component model of stress-related growth has been supported. For example, Widows, Jacobsen, Booth-Jones, & Fields (2005) found that cancer patients undergoing bone marrow transplantation made greater use of both positive coping mechanisms (i.e., positive reinterpretation) and avoidant coping mechanisms, and that this was associated with greater PTG in the post-transplant period. Also, Maerker (1998, 1999) found that PTG was predicted by constructive coping strategies (reappraisal; problem-focused coping and mastery) and by distractive, avoidant coping strategies (denial/palliation and emotion focused). These findings thus highlight the possibility of co-existing adaptive and maladaptive processes in PTG. These potential two differing sides to PTG may therefore contribute towards the inconsistent findings of whether PTG is associated with adjustment or psychological difficulties.

Alternatively, PTG may be an independent construct that is not necessarily associated with adjustment, but may in fact co-exist with distress (Tedeschi and Calhoun, 2006). Further studies are thus needed to confirm whether PTG could be a two-factor model, consisting of both a constructive and a maladaptive side to PTG. It is thus important that future studies incorporate both adaptive and maladaptive predictors of PTG. Altogether, the above studies nevertheless suggest that some individuals do indeed experience at least some positive changes after stressful events, and not only psychological distress.

2.3 Theoretical explanations for how PTG occurs

A variety of theoretical explanations have been put forward to account for how stress related growth or PTG occurs. Some of the best known theoretical accounts of PTG are for example; changes in schemas/assumptions (see part 2.3.1), rumination/cognitive processing (see part 2.3.2), coping processes and cognitive appraisals (see part 2.3.3) and cultural factors (see part 2.3.4). To get a better understanding of how PTG occurs, the potential relationship between these factors/processes and PTG will therefore be explored below.

2.3.1 Changes in schemas/assumptions

Caloumn and Tedeschi's (1998) functional descriptive model of posttraumatic growth (Tedeschi & Calhoun, 1996; 2004) is the most comprehensive theoretical framework of growth suggested to date. The model stresses the importance of appraisal processes (e.g., Janoff-Bulman, 1992; and Beck, Rush, Shaw and Emery, 1979) and suggests that traumatic incidents can shatter prior schemas (i.e. core beliefs and assumptions about self, others and the world), which in turn leads to a ruminative activity, as a way of trying to make sense of what has happened. This initial ruminative activity is further viewed as automatic and often distressing and a way in which the individual can rebuild the pre-trauma schema.

In this way this theory suggests that changes in schemas occur, as well as extensive rumination as a way of making sense of their experiences, which in turn can lead to an outcome of posttraumatic growth if adequate resources are available (e.g. social support).

Such changes in schemas in relation to PTG have however mostly gone unstudied, and those studies that have researched this potential link have found no such association between shattered assumptions and PTG. For example, Park and Fenster's (2004) longitudinal study of college students found no relationship between changes in world views and PTG. This finding corresponds to similar VT findings, which have mostly neither found any association between changes in schemas and trauma work, as has been suggested by Constructive Self Development Theory (CSDT) (McCann and Pearlman, 1990). To date, changes in worldviews thus appear to be unrelated to both VT and PTG.

2.3.2 Rumination/cognitive processing

Rumination and cognitive processing as an exploratory factor of PTG has fared somewhat better than the supposed schematic connection. Tedeschi & Calhoun (1996; 2004) and Calhoun and Tedeschi (1998; 2006) have specifically suggested that "growth does not occur as a direct result of trauma. It is the individual's *struggle* with the new reality in the aftermath of trauma that is the crucial factor in determining the extent to which posttraumatic growth occurs" (Tedeschi and Calhoun, 2004, p.5). According to them, this struggle may take some time, and this distress itself keeps the cognitive processing going. And indeed, several studies have found that cognitive processing, such as having intrusive thoughts and avoidant imagery of the traumatic experience is related to more stress related growth (e.g., Calhoun, Cann, Tedeschi, & McMillan, 2000; Park & Fenster, 2004). These findings thus propose that cognitive processing may be one of the processes by which PTG may occur.

2.3.3 Coping processes and cognitive appraisals

Other cognitive mechanisms such as coping processes and cognitive appraisals have also been suggested to account for how stress related growth or PTG occurs (e.g., Park and Fenster, 2004). Accounts supporting this view are mainly based on the framework of Lazarus and Folkman (1984). They have put forward that personal resources (e.g., social support), cognitive appraisals (e.g., seeing trauma as a threat), and coping processes (e.g., positive reappraisal) influence the outcomes of stressful encounters. The personal resources and cognitive appraisals can in turn influence outcomes both directly (e.g., threat appraisal may be directly associated with PTG) and indirectly (e.g., through the coping mechanisms used). Research supporting this model has found that cognitive appraisals such as threat (Armeli, Gunhert, and Cohen, 2001) and challenge appraisal (Armeli et al., 2001; Park and Fenster, 2004) are related to higher levels of PTG. Moreover, a number of studies have found coping strategies such as positive reappraisal and acceptance coping to be associated with or even predict stress- related growth (e.g., Park et al., 1996; Armeli et al., 2001). Thus, to date, it appears that coping processes and cognitive appraisals may be related to PTG following trauma exposure, although further studies are needed to confirm this link.

2.3.4 Socio-cultural factors

Finally, Calhoun and Tedeschi (2006) have also recently added socio-cultural factors to their model of PTG, as another potential influential factor on the development of PTG. The influence of proximate cultural influence, for example, was assessed by Weiss (2004) in a sample of women suffering from breast cancer and their husbands. He found

that the women and the husbands who answered "yes" to knowing somebody other than their spouse who "had experienced benefits from their (traumatic) experience" (p.265) were more likely to report PTG compared to those who did not report knowing such a person. Although only a preliminary finding, this may nevertheless suggest that socio-cultural factors such as views of family and friends on stress-related growth may actually influence the degree to which an individual will experience PTG. The connection between socio-cultural factors and PTG thus warrants further research.

2.4 Evidence of Vicarious posttraumatic growth (VPTG); Is it a valid concept?

It has been shown above that PTG can occur following experience of direct trauma or particularly stressful events. Following such discoveries some recent research has also looked into whether indirect or vicarious exposure to trauma can cause PTG. For example, Linley, Joseph, Cooper, Harris, and Mayer (2003) surveyed the positive and negative changes following vicarious exposure to the 9/11 terrorist attacks in America. They found that British individuals who had followed the incident through television viewing (i.e., vicariously) and perceived the incidents to be the work of religious fanatics, or an attack on their own values and beliefs, reported more positive changes. Their total mean PTGI score (11.93; SD 14.69) was however substantially lower than PTG reported in other samples who have experienced a direct trauma (e.g., mean PTGI score=83.47 in female parents having experienced the death of their child; Polatinsky and Esprey, 2000). The latter trauma of loosing a child is however considered by many as one of the most traumatic experiences one can have, and as such the incident would be expected to be

associated with more PTG. For as Tedeschi and Coloun (2004) have implied from their theory; it is "the individual's struggle with the new reality of the aftermath of trauma that is crucial in determining the extent to which posttraumatic growth occurs" (p. 5). A traumatic event that is perceived as more stressful, such as for example losing a child, would thus be expected to lead to more of a struggle and in turn also more PTG.

Findings of higher PTG scores from extra stressful incidents, however, does not necessarily mean that PTG can only occur after direct exposure to trauma. In fact, Weiss (2002) found that women experiencing breast cancer reported a mean PTGI score of 60.21 (SD 18.81), whereas their husbands, who vicariously experienced this trauma also reported high mean PTGI scores of 46.00 (SD 22.83). Some may argue that the husbands themselves were then experiencing a trauma. Nevertheless, other studies have also reported vicarious PTG (VPTG). For example, Barbero & Linley (2006) found that VPTG and positive changes following the Madrid bombings in 2004 were significantly associated with extraversion in Madrid residents that had not been involved with the bombings themselves. However, as the 13 PTGI short form (Tedeschi & Calhoun, 1996) version was used in this study, their mean PTG score cannot be compared with the other PTG studies, which have mainly made use of the 21 item PTGI (Tedeschi & Calhoun, 1996) or other scales such as for example the Changes in Outlook Questionnaire (CiOQ; Joseph, William & Yule, 1993). Still, further studies have found reported VPTG in members of the church who have to deal with the bereavement and suffering of others (Profitt, Calhoun, Tedeschi, & Cann, 2002), in funeral directors (Linley & Joseph, 2005) and in disaster response workers (Linley & Joseph, 2006). It does then indeed appear that

some amount of VPTG takes place for many who come in contact with the suffering of others. Altogether this research therefore suggests that PTG can occur vicariously, although it does appear to be adversial growth on a lesser extent to what is reported by individuals who have experienced direct, very stressful experiences.

2.5 Research findings of VPTG in psychologists

Many anecdotal references have been made about the potential positive effects of therapy work, particularly of trauma work. The pioneers on vicarious trauma, McCann and Pearlman (1990) for example, suggested that vicarious traumatisation reactions in trauma therapists could "be an area of potential growth for the helper" (p.146), particularly if the vicarious trauma concerned central beliefs or schemas of the therapist.

Little research has however been done on this area. One of the early noteworthy contributions on the matter came from Schauben and Frazier (1995). Although, their study was mainly set out to study the negative effects of trauma works, the qualitative part also concerned potential positive effects of working as a sexual violence victim counsellor. In fact, 45 % of the sample reported similar enjoyable aspects of their work, including how "their own growth and change was a positive aspect of working with survivors" (p.58). Schauben and Frazier (1995) further stated that this growth could, for example, happen as "the counsellors felt that they learned about themselves through their reactions to their clients and that it helped them to heal from their own past victimisation" (58). Ortlepp & Friedman's (2002) part time trauma counsellors further reported similar areas of growth from their work, including heightened awareness of the importance of

key relationships with family and friends (30%), and a greater sense of needing to appreciate life more (23%). In addition, 13% of the counsellors specifically reported that they thought that their work was associated with positive personal growth outcomes.

Arnold, Caloun, Tedeschi, & Cann's (2005) open-ended qualitative interviews of 21 trauma therapists also supported the case for such personal growth following trauma therapy work. In fact, all the participants described having positive responses to their trauma work, and 76% of them reported that "working with trauma survivors had a significant impact on their spirituality, 52% reported gaining an appreciation for their own good fortune in life, and 52 % reported gaining a sense of optimism about life" (p.239). Steed & Downing (1998) further reported positive and negative effects of trauma work. In particular, positive effects included personal growth related to seeing self as a) stronger e.g., "I see myself as being much more adjustable and flexible", and "I've become really clear about what I want to do with my life, and my own identity"; b) others as stronger more/resilient; e.g., "I've learnt how strong and resilient people are, and how much inner resources and strengths people have" and, c) having clarified values/attitudes/spirituality; "I spend a lot more time by myself, things like going for walks, and trying to make sense of life, - spending more time thinking about what the whole point of everything is". Similar growth content was thus found in these studies of VPTG, as found in studies reporting PTG from a primary trauma. Steed and Downing (1998) concluded that these accounts of growth and positive changes in meaning/spirituality and view of self and others suggested that the concept of vicarious trauma (VT) in therapists does not alone explain the full effects of trauma work. This is because VT does not account for these positive effects, and as such VT is an inadequate

conceptual framework for explaining the full effects of trauma work. An additional suggested framework such as Vicarious PTG (VPTG) in trauma therapists may thus be warranted to get a fuller, more holistic understanding of the potential effects of trauma work on trauma therapists.

Altogether these qualitative studies reporting personal growth following trauma therapy thus support the occurrence of VPTG. In fact, all the studies that have set out to look at potential effects of trauma work, have indeed found both positive effects, as those stated above, as well as negative effects, thereby suggesting that such work can result in both stress and personal growth, rather than stress *or* growth. Few quantitative studies have however tested out whether these findings can be generalised across larger sample sizes. One such study by Linley, Joseph & Loumidis (2005) examined the positive and negative effects of trauma work on 85 international trauma therapists. They replicated the qualitative findings of both positive and negative changes following trauma work. In addition, less negative changes and more positive changes following trauma work was associated with a higher sense of coherence (SOC). A further elaboration on this latter association will be described below in the factors associated with growth in therapists section.

The studies reviewed above have thus also found positive effects of trauma work. Questions do, however, remain as to whether such VPTG can occur solely from trauma therapy work, or whether it can also take place from working with others who may have mental health difficulties, but who have not necessarily experienced a trauma according to the DSM-IV. Radeke and Mahoney (2000) found that psychotherapeutically working

psychologists reported more emotional exhaustion (i.e., an element of burnout), as well as more positive changes following their work (e.g., feeling wiser and more experienced about life) compared to research psychologists. Again, this therefore proposed that psychologists do not have to work with individuals that have experienced a trauma (according to the DSM) to be able to experience growth or stress, but rather that clients' stressful experiences in general (e.g., anxiety, losses) that psychologists encounter all the time may also potentially affect the psychologist both positively and negatively.

More recently, Linley & Joseph (2007) found support for this latter idea. Their research of 156 therapists explored both the positive (i.e., personal growth, compassions satisfaction) and negative aspects (i.e., CF, burnout) of therapists' well being. The mean PTG score (from the PTGI) reported for the group was 64.42 (SD; 20.08), which is a higher mean PTG score than reported by many following a primary trauma, including breast cancer (M= 60.21; SD=18.81, Weiss, 2002) and accident/assault (M= 55.43; SD=18.14, Snape, 1997). Negative effects of therapy work, including burnout (M=18.56; SD=4.68) and CF (M= 10.27; SD=4.8) was also found using the Professional Quality of Life Scales (ProQOL; Stamm, 2002). This therefore implies that therapy work is indeed associated with not only negative effects, but also personal growth, or VPTG. Moreover, VPTG or personal growth is not necessarily specific to the aftermath of a primary trauma. Instead, such positive effects can also occur vicariously, even when therapists work with a variety of clients, that may not necessarily have experienced a primary trauma themselves (according to the DSM-IV) but may rather be struggling with other stressful

events, including losses, anxiety etc. Further studies are however needed to confirm these findings.

2.5.1 Factors associated with VPTG in psychologists/therapists

Again, as noted above, few studies have explored the potential positive effects of therapy on the therapist. The current part will thus first review one study which has examined individual and work factors associated with positive effects of therapy work. Second, there will be a brief review of the general PTG literature, to find other potential factors that could also be associated with personal growth in therapists.

Linley & Joseph (2007) recently found that having a transpersonal/humanistic counselling orientation (i.e., their proximal culture); longer lifetime therapy work; and more hours per week counselling clients, all correlated with therapists' personal growth. In addition, those therapists who had experienced a personal trauma and/or who had received personal therapy, as well as those who were receiving clinical supervision, were significantly more likely to score higher on the PTGI. Social support was on the other hand (as measured by the Crisis Support Scale; Joseph, Williams, & Yule, 1993) not found to predict PTG. These findings highlight some preliminary factors that appear to be associated with VPTG or personal growth in therapists. Further studies are however needed to confirm these findings. It is also uncertain whether these factors would be associated with growth in psychologists, who may not solely be working as therapists, but may also have other job commitments (e.g., including managerial commitments, teaching etc). Moreover, additional factors that have not as yet been studied in this context may

also prove to predict, or be associated with VPTG in therapists/psychologists. Such potential factors will therefore now be explored.

2.5.2 Additional factors that may be associated with personal growth in psychologists

The fist additional factor that may be associated with VPTG in therapists, that has been consistently shown to be associated with PTG following primary trauma, is coping. For example, PTG theorists such as Calhoun & Tedeschi (1998) and Janoff-Bullman (1992) hold that positive reappraisal coping (e.g., to look for something good in what has happened) is critical and a pre-requisite for personal growth to occur. This idea has now been supported by some preliminary studies of PTG following primary trauma. Park et al., (1996) for example, found that reported personal growth significantly correlated with positive-reinterpretation in a college sample ($r=0.55$, $p<0.01$). In fact positive reinterpretation was found to be a significant predictor of growth ($b=0.42$, $p<0.001$). More recently, Sears, Stanton & Danoff-Burg (2003) found that positive reappraisal coping at 3 months, predicted PTG at 12 months thereafter in a sample of females with breast cancer. Findings such as these suggest therefore, that positive re-appraisal may indeed be needed for PTG to occur. This may also be the case for reported VPTG or personal growth in psychologists, and as such needs to be assessed.

An additional coping strategy from the PTG literature that may also be associated with VPTG in psychologists is acceptance coping (e.g. attempting to accept the reality of the fact that it has happened). For example, in his college sample, Park et al (1996) found

acceptance coping to be significantly correlated with reported PTG ($r=.36$, $p<0.01$). Along with positive re-interpretation, acceptance coping was also found to be a significant predictor of growth ($b=.19$, $p<0.05$). Armeli et al., (2001) further found that personal growth was highest in those individuals that reported having experienced highly stressful events, as well as those who used coping strategies such as positive reappraisal and acceptance coping. Other additional "positive" coping strategies that have been found to be associated with PTG are religious coping (e.g. Pargament, Smith, Koenig, & Perez, 1998; 2000), problem focused coping (e.g., Maercker & Langer, 2001; Koening, Larson and Larson, 2001) and social support and venting coping (Park & Fenster, 2004). These findings therefore propose that a variety of positive coping strategies appear to be related to stress related growth from primary traumas that also may be related to the development of VPTG in psychologists.

However, negative, or more avoidant coping has also been found to be associated with PTG. For example, Weiss' (2004) longitudinal study of cancer clients, found that greater use of both positive reinterpretation *and* avoidance coping prior to having operations was associated with PTG after their operations. Also, in a parent sample who had children treated for leukaemia, parental anxiety and cognitive avoidance of their children's cancer related issues were found to be related to PTG after the end of treatment (Best, Straisand, Catonia, & Kazaly, 2001). Moreover, Maerker (1998, 1999) found that PTG was predicted by constructive coping strategies (reappraisal, problem-focused coping and mastery) and by distractive, avoidant coping strategies (denial/palliation and emotion focused coping). These findings thus further highlight the possibility of co-existing

adaptive and maladaptive processes in PTG. Such "negative" coping strategies in relation to VPTG thus also need to be explored in future research.

A final factor found in the PTG literature that may also be related to VPTG in psychologists, is their appraisals of own stress. For as Tedeschi and Calhoun (2004) suggest "growth does not occur as a direct result of trauma. It is the individual's struggle with the new reality in the aftermath of trauma that is crucial in determining the extent to which posttraumatic growth occurs" (p. 5). For example, many studies of PTG following primary trauma have found cognitive appraisal of the trauma, such as control (Park et al., 1996), harm (Park et al., 1996; Tedeschi and Calhoun, 1996) and threat (e.g., Armeli et al., 2001) to be associated with PTG.

It remains, however, uncertain as to how the cognitive appraisal of trauma could be related to VPTG in psychologists. One would expect that if the client touched on similar issues to those of the psychologist, this could bring up more distress (e.g., CF), if he/she had not come to term with own issues. More CF would then in turn be hypothesised to be associated with VPTG in the psychologist concerned. This would be in line with a recent study that indicated that own trauma was associated with and even predicted VPTG in therapists (Joseph & Linley, 2007). In addition, it would be in line with Cognitive Behavioural Theories and practices, which suggest that emotions stem from *the meaning* individuals give to events (e.g., Beck, Rush, Shaw and Emery, 1979). This may also mean that the perception of own stressful incidents/trauma could be associated with VPTG.

2.6 Summary of personal growth following therapy

This chapter has noted that traumatic experiences do not have to lead to distress, but can also lead to posttraumatic growth. No studies have however evaluated whether such PTG can occur vicariously through working therapeutically as a clinical or counselling psychologist. Also, the correlates, or even predictors of such VPTG in psychologists remains unknown. A variety of qualitative studies and a couple of quantitative studies have nevertheless put forward that some type of personal growth does occur from therapists' client work. Further studies assessing VPTG following psychologists' therapy work are thus warranted.

3. Trauma and woundedness in psychologists; stress inducing and/or a trigger for personal growth?

The literature review has shown that CF in therapists has most consistently been found to be associated with one's own trauma, more than any other factor. Also, one such link between one's own trauma and VPTG in therapists has been reported. It thus appears that *what links stress and growth is actually therapists' own trauma.* This leads to questions about why this potential link occurs and also whether the association between CF, growth and own trauma in therapists is actually as strong and clear cut as may have previously been suggested.

In terms of why a link between stress and one's own trauma may occur, some studies have suggested that health professionals themselves have experienced many stressful experiences and are therefore attracted to helping others in similar situations (e.g., Malan, 1979). This however, has been argued to mean that they themselves may be more susceptible to work related stress, as their clients may remind them about their own issue, and the therapists may then be more effected by the clients stress (e.g., Pearlman and McCann, 1995).

However, before exploring this potential link between therapists' own trauma, CF and VPTG, there is a need to get a fuller understanding of what constitutes a trauma. Hence, first, an overview of the differing definitions of trauma and woundedness will be looked at. Thereafter, the overall link between trauma/woundedness, stress and VPTG will be discussed in relation to the wounded healer paradigm.

3.1 Definitions of trauma and emotional woundedness

3.1.1 Definition of a trauma

Throughout history there have been disagreements over what constitutes a trauma. Historically, the term trauma derives from the Greek word for "wound" and was first used in a professional sense at the start of the twentieth century to describe mental shock (Brewin, 2003). In his book; 'Beyond the Pleasure Principle', Freud (1920) similarly saw trauma as a type of a wound and stated that "we describe as "traumatic" any excitations from outside, which are powerful enough to break through the protective shield." This idea was therefore based upon a preconception that the ego has developed a protective structure that can be broken down, or penetrated. Freud further emphasised the importance of the "psychological reality", that is the subjective experience of emotions and the unconscious aspects of trauma, rather than the objective experience itself; "In traumatic neuroses the operative cause of illness is not the triffeling psychological injury, but the effects of the fright- *the psychical trauma*" (Breuer and Freud, 1985; p.5).

The subjective side of trauma being psychic or mental is today emphasised in the Diagnostic and Statistical Manual of Mental Disorder's (DSM-IV-TR; American Psychiatric Association, 2000) definition of a traumatic stressor; "the person's response to the fear must involve intense *fear, helplessness, or horror* (or in children the response must involve disorganised or agitated behaviour) (Criterion A2)" (p. 463). In addition, APA has defined a traumatic stressor, also referring to the objective side of the experience, stressing that it needs to entail; "direct personal experience of an event that involves actual or threatened death or serious injury, or other threat 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 close family member or other close associate (Criterion A1)" (p. 463; APA; 2000).

However, such a definition of a trauma is very broad, and so it remains open to interpretation of what constitutes a trauma for each individual (Rojas and Pappagallo, 2004). In other words, the perception of what a trauma is can differ radically from person to person. This creates major problems in predicting who will suffer from difficulties post trauma experience. Moreover, even though an individual may see an experience as involving threat and feel fear, helplessness and /or horror at the time of trauma (i.e., meaning it is a trauma according to DSM-IV), this does not necessarily mean that the individual will develop post difficulties, such as for example, posttraumatic stress disorder (PTSD; i.e., including symptoms such as intrusion, avoidance and hypervigilance). In fact, recent research suggests that only a small percentage of same trauma exposed individuals actually develop the diagnosis, meaning that PTSD is actually an abnormal reaction to a traumatic situation (see Brewin, 2003).

For the very same reasons as just explained, the use of trauma as a predictor for CF is therefore unsatisfactory. As seen in Chapter 2, studies having assessed this link, have in fact found mixed results, with some research suggesting that own trauma in therapists is associated with CF (e.g. Way et al. 2004), whilst others have found no such link between stress and own trauma in therapists (Benatar, 2000). These studies have, however, merely

taken account as to whether therapists have themselves experienced a trauma, and not whether they still feel stressed when thinking about it, or feel like they have come to terms with the trauma itself (i.e. the secondary appraisal). In addition, only traumas according to the DSM-IV have been typically looked at, whereas it is well known that individuals can also be hurt/stressed by other factors, including losses, mental health, neglect etc, but that may not constitute a trauma per se. A further understanding of whether there is actually an association between therapist's own woundedness and stress/growth, rather than a direct link between trauma and stress/growth is thus needed.

3.1.2 Definition of emotional woundedness

To be emotionally wounded has been defined as to be emotionally "afflicted, distressed, or hurt" (Ward, 2007). Emotional woundedness thus constitutes a cognitive appraisal of how much an individual still feels subjectively hurt, afflicted and distressed by one or more stressful events/traumas anytime after it has happened. Unlike a trauma, which involves how an individual feels about a particularly stressful situation at the time it occurs (i.e. must involve intense *fear, helplessness, or horror;* DSM-IV-TR; APA, 2000), to be emotionally wounded, is rather about how the individual feels about a stressful situation anytime thereafter (e.g. whether he/she has come to terms with the experience; how distressing it still is to think about the stressful incident/trauma and how well one subjectively feels one can cope with it).

The term emotional woundedness is perhaps best known in relation to the notion of the wounded healer (e.g., Sedgwick, 1994). This idea of the wounded healer concerns how

some personal experience of suffering may be useful for helping professionals in better understanding their clients (Sedgwick, 1994). The wounded healer paradigm will be further explored below.

3.3 Woundedness/ troubled backgrounds in psychologists

It is to date, however, uncertain whether the term woundedness is relevant to the profession of psychology. It is therefore important to establish whether psychologists actually have more troubled backgrounds compared to other professions (thereby partly explaining the heightened stress level in such caring professions as seen in chapter 1).

Scarce research has been done on psychologist's personal issues. This may be due to psychologists feeling that revealing one's own vulnerability would be a taboo. This view probably often dates back to a sense that a psychologist's own unresolved personal needs may prevent him/her from focusing adequately on the client, or even exploit the therapeutic relationship to the detriment of the client (Guy, 1987). The therapists should thus remain a "blank screen". It has to be noted however that 'the blank screen' (a 'neutral' therapist stance in psychoanalysis, that has been argued to have many self-protective counter countertranference components; Freud, 1913), is firmly rooted in a traditionally Freudian psychoanalytic position. Clinical and counselling psychologists with other theoretical orientations, (e.g., CBT) may not see the need to stay so 'removed' from their clients, but rather offer an active, collaborative relationship as informed by CBT theorists (e.g., Beck, Rush, Shaw and Emery, 1979).

Still, other pressures on psychologists from professional codes of conduct, from for example, the British Psychological Society (BPS) may also make psychologists hesitant in disclosing their own current, or even past vulnerability. For example, point 2.4 in the BPS's professional code of conduct (2006) states the following: 'Psychologists should (i) Monitor their own personal and professional lifestyle in order to remain alert to signs of impairment; (ii) Seek professional consultation or assistance when they become aware of health-related or other personal problems that may impair their own professional competence; and (iii) Refrain from practice when their professional competence is seriously impaired'. Even though their personal experiences may not necessarily impede on their clinical work, codes of conduct such as these may mean that psychologists often refrain from talking openly about any potential personal psychological difficulties, in case they will be judged as clinically incompetent.

Despite this taboo in revealing own vulnerability, a variety of comments have nevertheless been made in regards to the connection between caring professions in general and own childhood difficulties, including calling the phenomenon "the helping profession syndrome" (Malan, 1979). This refers to the way in which the professional *"compulsively gives to others what he would like to have for himself"* (Malan, 1979, p.139). Indeed, some suggest that therapists' career choice is often motivated by a desire for self-healing (Goldberg, 1986; Kottler, 2003; Guy, 1987). Bowlby (1977) similarly describes "*compulsive care giving*", a pattern of behaviours displayed by individuals who's early attachments have been unsatisfactory: *" the typical childhood experience of such people is to have a parent who...was unable to care for the child but instead*

welcomed being cared for...the person who develops in this way has found that the only affectional bond available is the one in which he must always be the care giver, and that the only care he can get himself is the care he gives himself" (p 76). Both Henry (1966) and Rascusin, Abramowitz, & Winte (1981) support this notion and report that psychotherapists have often described their primary role in their family of origin as being "a caregiver". Accounts such as these propose that some therapists may have come into the profession because of a motivation to care for others, in a way that they themselves never were. It is important to note however, that not all therapeutically involved psychologists/therapists have been motivated to enter their career due to childhood difficulties, but may have a variety of other motivations to choose this occupation (e.g., wanting to help others because it makes them feel good; curiosity about people).

Despite this, many other dysfunctional and traumatic experiences in childhood have been noted in some therapist samples. For example, Elliot and Guy (1993) found that a large sample of psychotherapists reported higher rates of physical abuse, sexual abuse, parental alcoholism, psychiatric hospitalisation of parent, death of a family member, a greater family dysfunction in their family of origins compared to other professionals (not working in mental health). Notably, though, as adults the psychotherapists reported less mental health problems than the non-mental health professionals. This may mean that their job and potential own therapy had lead to healing/ personal growth, and/or alternatively that the psychotherapists were more reluctant to reveal vulnerability, due to their mental health professional status. Either way, what can be concluded from this study and the above accounts, is that it does indeed appear that some therapists have

experienced stressful and traumatic experiences in childhood, even more so than other professions. It is however unknown if this would also apply to a psychologist sample.

3.4 How emotional woundedness may relate to stress and personal growth in psychologists; the wounded healer paradigm.

"Only the physician who feels himself deeply affected by his patients can heal...the doctor is effective...only when he himself is affected.....only the wounded healer heals... But when the doctor wears his personality like a coat of armour, he has no effect" (Jung, 1989, p.134)

It has been described how own trauma, and particularly childhood trauma relates to stress such as CF in therapists. However, this connection has been found to be inconsistent. Despite this fact, no studies have actually researched whether woundedness may be related to growth and stress in psychologists. The wounded healer paradigm has rather typically been associated with Shamans (i.e., traditional healers that evolved in various tribal communities across the world). Shamanic faith presumes that shamans typically exhibit healing abilities, through communication with the spiritual world. Traditions held however, that the shamans had to endure traumas (e.g., physical wounds or being consumed by spirits), in order to gain compassion and sensitivity of a wounded healer, and so be able to facilitate healing for others by going between spiritual worlds (Halifax, 1982). Such traditional healing thus shared the common ground of professional healers, such as psychologists, of aiming to assist good health in others, often by using their own sense of self (i.e., the individual practitioner) as a vehicle for change in their clients.

Shamans have however healed in the context of spirituality, and the wounded sense of self has often been seen as a necessity for their ability to heal others, while psychologists have typically looked to science, and rather seen their own woundedness as a hinderance to helping others.

Nevertheless, in relation to psychology, Jung (1989) was one of the first contributors in stressing the importance of therapist's own 'wounds". He even went as far as reporting that *"Only the wounded healer heals"(Jung, 1989, p.134).* From this account it is thus clear that Jung thought that own woundedness was *necessary* for being able to connect to, and therefore also help his clients. Jung has described how and why he attempted to get an understanding of his own vulnerability in the following way:

"In order to grasp the fantasies which were stirring in my 'underground', I knew that I had to let myself plummet down into them, as it were. I felt not only violent resistance to this, but a distinct fear. For I was afraid of losing command of myself and becoming a pray to fantasy- and as a psychiatrist I realised only too well what that meant. After prolonged hesitation, however, I saw that there was no other way out. I had to take the chance, had to try to gain power over them: for I realised if I did not do so, I ran the risk of their gaining power over me. I could not expect of my patients something I did not dare to do myself. The excuse that a helper stood at their side would not pass muster, for I was well aware that the so called helper—that is, myself—could not help them unless I knew their fantasy material from my own direct experience, and that at present all I possessed were a few theoretical prejudices of dubious values. This idea—that I was committing

myself to a dangerous enterprise not for myself alone, but also for the sake of my patients—helped me over several critical phases (Jung, 1989; 178-179).

It is clear from this passage that Jung not only saw woundedness as necessary, but also how his own wounds should not be avoided, but explored to become fully aware of these. This was done mostly to get a fuller understanding of own difficulties, so that he could gain a more complete understanding of client's wounds, based on his own experiences. The need for such own self awareness was further stressed in the following passage;

"We have learned to place in the foreground the personality of the doctor himself as the curative or harmful factor;...what is now demanded is his own transformation-the self education of the educator" (Jung, 1929, p.74)

According to Jung, such self-awareness, or what he called a surgeons "clean hands" was necessary, as the patients could somehow "look into the soul" of the analyst, thereby find out how he himself handles his own problems, and whether he did indeed "practices what he preaches" (Jung, 1913, p.198).

The analyst should not remain unaffected by his client, however, as the receptive sense of the client's issues is the curative factor itself. In fact, Jung suggested that the "mutual transformation" of both therapist and client first happens when the therapist *"quite literally takes over the sufferings of his patient and shares them with him"* (Jung, 1946, p.172). This appears to be similar to today's idea of projective identification. In this way,

Jung thus saw it as *the destiny or fate of the analyst to be psychologically infected by his client*, as this itself, he thought, was the key for transformation to occur.

In this way it appears that Jung suggested that the therapist could be both infected and grow from the "reciprocal influence" of client and therapist, and that this process is necessary for change to occur. In addition, the client's state of mind can be nourished, rather than restricted by the therapist's wounds, because of the unconscious connections with such "wounds". In fact, particularly in his later years, Jung saw his own "hurt" as the measure of his *"power to heal"* (Jung, 1951). He started quoting the myth of Asklepios, "the wounded physician", whose incurable wound actually mediated his healing power (Jung, 1951). Jung thus stressed that therapist's own woundedness was crucial in connecting with and therefore also healing the client, while "*at all times keep[ing] watch over himself*" (Jung, 1951, p.133), again emphasising the importance of the therapist's self-awareness such as a willingness to look into and deal with own woundedness.

Although this idea of the wounded healer has mostly been overlooked in relation to psychotherapy in recent years, there are still some contemporary therapists/researchers who have discussed this subject matter. For example, Guy (1987) has commented on how a desire for self healing may be a strong motivator for entering psychotherapy training, and that therapists are often seen as suffering from emotional distress in differing forms and may therefore be seen as modern day shamans. In fact, he suggested that it would be naïve to think that therapists are free from emotional distress and needs.

Guy (1987) has however further pointed out that therapists' initial desire to relive own stress, does not need to be entirely dysfunctional. Instead, he has suggested that therapists may successfully resolve their own issues through clinical training, supervision and through entering their own therapy, as these all require introspection and insight and can therefore further lead to personal growth. Moreover, he has put forward that further emotional growth and healing can take place in the therapist from the direct result of conducting therapy with clients. For example, Guy stated that "the insight gained from patients, as well as the satisfactions derived from the intimacy, reportedly promote ongoing change and significant emotional growth in the therapist over the course of a career in psychotherapy" (1987, p.15). In line with Jung, he further proposed that the therapist's wound may indeed make the therapist more empathic, sensitive and effective in treating his/her clients and quotes that "*personal experience remains one of life's best teachers, bringing both wisdom and empathy*" (p. 15). Guy did however note a word of caution and stated that therapists can only be effective if their own distress is not overpowering their ability to attend to their clients, thereby again stressing the importance of working through own issues such as Jung did. This is further emphasised by Sedgwick (1994), who discussed how projections can hook onto therapists' wounds.

However, there has been scarce, even almost non-existent research on the wounded healer topic. The stigma associated with clinicians' woundedness may be the reason for the gap in researching this important area. It may be that therapists have felt uncomfortable about admitting to having, or even ever had their own psychological issues. This is specifically in the context of clinical psychology, which has been grounded

in a medical model, in which pathologising patients has been the norm. Admitting to your own difficulties then, could potentially lead the clinician to also be pathologised and seen as 'ill'. Moreover, this could then lead to the psychologist concerned being accused of being an incompetent therapist who could have had negative effects on their clients. This stigma attached to clinicians' own woundedness, may therefore, have prevented psychologists from researching this topic. This has thus prohibited the community from discovering both the potential negative (e.g., more CF?) and positive effects (e.g., more empathy and personal growth?) of psychologists' own emotional wounds.

Altogether, the described historical and modern day accounts of the wounded healer, nevertheless imply that emotional wounds may be useful in enhancing growth and empathy. The accounts do not, however, shy away from claiming that such wounded healing can also be stress inducing. They therefore highlight the importance of self awareness. Moreover, the accounts suggest that it is not having had/having a wound per se, that would determine stress in practitioners, but rather the way in which the practitioner is coping with the wounds/having come to terms with the wounds, which is important for stress outcome.

3.5 Woundedness, stress and growth in Clinical and Counselling Psychologists

Some questions could be raised over whether woundeness, stress and growth are relevant to both psychology specialisations such as clinical and counselling psychology. Although, members of both disciplines have been found to be equally involved in the practice of psychotherapy and assessment, with quite a bit of overlap in relation to their

work settings and practice methods (e.g., Brems and Johnson, 1997), differences between the disciplines may exist in their underlying value systems (Woolfe, 1996). It remains however uncertain as to whether such potential differences in philosophy could influence the degree of stress and growth in clinical and counselling psychologists.

Woolfe (1990; 1996) has specifically attempted to describe the underlying values of counselling psychology. For example, he has suggested that while counselling psychology has traditionally put an emphasis on the helping relationship as a crucial variable in successful therapy (i.e., with key personal therapist qualities such as empathy, non-possessive warmth and authenticity; Rogers, 1961), there is a growing awareness of the importance of this among other disciplines, such as clinical psychology as well. Indeed, for both specialisations, it is now well established that that the quality of the therapeutic alliance predicts treatment outcome (Horvath & Symonds, 1991; Martin, Garske, & Davis, 2000). Moreover, even therapies such as Cognitive Behavioural Therapy (CBT), which have traditionally not placed such importance on the relationship, now often do (e.g., see Safran, & Segal, 1996). It has to be noted nevertheless that generally, the emphasis put on the therapeutic relationship does differ among theoretical orientations (e.g., with it typically being key in humanistic work and often less so in traditional CBT). The use of the therapeutic relationship as a vital therapeutic variable then, may not necessarily be more associated with the psychologist specialisation chosen, but rather the main theoretical orientation of the individual psychologist. Moreover, the theoretical orientation chosen has been further found to be related to personality styles in counselling psychologists students, with directive models such as CBT being related to

interpersonal boldness, systemizing and confirming, while non directive orientations such as psychodynamic work has been found to be associated with higher intuitiveness scores (Scragg, Bor and Watts, 1999). Again however, it remains unknown whether such differing personality styles would make the individual psychologist more susceptible to client related stress, and whether differing personality styles would go for clinical rather than counselling psychology training and visa versa.

Still, the importance of the use of the self as an active ingredient in the helping process, and the ongoing understanding of the psychologists own psychological processes, is seen as particularly key in counselling psychology (Woolfe, 1996). This is demonstrated by counselling psychologists having to undertake at least 40 hours of their own therapy as a part of their training, something which does not take place in clinical psychology training. Moreover, there seems to be a culture in counselling psychology in which the wounded healer paradigm is recognised as a positive attribute that will help the psychologist to better understand and empathise with their clients (e.g., counselling psychology programmes often encourage prospective student to reveal a difficult background as a reason for entering the profession). Little has however been written about this. It therefore remains unknown whether counselling psychologists would be more wounded and/or make more use of their sense of self in therapy, and as such may potentially be more susceptible to stress such as CF from working with their clients, in comparison to clinical psychologists. There is to date however no evidence that the training specialisation is related to differences in levels of CF. For example, a previous study found no associations between clinicians' therapeutic training and CF, nor any significant

correlations between current therapeutic practice orientation and CF (Linley and Joseph, 2007). Nothing would thus indicate that there should be any differences in CF between clinical and counselling psychologists. Instead, there is a need to assess potential associations between psychologists' current emotional woundendess and their CF, as no findings are demonstrating that counselling psychologists are more wounded than clinical psychologists, although this may be indirectly encouraged when entering counselling psychology training.

A clearer divide in values may however have traditionally existed between clinical and counselling psychology, when it comes to the emphasis on sickness or well-being. Clinical psychology, for example, evolved within a medical, disease model, in which patients' pathology were treated. Counselling psychology has rather had an emphasis on enhancing psychological well being, without labelling their clients as ill. Also, they have traditionally seen their clients' potential for growth and self-actualisation (Woolfe, 1996). This is because the origin of counselling psychology is rooted in a humanistic orientation (e.g., 'becoming what one is capable of becoming'; Rogers, 1961). This may therefore suggest that counselling psychologists may also be more susceptible to viewing themselves as having more potential for personal growth, when in comparison to clinical psychologists. This would further be supported by previous findings linking posttraumatic growth with proximal culture (e.g., Weiss, 2004). No known studies have however to date evaluated whether there are any differences in clinical and counselling psychologists' views as to whether they feel they personally grow from their client work.

In short then, it remains unknown whether clinical and counselling psychologists are differently affected by their clients, despite their similar areas of work.

3.6 Summary of woundedness, stress and growth

The above has shown that therapists have often themselves gone through traumatic/difficult experiences. It has been suggested that some health care professionals such as psychologists may be motivated to enter the profession because of their own troubled backgrounds and wanting to care for others the way they were not cared for themselves. Moreover, the wounded healer paradigm has further proposed that a clinicians' emotional woundedness could be positive, in the sense that this can enhance personal growth/empathy in psychotherapeutically working therapists. Nevertheless, the paradigm has also proposed that wounded healers will inevidently feel "infected" by their clients distress, and that self-awareness and working through one's own woundedness is therefore essential. However, only one account (i.e., Joseph & Linley, 2007) have studied and indeed found an association between therapists' own trauma and growth. Also, few studies have looked at the potential connection between trauma/woundedness, own therapy and CF. Finally, no studies have evaluated whether there are any differences in woundendess, stress and growth between clinical and counselling psychologists. Future research is thus needed to evaluate these underlying assumptions that the wounded healer paradigm is based upon.

Part 2: The study

4. Rationale for doing study

4.1 Summary of criticism of previous research: what is missing?

The literature review has shown that theories and empirical research suggest that there are a range of factors which may prompt stress (i.e. CF) or personal growth (i.e. vicarious posttraumatic growth) from client work.

There are however discrepancies in previous CF research as to which factors may bring about CF and particularly whether trauma is related to CF. Such discrepancies in findings may be due to the fact that all studies to date have assessed whether CF is associated with having experienced a trauma, thereby ignoring the subjective view of whether the clinician still feels wounded or distressed by the incident.

Moreover, chapter 1 has demonstrated that research on the negative effects of therapy have mainly concerned American or Australian *trauma therapists*. Few studies have however tested out whether CF is specific to trauma client work, as CF theorists have suggested (e.g. Figley, 2002; Stamm, 1999). It thus remains unknown whether British psychologists with a more generic caseload (i.e., some trauma clients) and who do not only have a job involving therapy (i.e., often also involving managerial and teaching aspects) can be negatively affected by their client work (i.e. CF). It is further particularly important to evaluate the potential negative effects of therapy in this period of time, because a lot of money is currently being invested into talking therapies (e.g., Improving

Access to Psychological Therapies; IAPT) in Britain, which is bound to put a lot of pressure upon psychologists.

Also, all of the quantitative studies of CF to date have made use of a survey methodology, whilst the remaining qualitative studies have used open ended interviews. The validity of such interview findings could however be put into question, as some clinicians may be very reluctant to fully admit openly to be negatively affected by their clients, due to the potential stigma attached. Despite the positive confidential aspects of surveys, this method is by no means less problematic, due to the very low response rates found (i.e., 32% to 55.4%; Pearlman & MacIan, 1995 and Deighton, Gurris & Traue, 2007 respectively), and consequent potential sample bias (i.e., differences between the responding and the non-responding clinicians; Howell, 2002) and therefore low generalisability and validity. Furthermore, other criticisms of previous CF studies include the frequent use of non standardised measures (e.g., Shauben and Frazier, 1995); use of non-specific measures that were not originally designed for assessing CF (e.g., Kassam Adams, 1995); use of scales that may not be sensitive enough in detecting VT (i.e., the TSI belif scale); making use of too small samples that gave the study poor power (i.e., Minnen & Keijsers, 2000; N=40); and finally, the use of many different measures of CF, which makes the comparison of findings difficult. These methodological criticisms therefore put some of the previous CF findings into question.

In addition, chapter 2 has shown that most studies of therapists and psychologists have focused on psychopathology outcomes such as burnout, VT or CF, despite the fact that it

now appears from the reviewed preliminary studies, that growth from working with clients can indeed occur. This area of growth has however, largely been ignored, despite the recent rush of interest in positive psychology. In fact, it still remains uncertain which individual and work factors are related to psychologists' positive and negative effects of client work. Again, however, the methodology used has been surveys and interviews. The same criticisms as discussed above in relation to CF and the use of the survey methodology, therefore also apply to previous VPTG research. Also, as the study of VPTG is still in its infancy, with only 2 previous quantitative studies having assessed VPTG in clinicians, no standardised questionnaires have been developed to specifically measure such growth from work in clinicians. The findings from previous research must therefore be interpreted with these limitations in mind.

Overall, chapters 1-2 have shown that it remains unknown whether coping strategies, proximate culture (i.e., clinical or counselling psychologists) and cognitive appraisal of having come to terms with own trauma/ stressful incidents (i.e. current emotional woundedness), as well as other known factors (e.g., SOC) correlate and/or together predict such CF and VPTG in psychotherapeutically working psychologists, as suggested by models of stress (e.g. Lazarus & Folkman, 1984) and growth (e.g. Calhoun & Tedeschi, 2006; Park et al., 2004).

The only conclusion that can be made to date is, therefore, that negative effects of therapy (e.g. CF) alone cannot account for all the potential effects of therapy on psychologists. In other words, by itself CF is an inadequate conceptual framework for understanding the

full range of the potential effects of therapy on psychologists. The recognition of, and investigation into, both psychologists positive and negative effects of therapy is thus needed in order to get a more comprehensive and holistic approach to the phenomenon. In particular, a more holistic understanding of whether psychologists' personal vulnerability (i.e. trauma, current emotional woundedness, social support, coping and SOC) and/or work factors (trauma client load and overall client load) are CF inducing and/or personal growth enhancing is warranted.

4.2 Aims

The current study aimed to examine the correlates and predictors of CF and VPTG in British clinical and counselling psychologists. More specifically, the study aimed to develop a holistic model of how psychologists can be effected both negatively (CF) and positively (VPTG) by their client work, and how these are related to either the nature of the job (e.g., trauma client load; client load) and/or psychologists' own vulnerability/individuality (i.e. current emotional woundedness; experience of trauma; SOC, ways of coping; proximal culture). The exact aims of this study, as developed from previous theories and research thus were to evaluate:

i) CF (CF):

1. Whether any of the following individual factors are associated with CF: age; experience; social support; current emotional woundedness; SOC; coping factors
2. Whether work factors such as, client load and trauma client load are associated with CF.

3. Whether any of the following combined individual and work factors predict CF: age; experience; social support; current emotional woundedness; SOC; coping factors; client load and trauma clients.
4. Whether the unstudied factor emotional woundedness adds predictive value to the multiple regression model.

ii) Vicarious Posttraumatic Growth (VPTG)

5. Whether psychologists who have experienced a trauma report more VPTG, compared to those psychologists who have not experienced a trauma
3. Whether proximal culture may be making counselling psychologists more likely to report personal growth following client work, compared to clinical psychologists.
.4. Whether psychologists who have received personal therapy are more likely to report higher VPTG compared to psychologists who have not received personal therapy.
5. Whether any of the individual factors (i.e., experience, current emotional woundedness, CF, social support; coping factors) are associated with VPTG
6. Whether work factors such as client load, trauma client load are associated with VPTG.
7. Whether any of the combined individual and work factors (i.e., experience of current emotional woundedness, CF, social support; coping factors; client load, trauma client load) can successfully predict VPTG.

8. Whether unstudied factors, such as current emotional woundedness and coping factors add additional predictive value to VPTG.

4.3 Why study this and why use this method?

A quantitative design was chosen over a qualitative design in this study. This was because previous qualitative studies had already explored the nature of stress from client work (CF; e.g. Steed and Downing, 1998) and personal growth from therapy work (e.g., Steed and Downing, 1998; Benatar, 2000; Ortlepp and Friedman, 2002). Some exploratory qualitative research has thus been completed in this area. Nevertheless, personal growth from therapy has, however, been largely overlooked in quantitative studies (i.e. only 2 such studies were found; Linley & Joseph, 2007, Linley, Joseph, and Loumidis, 2005). In addition, although quantitative research has studied factors related to CF in therapists, the findings have been very inconsistent, and have mainly concerned American trauma therapists (Sabin-Farrell & Turpin, 2003). It thus remained unknown whether British psychologists with a more generic caseload (i.e., some trauma clients) were negatively affected by their client work. Such an evaluation required a quantitative design

On top of this, a quantitative method was chosen over a qualitative method because in accordance with the aims of the current study; a quantitative method enabled an exploration of the range of factors that were associated with or even predicted CF and posttraumatic growth (VPTG). Altogether, these factors thus made a quantitative method more favourable, compared to a qualitative method.

Finally, the CF (CF) concept was chosen over other related concepts (e.g. Vicarious Trauma or burnout) to describe/measure psychologists' stress from client work. Unlike CF, Vicarious Trauma (VT) was not selected because the evidence for the construct remained questionable (see theoretical research review). Also, burnout was not chosen because this term is not specific to the stress related effects of client work, but human work in general (see definition).

4.4 How is method and topic choice related to counselling psychology?

While acknowledging counselling psychology's emphasis on the subjective, more qualitative description of experience, it was also important to remember that the profession is firmly rooted in a human science perspective (Strawbridge & Wolfe, 2003). The current quantitative methods used, with it's emphasis on finding what factors related to psychologists' CF and personal growth from therapy was thus highly related to the philosophical underpinnings of counselling psychology.

Also, the current study's topic was highly related to counselling psychology values. In fact, it was about counselling psychologists. For example, the study's emphasis on developing a model of psychologists' positive and negative effects of client work and thereby finding what factors can *maximise* psychologist's welfare was in line with counselling psychology's super ordinate goal on maximising individual's wellbeing (Barkham, 2003). This was not only important for psychologists' wellbeing, but also for their ability to fully attend to their clients and their therapeutic relationships, a value

which is at the heart of what it means to be a counselling psychologist (e.g., Woolfe, 1996).

Second, the growth aspect investigated in the current study was grounded in counselling psychology's forefather: Roger's core emphasis on seeing each individual's potential for personal growth (e.g., Rogers, 1961). Third and finally, the subject matter of the "wounded healer", as raised in this study, has a historical connection with counselling, as for example pointed out by Mearns and Dryden (1990).

Altogether, the above has shown that the method and subject matter emphasised in this current study were highly in line with the philosophy of counselling psychology.

4.5 Hypotheses

The following hypotheses were based on previous empirical research, theories and the aims of the current study:

i) CF hypotheses:

H1: Psychologists' CF will correlate with and/or be predicted by:

a) work factors including experience and trauma client caseload.

b) personal vulnerability factors including: current emotional woundedness; negative coping strategies; sense of coherence; and less social support.

ii) Vicarious posttraumatic growth hypotheses:

H2: The trauma group will report more vicarious posttraumatic growth compared to the no trauma group.

H3: Counselling psychologists will report more vicarious posttraumatic growth compared to clinical psychologists.

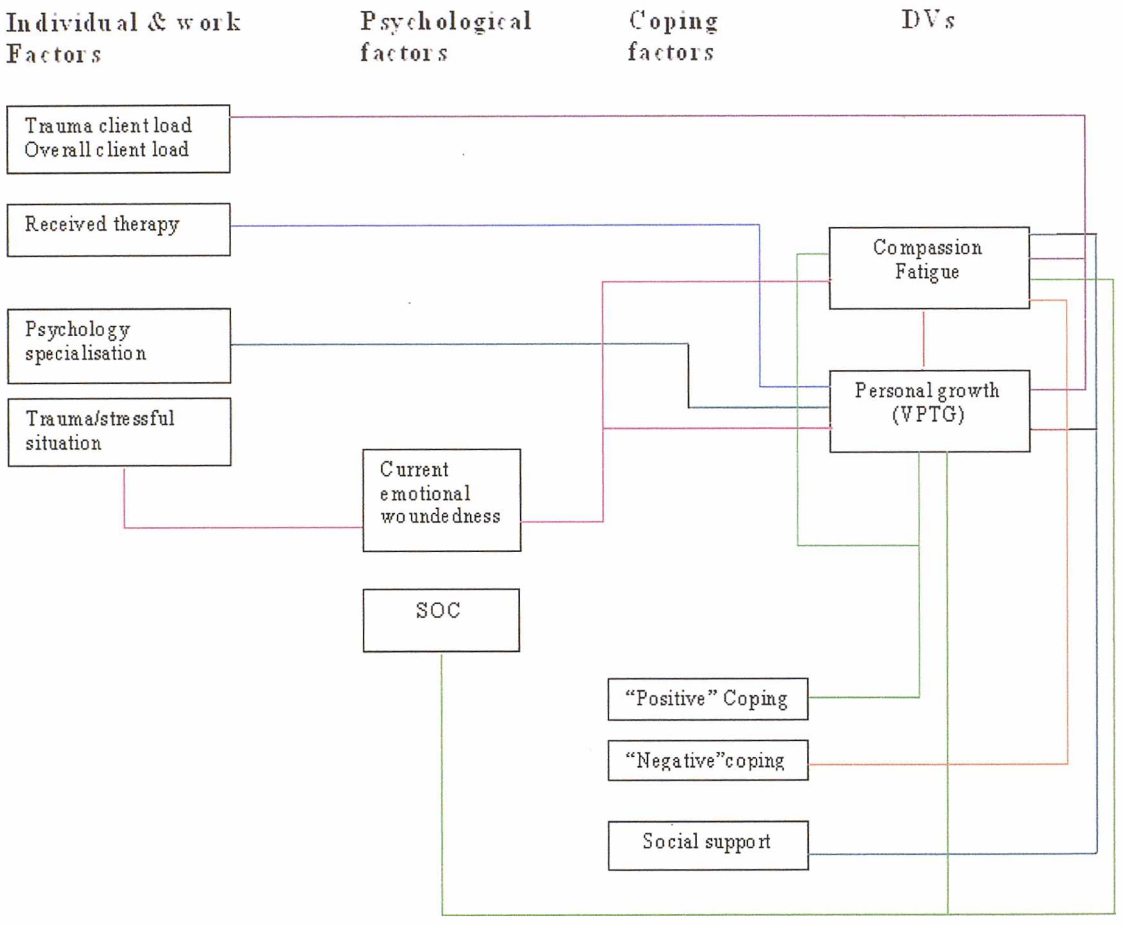
H4: Psychologists who have received psychotherapy will report more vicarious posttraumatic growth compared to those who have not.

H5: Psychologists' vicarious posttraumatic growth will correlate with and/or be predicted by:

a) work factors including: experience; client load; trauma client load.

b) individual factors including: social support; current emotional woundedness; CF; being a counselling psychologist and coping mechanisms (i.e. positive reinterpretation; acceptance coping, problem focused coping; religious coping; venting and avoidant coping).

Figure 4.1: a graphical representation of the hypotheses



5. Method

5.1 Design

A non-experimental, quantitative, cross-sectional design was used to investigate the characteristics related to psychologists' positive and negative effects of therapy work. It was non experiential in nature because the sample was not randomly assigned to conditions, there were no control groups, and observations were not compared on pre and post conditions (Coolican, 1996). Instead, all participants completed the same battery of structured questionnaires. Moreover, post hoc comparison groups were created, such as; trauma (those reporting a trauma vs. no trauma) and received own therapy or not. This way, comparisons of stress (i.e., CF) and personal growth (i.e., VPTG) from therapy could be made between these groups and between the other nominal factor; psychology specialisation (i.e., clinical and counselling psychologists). The comparison groups were thus the independent variables (IVs), in conjunction with other individual characteristics (i.e., current emotional woundedness; coping; social support and SOC) and work characteristics (hours of client work, trauma client load, experience). The dependent variables (DVs) were CF and VPTG.

5.2 Participants

Participants were an opportunity sample of clinical and counselling psychologists found in the BPS Directory of chartered psychologists. Clinical and counselling psychologists with potentially non-psychotherapeutic jobs, noted by for example a university address, were excluded from the study due to the study's intension of looking at the effects of psychologist's psychotherapeutic work.

In order to determine the needed sample size, a power analysis was conducted using G*Power (Faul, Erdfelder, Lang, & Buchner, 2007). A first power analysis evaluated how many participants were needed for calculating whether there were differences in reported personal growth between 2 groups. For an independent sample t-test with a 0.5 effects size, an Alpha significance level of 0.05 and a power value of 0.80, a total sample size of 102 participants was needed.

A medium effect size based on Cohen's estimates (Cohen, 1988; Howell, 2002) was chosen for this study, because prior research on the area is scarce, meaning that the chosen effect size for the current study could not be based upon estimates from previous studies. Moreover, a power value of 0.80 was used for the two above calculations, because as Howell (2002; p. 231) states this "makes a Type II error four times as likely as a Type I error, which is probably a reasonable reflection of their relative importance".

A second power analysis was next calculated to discover how many participants were needed to determine whether individual characteristics (i.e., current emotional woundedness, differing ways of coping, SOC and social support) and work characteristics (hours of client work, trauma client load) were associated with CF and VPTG. Again, using a medium effect size (i.e., r=0.3; Cohen, 1988) an Alpha significance level of 0.05 and a power value of 0.80, a total sample size of 64 participants was needed. In fact, even if the power value was increased to 0.95, a total sample of 111 participants would be required.

Finally, a specific sample size calculation was undertaken for the multiple regressions, as power calculations have been noted to be less sensitive in relation to regression (Tabachnick & Fidell, 2007). Instead, in accordance with Tabachnick & Fidell's (2007) recommendation, an appropriate calculated sample size for regression would be a sample size of 50, plus 8 times the number of predictors (i.e., 50+ (8x8)), meaning an approximate needed sample size of 114 participants.

One hundred and twelve participants fully completed and returned their questionnaires. This was an adequate sample size that enabled the researcher to gain the required power for the tests, as calculated above. The majority of the participants were white, forty something, female psychologists who were regularly supervised and had received psychotherapy themselves. They worked a mean 34 hours a week and saw a mean 16 clients a week. For a full description of the participants characteristics please see Table 5.1 (p. 99).

5.3 Ethical approval

Ethical approval for the current study was achieved prior to commencing data collection from London Metropolitan University ethical committee. Some ethical considerations in regards to the current study concerned questions in regards to psychologists' potentially difficult traumatic experiences. In order to make sure that ethical standards were met, the present study therefore decided against asking what type(s) of traumatic/stressful

experiences the psychologists had experienced, as this could potentially be painful to be reminded about (e.g. childhood sexual abuse).

5.4 Materials

All participants were given a demographic questionnaire; a Current Emotionally Wounded Scale (CEWS); The professional Quality of life scale; CF/Secondary Trauma Scales (ProQOL-R III: Stamm, 2005); the Posttraumatic Growth Inventory (PTGI; Tedeschi & Calhoun, 1996); The Brief COPE (Carver, 1997); the SOC Orientation to life questionnaire (SOC-13, Antovnosky, 1987) and the Multidimentional Scale of Perceived Social Support (MSoPSS; Zimet, Dahlem, Zimet & Farley, 1988).

All the noted questionnaires, the reason for using these and their reliability and validity, if appropriate, were evaluated below.

5.4.1 Demographic questionnaire

The demographic questionnaire included questions on: gender; age; marital status; ethnicity; psychology specialisation; type of employment; years of practice; hours of overall work a week; hours of client work a week; hours of trauma clients a week; age group of client population served; severity of client population difficulties; being supervised and/or supervising others; received psychotherapy; and whether they had themselves ever gone through a trauma (defined in the questionnaire according to DSM-IV) (see appendix 1). All questions were closed with given response options (i.e. nominal

groups), except for those questions concerning count (i.e. amount of clients seen a week) or in regards to age or years of practice (experience).

5.4.2 The Current Emotionally Woundedness Scale (CEWS)

A questionnaire on emotional woundedness was included in the current study because previous research on whether therapist's own trauma is related to CF has been inconsistent, with some studies suggesting that own trauma is a risk factor for CF in psychologists, whereas other studies have not (see chapter 1). The researcher thus wanted to evaluate whether such discrepancies in findings could be related to whether the individual had come to terms with his or her difficulties, rather than having had experienced a trauma or a stressful situation per se. Also, it was important to assess whether such own woundedness was related to personal growth. As no standardised questionnaires were found to evaluate the construct of current emotional woundedness, the researcher wanted to construct a brief questionnaire herself. Previous assessment of cognitive appraisal of own trauma in other studies have been assessed making use of 1 question only (e.g., Park and Fenster, 2004). The researcher felt this was unsatisfactory, and thus set out to construct a brief questionnaire herself that could assess cognitive appraisal of the extent to which a clinician had come to terms with own stressful incident/trauma(s). According to Oppenheim's questionnaire design suggestions (Oppenheim, 2001), the following stages were involved in the construction of the CEWS.

First, the construct was discussed in length with colleagues and a variety of questions were suggested (i.e., an unofficial focus group). The questions were piloted for a fist time

on a sample of 25 psychologists. Due to validity concerns with some questions not seeming to measure what they were supposed to measure and after several discussions with colleagues, most of the questions were again adapted and changed. A second batch of 7 questions was then piloted on a sample of 6 psychologists. The psychologists were again asked to complete the full questionnaire packages (including all the other questionnaires, such as the PTGI which had not been included in the first pilot study), in order to pre-test the CEWS to evaluate how they responded on the overall questionnaires and to the specific questions, and to examine whether the CEWS construct was associated with other distress concepts (e.g., CF). Also, the respondents were asked for brief written feedback about what they thought of the CEWS (i.e., a] what do you think of the CEWS?; b] what do you think of the wording of the questions included in the CEWS?; c] Do you think the questions capture the meaning of emotional vulnerability?; and d] Anything else you would like to feedback about the CEWS, the study or the use of the other questionnaires?). This way, the researcher was able to evaluate whether the wording made sense, whether the questions overall captured the emotional vulnerability concept, and to test out their CEWS responses and how this related to the remaining data.

However, even after overall good feedback from the respondents from the second pilot study, it further became clear that only 4/7 of the items were appropriate to use. This was because these latter items correlated highly, whereas the 3 remaining items did not. Also, responses rated on a 10 point Likert like scale were instead changed to the more commonly used 5 point Likert scale (0=Not at all; 5= either Extremely stressful or Fully or Very Much). This was done as there was not a wide enough response range to use a 10

point Likert scale. A reliability analysis of the 4 final, 5 pointed Likert scale items further confirmed the internal reliability of the woundedness scale was an Alpha value of 0.856. The final version of the CEWS thus showed itself to be of good internal reliability. A factor analysis further confirmed that all 4 items loaded highly on the same factor, thereby suggesting the items were all measuring the same construct. These preliminary findings thus suggested that CEWS had good psychometric properties.

5.4.3 The professional Quality of life scale; CF/Secondary Trauma subscale (ProQOL-R III)

The ProQOL-R III (Stamm, 2005) is the third, new updated version of the classical CF Test (Figley, 1995). The update was due to noted psychometric difficulties of the classic version (e.g., Jenkins and Baird, 2002) and consequently the current version has addressed problems such as separating burnout and secondary trauma. The new version has also been shortened from 66 to 30 items, thereby reducing participant burden. Moreover, the assessment of the positive effects of care giving has also been added. The new ProQOL thus consisted of three subscales; including Compassion Satisfaction, Burnout and CF.

The current study only made use of the CF subscale. CF concerns those emotionally effected by the trauma of another (see part 1.2.2 for a fuller definition). The subscale has 10 items in which the participants responses to the items ranged from 0 to 5, with each number corresponding to the following meaning; 0=Never, 1=Rarely, 2= A few times, 3= Somewhat Often, 4 =Often and 5 =Very often.

The revision of the subscales was based upon over 1000 participants from multiple studies, and the preliminary psychometric properties of the scale were promising. For example, Cronbach's Alpha reliabilities (i.e., consistency of measurement) for the CF scale was Alpha=0.80. Although this value was somewhat lower than the original test, the scores on the current version were more reliable due to being a shortened version with only half the items (e.g., The Spearman Brown Formula had an original reliability of 0.82., whereas the reliability on the shortened scale was 0.69.). Moreover, Jenkins and Baird (2002) recently assessed the validity (i.e., the extent to which the test measures what it claims to measure) of the classical version of the ProQol; named the CF Self-test for Practitioners (CFST; Figley, 1995) in relation to the Traumatic Stress Institute (TSI) Belief Scale (Pearlman, MacIan, Johnson and Mas, 1992), the MBI and the SCL-90-R in sexual assault counsellors and domestic violence counsellors. They found that the CFST and the TSI belief scale showed good concurrent validity (i.e., $r\ (98)=0.58$, $p<0.001$), although useful discrimination with burnout. In other words, the tests seemed meaningful, useful and appeared to be measuring the same condition or criterion at the same point in time, and they did not correlate highly with burnout (i.e., which suggested that STS and VT are distinct constructs). Furthermore, the two former scales also showed strong convergence with general distress as measured by the SCL-90-R, yet adequate independent shared variance. Thus, although the research for this scale is still ongoing, the ProQol appeared to be a promising measure of secondary traumatic stress. The ProQOL (Stamm, 2005) was used in the current study to assess CF in psychologists.

5.4.4 Posttraumatic Growth Inventory (PTGI)

The PTGI was originally designed to measure the positive legacy of primary trauma(s) (Tedeschi & Calhoun, 1996), but has also been recently used to assess the positive effects of seeing trauma clients on trauma therapists (Linley, Joseph & Loumidid, 2005) and the personal growth of therapists working psychotherapeutically (Linley & Joseph, 2007). It was this latter way of utilising the PTGI that was going to be made use of in the current study.

The PTGI is a 21 item structured questionnaire of personal growth, using a 6 point Likert Scale (With 0= "I did not experience this change as a result of my (therapy) work"; 5= "I did experience this change to a very great degree as a result of my (therapy) work"). The scale assesses perception of growth in relation to 5 areas including; 1) relating to others; 2) new possibilities; 3) personal strength; 4) spiritual changes; and 5) appreciation for life (Tedeschi & Calhoun, 1996). For example one sample item states that "I've discovered that I am stronger than I thought I was".

Test-retest reliability over two months for the PTGI has been reported as 0.71 (Tedeschi & Calhoun, 1996). Also, a good internal reliability coefficient of 0.93 has been recorded for the total 21 item scale (Tedeschi & Calhoun, 1996; Shakespare-Finch, Smith, Gow, Embelton, and Baird, 2003). Smith's (2001) examination of the PTGI further reported that the scale was a reliable and valid measure of growth through adversity. Thus, although research on this scale is currently in its infancy, early findings on the PTGI's

reliability and validity seems encouraging, and as such it still remains the most used scale on stress related growth.

The rationale for including the PTGI in the current study was to assess whether clinical/counselling psychologists' psychotherapeutic work is growth enhancing, (as assessed through the PTGI). Moreover, the researcher also wanted to see what factors could predict personal growth in psychotherapeutically working psychologists.

5.4.5 The Brief COPE

The Brief COPE (Carver, 1997) is a 28-item self-report questionnaire that measures 14 differing coping dimensions (2 items on each scale. These are; 1) active coping, 2) planning, 3) using instrumental support, 4) using emotional support, 5) venting, 6) behavioural disengagement, 7) self-distraction, 8) self-blame, 9) positive reframing, 10) humour, 11) denial, 12) acceptance, 13) religion, and 14) substance use. The scale is the abbreviated version of the COPE inventory (Carver, Scheier and Weintraub, 1989) and was developed based upon well acknowledged theoretical models of coping (i.e., Lazarus' transactional model of stress, 1984; behavioral self-regulation model, Carver and Scheier, 1998). In addition, the brief cope assesses several known effective and ineffective ways of coping and is easy and quick to use. Despite each scale only including 2 items each, reliabilities statistics have been reported to range from 0.50 (venting) to 0.90 (substance use). In fact, 11/14 scales exceed an Alpha value of 0.60 (except for venting; 0.50; denial; 0.54; and acceptance; 0.57). Despite this, even the venting scale has a minimally acceptable reliability statistic, as it exceeds 0.5 (Nunnaly, 1978).

Brief COPE was used in the current study because it represents one of the only standardised, brief self-report measures that assess general adaptive and maladaptive coping skills. A brief measure of coping was needed to reduce participant burden, as there were also other questionnaires included in the study. Moreover, the Brief COPE was needed to assess whether ways of coping were related to or could even predict psychologists' CF and/or VPTG.

5.4.6 Sense of Coherence Scale –Short form (SOC-13)

The SOC-13 (Antonovsky, 1987) is a 13 item self report questionnaire that measures individuals' orientation towards life. More specifically, the instrument assesses people's perception of the world as comprehensible (e.g., "do you have very mixed up feelings and ideas?"), manageable (e.g., "Do you have the feeling that you're being treated unfairly?") and meaningful ("How often do you have the feeling that there is little meaning in the things you do in your daily life?"). Each scale has 4 items and each response is answered on a 7 point Likert scale (e.g., 1= very often; 7= seldom or never). Moreover, a higher SOC score indicates a greater sense of coherence and of comprehensibility, manageability and meaningfulness in one's daily life.

A recent review of the psychometric property of the SOC-13 found Alpha values in 127 studies using the scale to range from 0.70 to 0.92, thereby showing that the measure has high internal reliability (Erikson & Lindstrom, 2005). The reviewers further went on to conclude that the SOC appears to be a "reliable, valid and cross-culturally applicable instrument measuring" that is particularly related to mental health.

Having such good psychometric properties in mind, the researcher wanted to make use of the scale to test whether SOC scores correlated and/or predicted CF and personal growth from therapy work.

5.4.7 The Multidimentional Scale of Perceived Social Support (MSPSS)

The MSPSS (Zimet, Dahlem, Zimet, and Farley, 1988) is a well known 12 item self report measure of perceived social support from a significant other, family and friends. For example a sample item includes "I get the emotional help and support I need from my family". The respondents were then asked to answer on a scale from 1 (Very strongly disagree) to 7 (Very strongly agree).

The assessment of social support has been deemed important by many because it is often been viewed as a risk or protective factor for the development of psychological stress. It was thus central that the assessment of social support was included in the current study. Moreover, the MSPSS was also chosen because the scale is brief (thus reducing participant burden) and because the scale has shown good psychometric properties. For example, Zimet et al (1988) reported Cronbach Alpha internal reliability values of 0.91, 0.87, and 0.85 for the significant other, family and friends subscales respectively. Moreover they found an overall reliability Alpha of 0.88. In addition, test-retest reliability for the whole scale at 2 and 3 months was 0.88. Clara, Cox, Enns, Murray, and Torgrude (2003) further confirmed the structure of the instrument through a confirmatory factor analysis. Thus, the MSPSS appears to date to be a reliable measure of social support.

5.5 Procedure

5.5.1 Pilot study

The researcher wanted to examine correlates and predictors of psychologists' positive and negative effects of client work. However, as no specific questionnaire measured clinicians' personal growth from therapy, the Personal Orientation Inventory (POI, Shoestrom, 1976) which measures self actualisation was considered. A pilot study with 25 psychologists, however, revealed that the POI was far too time-consuming, and many of the psychologists stated this as a specific reason for not completing the questionnaire package.

Briefly thereafter, Joseph and Linley (2007) made use of an amended version of the Posttraumatic Growth Inventory (PTGI; Tedeschi and Calhoun, 1996) to assess personal growth from therapy work. As the amended version of the PTGI was brief and more specifically related to the aim of the current study, this latter scale was chosen over the POI to measure psychologists' personal growth from therapy work.

The new questionnaire package (with PTGI, rather than the POI) and an amended version of the CEWS were next piloted on a sample of 6 psychologists (a small pilot study due to time constraints). This package gained good feedback from the psychologists, and meaningful responses. The only changes thereafter made to any of the items in the questionnaire package were to the CEWS, due to low correlations among questions (see part 5.4.2 for more information). Overall the pilot studies had nevertheless highlighted several flaws in the previous survey formats, and so improved the ease of completing the

questionnaires (i.e., length of time spent to fill it out) and the meaningfulness of the questions included. Perhaps most importantly, the pilot studies had enabled the shaping on the new CEWS, which was critical to examine one of the main aims of the current study, of whether the extent of a psychologist's own current emotional vulnerability is related to their negative and positive effects of client work.

5.5.2 Current study

Three hundred questionnaire packs were mailed to randomly selected psychologists noted in the BPS Directory of chartered psychologists. One hundred and fifty packs were sent to counselling psychologists, a further one hundred and fifty were sent to clinical psychologists.

The selected participants were invited to take part in research on psychologists' stress and personal growth. The information letter further informed the participants that the data would remain anonymous and confidential, and that the return of the questionnaires would be considered as consent for taking part in the study (see Appendix 1 for full information letter plus the remaining questionnaire pack). Moreover, at the end of the questionnaire, the respondents were given information on who to contact for support, if needed.

5.5.3 Statistics

Descriptive and inferential statistics were completed using the Statistical Package for the Social Sciences (SPSS).

Individual independent t-tests were next chosen to evaluate differences in reported VPTG between the nominal factors: trauma groups (yes or no); psychology specialisation (clinical or counselling psychologists) and received therapy group (yes or no). Individual t-tests were chosen over an ANOVA because the IV's only had 2 levels and because there were no hypothesised interactions.

Correlations were thereafter run in order to get a broad sense of which variables were associated with CF and VPTG. Knowledge of a broad sense of associated factors were needed to build a model of positive and negative effects of client work.

Finally, multiple regressions were performed to reveal the best combined predictors of the constructs, as well as the amount of variance these predictors could account for in CF and VPTG. Also, this method was chosen to examine whether previously unstudied factors such as current emotional woundedness and coping added predictive value to models of CF and VPTG. Multiple regressions and correlations were chosen over structural equation modelling because the aim of the current study was to build a model, rather than test one out, something correlations and multiple regressions were more suitable for.

Moreover, a forced entry multiple regression was chosen over other multiple regression procedures. This meant that all the predictors were forced into the model simultaneously,

something which is called 'Enter' (Field, 2005). This was chosen over other multiple regression methods (e.g. stepwise) because it was a principally an exploratory study.

5.6. Pre-analysis

Descriptive statistics from the Statistical Package for the Social Sciences (SPSS) were completed to explore the data, in order to illuminate features of the data before embarking on the statistical tests. Nominal data was described using frequency counts and percentages, whilst interval data was described using mean, standard deviations (SD's), maximum and minimum scores. Also, histograms, skewness and kurtosis statistics and box-plots were performed, in order to check whether the variables were normally distributed and had outliers and/or extreme scores. This was done to consider whether the variables were suitable for parametric testing.

5.6.1 Participant individual and work characteristics

Out of the 300 individual questionnaire packages sent, 124 were returned. The return rate was thus 41.33 %, which is about average, considering that other similar studies assessing stress in therapists have reported a return rate ranging from 32% (Pearlman & MacIan, 1995) to 55.4% (Deighton, Gurris & Traue, 2007). However, 12 out of the 124 returned packages were however not included in the study, due to being insufficiently filled out, or because they were currently not practicing due to retirement, or leave because of illness or maternity leave. Altogether, the usable sample was thus 112, 80 of whom were females and 32 of whom were males. Even though gender had been proposed by some studies as a relevant factor linked to CF (e.g., Kassam-Adams, 1995), a decision was made to drop

this comparison, as the researcher could not make gender comparisons due to unequal groups of males and females (i.e., 71% female, 29% male – ratio of 2.5:1 for females to males), and because the vast majority of studies had not found such a difference in CF between men and women (e.g., Way et al., 1999; Linley & Jospeh, 2007).

Table 5.1 shows the demographics of the sample. This demonstrates that the majority of the participants were white females that were married or living with a partner; were regularly supervised; had received own psychotherapy, and were mostly seeing adult clients only. Moreover, although the mean average hours of work a week were 34 hours, this varied greatly between the psychologists, with some reporting working about 10 hours a week, whereas others reported working 60 hours a week. Similarly, some of the psychologists noted seeing up to 35 clients a week, whereas others stated that they were only seeing 4 clients a week.

Table 5.1: Participants' demographic characteristics (N=112)

Nominal Variables	*Sample Statistics*	
	Frequency	*Percent*
Gender		
Male	32	(28.6%)
Female	80	(71.4%)
Ethnicity		
White	99	(88.4%)
Mixed	3	(2.7%)
Asian or Asian British	3	(2.7%)
Black or Black British	3	(2.7%)
Chinese	2	(1.8%)
Other	2	(1.8%)
Maritial status		
Married or living with partner	82	(73.2%)
Single	24	(21.4%)
Separated/divorced	6	(5.4%)
Psychology specialisation		
Counselling psychologists	62	(55.4%)
Clinical psychologists	50	(44.6 %)
Regularly supervised		
Yes	105	(93.8%)
No	7	(6.3%)
Regularly supervise others		
Yes	75	(67%)
No	37	(33%)
Received own psychotherapy		
Yes	93	(83%)
No	19	(17%)
Age of clients seen		
Adults	85	(75.9%)
Children/ adolescents	9	(8%)
Older adults	7	(6.3%)
All ages	11	(9.8%)
Severity of client population problems		
General mental health	26	(23.2%)
Severe/chronic mental health	23	(20.5%)
A mixture of severe and general Mental health	63	(56.3%)

Variable	*Sample Statistics*
	Mean, SD
Age [a]	
Mean	41.31
SD	10.272
Minimum	27
Maximum	80
Years of practice as a psychologist	
Mean	8.76
SD	7.843
Minimum	1
Maximum	33
Hours of work a week	
Mean	33.8
SD	8.99
Minimum	10
Maximum	60
Hours of client work a week	
Mean	16.4
SD	6.1
Minimum	4
Maximum	35
Hours of trauma client work a week	
Mean	4.7
SD	4.7
Minimum	0
Maximum	21

[a] Reported in years

As some of the work characteristics were to be used in parametric tests, this data was checked for the normal distribution assumption making use of histograms, skewness and kurtosis statistics (see Appendix 2a). The histograms and statistics showed that the variable; hours of client work was normally distributed, with a non significant skew (z skew; 0.318/0.229=1.389) and a non significant kurtosis (z kurtosis; 0.070/0.455=0.154). However, the trauma clients load factor was significantly positively skewed (i.e., z skew; 1.526/0.228=6.693) at $p<0.001$, and with an equally significant leptokurtic distribution (i.e., z kurtosis; 1.903/0.453=4.201). This meant that most of the psychologists were seeing smaller amount of trauma clients a week. Also, the variable years of practice was found to be significantly positively skewed (i.e., z skew; 1.228/0.228=5.3886) again at $p<0.001$, although normally peaked (z kurtosis; 0.790/0.453=1.744). In order to correct these abnormalities in the data, log transformations were applied to both trauma client load and to years of practice. This resulted in near normal distributions for both trauma client load (i.e., z skew;0.015/0.228=0.065; z kurtosis; --0.633/0.453=-1.397) and years of practice (z skew; -0.215/0.228=-0.943; z kurtosis; -0.922/0.453=-2.035). Although, years of practice now had a significant platykurtic distribution, this was only at the $p<0.05$, which is seen as acceptable in larger samples, as this can give rise to small standard errors (Field, 2005). All 3 variables had thus reached the appropriate standards for the normal distribution assumption for parametric tests.

5.6.2 Participants' experience of stressful situations/traumas and current emotional woundedness

The psychologists' experience of trauma(s), particularly stressful situations and current emotional woundedness has been displayed below in Table 5.2. This shows that 55 of the psychologists responded "yes" to having experienced a trauma, defined according to the DSM-IV (APA, 2000) while 57 stated "no". There were no significant differences in reported traumas between clinical and counselling psychologists ($t(110)=1.350$, $p>0.05$).

Moreover, when the respondents were asked whether they had experienced a particularly stressful situation[2], 102/112 (91%) psychologists confirmed that they had experienced such an incident at some point in their lives. Of these 55 (46%) could be considered a traumatic incident based on DSM-IV criteria (APA, 2000), whilst 47 (46%) did not correspond to how the DSM-IV (APA, 2000) has defined a traumatic incident, despite being seen as highly stressful incidents for the participants concerned.

The mean overall current emotional woundedness score, as measured by The Current Emotionally Woundedness Scale (CEWS), was 7.13 (SD=2.73) out of a potential score of 20 for the sample. This meant that on average the psychologists were only slightly emotionally wounded. In other words, on average the psychologists had almost fully come to terms with their stressful life experiences. Moreover, the mean woundedness score for the trauma group was 7.65(SD=2.77), whereas the mean woundedness score for the no trauma group was 6.02 (SD=3.65), and the mean woundedness score for the no

[2] A particularly stressful life event(s) was defined in the current study as one or more experience(s) of trauma and/or neglect, major losses through death or ending/separation of long term relationships, own psychological difficulties or serious physical illness.

trauma, but had experienced particularly stressful incident group was 7.30 (SD=2.58). This showed that there was not much difference in the reported emotional woundedness between trauma group and stressful experience group.

Table 5.2: Psychologists' experience of stressful situations/traumas and current emotional woundedness

Nominal Variable	*Frequency*	*Percent*	*Variable mean(SD)*	*Possible Range*
Trauma (according to DSM-IV)			**Current emotional woundedness** [a]	
Yes	55	(49.1%)	7.65(2.77)	4-20
No	57	(50.9%)	6.02(3.65)	4-20
Total	112	(100%)	7.13 (2.73)	4-20
Particularly stressful situation(s)[3]			**Current emotional woundedness** [a]	
No stressful incident, no trauma	10	(8.9%)	0(0)	
No trauma, but has experienced particularly stressful incident(s)	47	(42%)	7.30(2.58)	4-20
One or more trauma(s) (DSM-IV)	55	(49.1%)	7.56(2.77)	4-20
Total	112	(100%)	6.78(3.32)	4-20

[a] Current emotional woundedness was measured by The CEWS (CEWS), developed by the researcher for the present study. Psychometric properties of the scale can be seen in the method section.

The Current Woundedness data was checked to see whether the statistics were suitable for parametric testing. First, the scale was Likert like data, which is typically treated as interval scaling (i.e. there is a regular interval between the numbers on the scale, but no absolute zero) (Tabachnick and Fidell, 1983). The woundedness measure thus met the first parametric assumption. Moreover, normal distribution and outlier checks were completed using a histogram, box plots, and kurtosis and skewness statistics (see Appendix 2b). An inspection of the histogram revealed that current emotional woundedness scores were positively skewed (i.e., scores were clustered more around the lower end of the scale, indicating that most psychologists scored low on current emotional woundedness). This positively skewed shape warranted further inspection for normality, and so kurtosis and

skewness statistics were examined. Skewness (i.e.,0.793) and kurtosis (i.e., -0.022) statistics were both found to deviate from 0, which indicated that current emotional woundedness scores were not perfectly normally distributed. These skewness and kurtosis scores were next converted to z scores, in order to standardise these, so that the scores became more meaningful. First, in accordance to Field (2005) the kurtosis was converted to z scores (i.e., -0.022/0.453=0.048). The z score meant that the kurtosis was non-significant, but rather normally peaked (i.e., it was below an absolute value of 1.96). Next, skewness of the distribution was converted to a z score (i.e., 0.793/0.228=3.478). Such a skewness value above 2.58, but below 3.29, indicated that the distribution was significantly skewed at $p<0.01$. This variable was therefore transformed using a logarithm, which resulted in a normal skew (i.e., z. skew; 0.195/0.228=0.855), although a $p<0.5$ significantly platykurtically distribution (z kurtosis; -0.991/0.453=-2.185). This was however acceptable, because according to Field (2005), larger samples can sometimes give rise to small standard errors, and the kurtosis was less significant than the skew when the variable was not transformed. Finally, a box plot revealed that there were no outliers or extreme scores. Altogether, this thus suggested that the current emotional woundedness data was sufficiently normally distributed to make use of in parametric tests.

Normal distribution was not however undertaken across the independent variable levels of the factors trauma and particularly stressful situations, because these variables were not used as IV's with current emotional wounedness as a dependent variable in any t-test or ANOVA analyses. Table 2 informing about differences in reported current emotional

woundedness between trauma and stressful situation groups therefore remained purely descriptive.

5.6.3 Sense of Coherence (SOC), coping and social support variables' descriptive statistics

Table 5.3 showed that the psychologists reported an overall mean score of 65.01 on the SOC-13 (Antonovsky, 1967), from a potential range of a minimum score of 13 and a maximum score of 91. It was however difficult to interpret whether this should be seen as a small, normal or large mean sense of coherence, as Antonovsky never defined any norms for the SOC scores (Eriksson and Lindstrom, 2006). In order to get a fuller understanding of the extent of the psychologists' sense of coherence, comparisons were made between SOC scores from the current study and SOC scores from other samples. This can be seen in the discussion.

A histogram demonstrated that the SOC variable showed itself to be slightly negatively skewed, although normally peaked (kurtosis) (see Appendix 2 c). A further look at the statistics found that the kurtosis was significant at a $p< 0.05$ (i.e., 0.925/0.453= a Z score f 2.042), which is seen as an acceptable kurtosis (Field, 2005). The skewness was however found to be significant at a $p<0.001$(i.e., -0.800/0.228= a Z score of-3.508). This indicated that there was a very significant negative skew. Moreover, box-plots showed no extreme scores, although 3 outliers. In order to correct the skewed distribution of scores, both a log transformation and a square root transformation was tried, but both failed to normalise the data. As the researcher was hesitant to remove the outliers, due to having

no good reason to believe that these cases were not from our intended population, a change in scores was attempted. In line with Field's (2005) suggestion, 2 outlier scores (both at 34 SOC points) were changed to the next highest scores plus one (i.e., 42 SOC points). This resulted in an acceptable skewness (i.e.,-0.571/0.228=-2.504) and kurtosis (i.e., 0.159/0.453=0.351). Both skewness and kurtosis was thus below a z score of 2.58, meaning that although the distribution was skewed at a significant level of $p<0.05$, this was satisfactory. The SOC data had therefore showed itself to be of adequate normal distribution and thus reached the first parametric assumption.

Table 5.3: SOC, coping and social support variables (N=112)

Variable	*Mean*	*SD*	*Minimum*	*Maximum*	*Potential range*
SOC total score	**65.01**	**9.86**	**34**	**83**	**13-91**
MSPSS Support overall score	**69.49**	**10.65**	**40**	**84**	**12-84**
Significant Other support	24.90	4.48	4	29	4-28
Family support	22.03	5.39	4	29	4-28
Friends support	22.77	3.98	12	28	4-28
Coping variables (Brief COPE)					
Self distract	4.64	1.63	2	8	2-8
Denial	2.15	.53	2	5	2-8
Substance use	2.70	1.19	2	8	2-8
Self blame	3.55	1.50	2	8	2-8
Behavioural disengagement	2.34	.72	2	7	2-8
Emotional support	5.35	1.53	2	8	2-8
Instrumental support	4.94	1.37	2	8	2-8
Active coping	5.61	1.53	2	8	2-8
Venting	4.65	1.44	2	8	2-8
Humour	3.94	1.59	2	8	2-8
Positive reframing	4.59	1.43	2	8	2-8
Acceptance	5.37	1.63	2	8	2-8
Religion	3.23	1.73	2	8	2-8

In terms of the social support variables, the descriptive statistics further demonstrated that the sample showed a mean score of 69.49 (SD=10.65) on global social support. The

social support variables' skewness and kurtosis were converted to z scores and inspected through histograms, in order to check whether they were distributed normally (see Appendix 2d). Overall support was slightly negatively skewed (-0.648/0.229= a Z score of -2.893) at a $p<0.1$ level, which was tolerable, while the kurtosis was non-significant (i.e., -0.224/0.455=-0.492). In addition, the friend support variable showed itself to be n-significantly skewed (i.e., -0.420/0.229=-1.834) and n-significantly peaked (i.e., -0.528/0.455=-1.160), thereby suggesting it was from a normally distributed population. The overall support and friend support variables therefore both reached the normal distribution assumption.

The family support item was, however, found to be significantly negatively skewed (i.e., -1.274/0.229=-5.563) and platicurtically distributed (kurtosis: 1.722/0.455=3.784) at a $p<0.001$. Moreover, significant other support was even more negatively skewed (i.e., -2.282/0.229=-9.965) and majorly plasticurtically, or flatly distributed (i.e., 6.199/0.455=13.624), both at a $p<0.001$ level, as also suggested by the histogram. In order to correct these problems, a transformation of the family support variable was first attempted (both a log transformation and a square root transformation). However, as this did not improve the distribution, a change in the 4 outliers scores (i.e., one unit above the next highest score in the data set) was completed, again in accordance with Field's suggestions (2005). This resulted in a reduction in both skewness (i.e., -0.854/0.229=-3.729) and kurtosis (i.e., 0.114/0.455=0.251), although the family support variable still remained significantly skewed at $p<0.001$. Also, as the significant other scores were significantly negatively skewed and plasticurtically distributed, the 4 extreme scores were

changed, again to one unit above the next highest score in the data set (i.e., 15). This resulted in an acceptable kurtosis (i.e., 1.429/0.455=3.141), although still a highly significant negatively skewed distribution (i.e., -1.417/0.229=-6.188) at a $p<0.001$.

The family support and the significant other support variables were nevertheless deemed as tolerable, as the "Central Limit Theorem" supports giving up this requirement if the sample size is sufficiently large (i.e. $N > 50$) (Howell, 2002). This theory states that as n increases, the shape of the sampling distribution approaches normal (Howell, 2002). In other words, as the sample size increases, just about any distribution (normal or non normal) will tend to behave normally. This is because, if the sample size increases, the variance decreases, which means that it will result in a tighter, more normal distribution. The Central Limit Theorem thus justified the usage of the Significant Other and Family Support variables, despite the detected negative skews in both distributions.

The descriptive statistics from Table 5.3 further demonstrated that some of the coping variables had small SD's (e.g., denial and behavioral disengagement), which suggested that there may not be enough variation in scores. In order to further check whether the data was normally distributed, histograms, skewness and kurtosis statistics, as well as boxplots were completed (see Appendix 2e). These showed that the variable denial had 3 extreme scores. Also, a histogram of denial further showed itself to be positively skewed and have a leptokurtic, or pointy distribution. In other words, almost all the scores were centered on 2, meaning that the psychologists did not report to use denial as a way of coping. This was further demonstrated in the kurtosis statistics, with the Z skewness

statistic deviating massively from 0 (i.e.., 4.384/0.229=19.061), and the z kurtosis statistic opposing the normal distribution requirement even more (i.e., 20.770/0.455=45.449). The z kurtosis and z skewness statistics for the variable denial had thus been shown to be significantly large for the sample size. This was because denial had too little variation in scores. As this could not be fixed using transformations or removing or changing outliers, denial was discarded from the current study, due to not being sufficiently valid (i.e. not measuring what it says it did).

Most of the other COPE variables nevertheless were found to be normally distributed from calculating the z skewness and the z kurtosis values, as well as from looking at the histrograms (see Appendix 2e). For example, when calculating the skewness and kurtosis z scores as shown above, self distract; active coping; emotional support; instrumental support; positive reframing; planning and acceptance were all found to be non significantly skewed or peaked (i.e., with a z values less than 1.96). Moreover, although venting was found to be positively skewed (i.e., 0.590/0.229= z skewness of 2.576), this was only at $p<0.05$. This was also the same for humour, which was also positively skewed (i.e., 0.6631/0.229= z skewness value of 2.895) at a $p<0.01$. This was satisfactory however, as the skewness was below the upper z skewness threshold of 3.29 (Field, 2005).

The remaining coping variables, such as religion, self-blame, behavioural disengagement and substance use were however found to all be positively skewed, and with either a leprokurtic (e.g., behavioural disengagement and substance abuse), or a platykurtic

distribution (e.g., religion). This was further demonstrated by the converted z kurtosis and z skewness values. For example, for behavioural disengagement, both the positive skew (i.e., 1.980/0.229=8.646) and the z kurtosis (i.e, 3.651/0.455=8.024) were significantly large for the sample at $p<0.001$. This was also the case for substance use (i.e., z skew; 1.674/0.229=7.310; and z kurtosis; 2.407/0.455=5.290); religion (i.e., z skew; 1.397/0229=6.100; and z kurtosis; 1.095/0.455=2.406), and self blame (i.e., z skew; 1.170/0.229=5.109; and z kurtosis; 1.038/0.455=2.281). These variables thus failed to demonstrate even near-normal distributions. These latter coping factors were consequently tried to be transformed (through logarithm10 and the square root), but they then became even more skewed. Instead, outliers and extreme scores were replaced by the next highest scores (Field, 2005). In other words, the self blame outlier from subject 4 of a score of 8 was replaced by a score of 7; 4 religion outliers of score 8 were replaced by 7; and one extreme score of 5 in behavioural disengagement was replaced by a value of 4. This resulted in positive z skewness being reduced for religion (z skewness=5.227); self blame (z skewness= 4.856) and behavioural disengagement (z skewness= 7.498), although they all remained significantly skewed at $p<0.001$. The outliers in substance abuse and behavioural disengagement were however not replaced, as these scores were so low already, and a replacement would mean that the variance in scores would only be 2-3 (for behavioural disengagement) or 2-4 (for substance abuse). Altogether this meant that the 4 variables still remained non-normally distributed, and so did not meet the first parametric assumption. They were however not discarded, as this could potentially mean a loss of important associations between particular types of coping and stress and personal growth in psychologists, and as this only was an exploratory study. This waiving

of the normal distribution requirement was nevertheless possible, because again the "Central Limit Theorem" supports this if the sample size is sufficiently large (i.e. $N > 50$), as discussed above (Howell, 2002). This was further acceptable because psychometric testing, such as multiple regression remains robust (Rasmussen, 1989). Taken together with the fact that the COPE variables were of Likert like scaling, all COPE variables, except for denial, were satisfactory to use in the parametric tests.

5.6.4 Compassion Fatigue (CF) descriptive statistics

Means, SD's, minimum, maximum and norm scale scores of CF as measured by the ProQol scale (Stamm, 2005) were demonstrated in Table 5.4. This showed that the mean CF score in the current sample was 10.76 (SD=6.20) out of a possible 50. There were no significant differences in reported CF between men and women ($t(110)= -0.312$, $p>0.05$). The range reported between the minimum and maximum CF scores revealed that the psychologists reported highly varied scores.

Table 5.4: CF statistics in British psychologists (N=112)

Variable	*Mean*	*SD*	*Minimum*	*Maximum*	*Possible scale min-max scores*
CF	10.76	6.20	1	29	0-50

In order to prepare the data for parametric tests, the CF variable was checked for its suitability for parametric testing, making use of the 3 parametric assumptions. First, it was clear that the scale was based upon Likert scaling, which is typically treated as interval scaling. The stress measure thus met the first parametric assumption. Second, a histogram, skewness and kurtosis statistics were calculated in order to investigate

whether CF scores were normally distributed (a second parametric assumption). The histogram and statistics can be seen in Appendix 2f. The histogram showed that the variable was positively skewed (meaning that the psychologists had a tendency to report lower stress scores, rather than higher stress scores), but with an apparent normal kurtosis. This was further confirmed through the skewness (i.e., 0.982/0.228= Z skew of 4.307) and kurtosis (0.514/0.453=z kurtosis of 1.135) statistics. After an attempted logarithm (lg10), and change of 1 outlier, to a unit above the next highest score, the skew had reduced to a non significant z skew of -1.245. Moreover, the transformed CF variable came out as non significant on the Kolmogrov-Smirnov test ($p>0.05$), which meant that distribution of the sample was not significantly different from a normal distribution (i.e., normal). Thus the transformed CF met the second parametric assumption, which meant it was suitable to use in parametric tests.

5.6.5 Vicarious Posttraumatic growth (VPTG) descriptive statistics

Table 5.5 revealed that the psychologists scored a mean overall growth score, or VPTG score from the PTGI of 47.05 (SD=20.62). There were no significant differences in VPTG between men and women ($t(110)=0.529$, $p>0.05$). Moreover, the rather large SD and range (i.e., 87) for this latter variable further suggested that this data may include some extreme scores or outliers, which may have made the data unsuitable for parametric testing. Box plots of the VPTG overall scores as shown in Appendix 2g, suggested however that this was not the case, and that no outliers or extreme scores were in fact found. Also, a histogram further revealed that the VPTG data looked normally distributed (see appendix 2g).

Table 5.5: Vicarious posttraumatic growth statistics in British psychologists (N=112)

Variable	*Mean*	*SD*	*Minimum*	*Maximum*	*Possible min-max scores*
VPTG overall score	47.05	20.62	0	87	0-100

This apparent normal distribution was further confirmed by the z skew (i.e., -0.272) and the z kurtosis (i.e., -1.201) statistic, and the Kolmogorov-Smironov test, that came out non-significant (p.>0.05). Taken together with the fact that the PTGI was based on Likert like scaling, and therefore treated as interval measurement, the overall VPTG data was suitable for parametric testing.

Further assumption checks at every level of each independent variable were however needed, as unlike the other continuous variables, the VPTG data was to be used in tests of difference (i.e., t-tests) (see Appendix 2g). First, normal distribution checks were applied to the VPTG data in the trauma and the no trauma group, by splitting the SPSS outputs. This revealed that the both no trauma (z skew; -0.0655; z kurtosis; -0.247) and trauma groups' (z skew; -0.289; z kurtosis; -1.374) VPTG scores were from normal distributions (see appendix 2 f). Second, split files were applied for the clinical and counseling psychologists groups. Further statistical descriptives then showed that although VPTG in the counselling psychology group (i.e, z skew; -1.862; z kurtosis; 0.154) and the clinical psychologiy group (i.e., z skew;-1.192; kurtosis; 0.370) were negatively skewed, these were non-significant. VPTG at each level of psychology specialisation thus appeared to

come from normally distributed samples. Both these findings were further confirmed by the Kolmogorov-Smironov test that came out as non-significant (p.>0.05).

Third and finally, split files of VPTG for psychologists having received personal therapy versus those psychologists who had not received personal therapy were put into operation (appendix 2g). It was then detected that VPTG scores for both psychologists who had themselves received therapy (z skew=-0.484; z kurtosis= -1,196) and those psychologists who had not received therapy (z skew=-0.197; z kurtosis= -0.115) were normally distributed. This was also confirmed by inspecting the histograms and from the non significant Kolmogorov-Smironov test (p.>0.05).

Altogether these checks thus found VPTG to fulfill the parametric assumption of normal distribution. Levene's tests were however needed to test for the third parametric assumption; homogeneity of variance (see appendix 2g), as we were looking at groups of data, rather than continuous data. Homogenecy of variance means that the variance of an outcome variable of one group of data should be the same in the other group of data (Field, 2005). All three Levene's tests were found to be non-significant (p>0.05), which meant that the variances in VPTG between trauma groups, received psychotherapy groups and psychology specialisation groups were roughly equal (Appendix 2g). The third and final parametric assumption of homogeneity of variance was thus met.

6. Results

6.1 Inferential statistics

Having established that all the factors above had met the appropriate parametric assumptions so far (except for denial, which had consequently been discarded), various parametric tests were employed to analyse what factors related to and predicted CF and personal growth (VPTG) in the psychotherapeutically working psychologists. Parametric tests were preferentially chosen over non-parametric equivalents due to their greater sensitivity to the data, as they use all the information from the data (e.g. values, size of differences, and not only ranks as non parametric tests would do) which results in greater power in detecting significant findings (Howell, 2002). Power has been defined as "the likelihood of detecting a significant difference when the null hypothesis is false", i.e. the probability of not making a type II error (Coolican, 1996). Thus, parametric tests were chosen over non parametric tests because the former have more power in detecting patterns in the data.

SPSS was used to perform independent t-tests, correlations and multiple regressions. The t-tests were used to test out differences in personal growth between groups (nominal IV's). Moreover, the correlations tested associations between the remaining IV's (of interval measurement) and CF and personal growth (VPTG). Finally, multiple regressions were used to determine which factors best predicted CF and personal growth from therapy in psychologists. Forced entered multiple regressions were chosen, because this was largely an exploratory study, and so little previous research could justify the order of

the predictors. Thus, simultaneously entered variables were most appropriate. The analyses performed will now be described.

6.1.1 Compassion fatigue (CF) inferential statistics

Correlations were performed prior to a multiple regression, in order to get a broad sense of which variables were associated with CF, and to make sure there were no high inter-correlations that would affect the multiple regression outcomes. As the hypotheses were directional, 1-tailed tests were used. In line with Cohen (1988), the current correlations were interpreted according to the following: if r=0.1, the correlation was considered as small, and if r=0.3 it was seen as medium, and finally if r=0.50, the association was seen as large.

A forced entered multiple regression was thereafter used to examine which combined factors best predicted CF, and whether current emotional woundedness could add predictive value to the model. No t-tests were however performed to test out differences in CF between the nominal factors (i.e. trauma; psychology specialisation and received therapy groups), because no hypothesised relationships existed between these latter nominal factors and CF (nor none were found when tested out).

H1: a) Psychologists' Compassion Fatigue (CF) will correlate with: i): work factors including experience and trauma client loads and; ii) personal vulnerability factors including: current emotional woundedness; negative coping strategies; sense of coherence and less social support.

Pearson's r correlations evaluated whether psychologists' CF correlated with individual and work factors (see table 6.1 and 6.2 below). In line with the above hypothesis set, CF was highly positively correlated with current emotional woundedness ($r=0.428$, $p<0.01$); self-distraction ($r=0.394$, $p<0.01$); behavioural disengagement ($r=0.349$, $p<0.01$) and self blame ($r=0.390$, $p<0.01$) and moderately positively associated with; substance use ($r=0.243$, $p<0.01$) and venting ($r=0.232$, $p<0.01$). Also, CF had a small positive associations with reframing ($r=0.157$, $p<0.05$); and religion ($r=0.168$, $p<0.05$).

Furthermore, CF had a large negative association with SOC scores ($r= -0.535$, $r<0.01$) a medium negative correlation with overall support (MSPSS) ($r= -0.237$, $r<0.01$) and family support; ($r= -0.251$, $r<0.01$) and a small negative association with active coping ($r= -0.186$, $p<0.05$). All other hypothesised work associations with CF, including: experience (years of practice) ($r=0.085$, $p>0.05$); trauma client load ($r=0.029$, $p>0.05$), and the remaining coping strategies (i.e., planning; humour; acceptance; emotional and instrumental support) were n-significant.

Table 6.1. Significant Pearson's r correlations and p-values for associations between CF and individual factors (N=111)

Variable	Current Emotional Woundedness	SOC	Family support	Overall support	Self distract	Self blame	Behavioural disengagement	Substance use	Venting	Active coping	Religion	Positive reframing
CF	0.428**	-0.535**	-0.251**	-0.237**	0.394**	0.390**	0.349**	0.243**	0.232**	-0.186*	0.168*	0.157*

Note. All are one tailed. *p<0.05,**p<0.01.

Table 6.2. Factors that did not correlate with CF (N=111)

Variable	Trauma clients	Friend support	Experience	Significant Other Support	Humour	Planning	Acceptance	Emotional Support
CF	0.029	-0.110	0.085	-0.146	0.102	-0.028	0.075	0.114

Note. All are one tailed Pearson correlations.

The large associations (i.e., CF and current emotional woundeness; CF and SOC) and the medium associations (i.e., CF and self distract; CF and behavioural disengagement; and CF and self blame) were further checked using scatter plots, in order to confirm their linear relationships (see Appendix 4). This was done because the Pearson correlation alone could be very misleading, as it was a measure *of the supposed linear relationship* between two variables (Kinnear and Grey, 1999), and thus the associations found needed to be checked for such linearity. The scatter plots illustrated that both current emotional woundededness and SOC individually showed strong linear relationships with the CF construct. Thus both a) the psychologists' sense of coherence (SOC) and, b) the psychologists' current emotional woundedness were highly associated with the psychologists' tendency to become negatively affected by their clients' difficulties (CF). In other words, the less psychologists saw their lives as meaningful, comprehensible and manageable, the more negatively affected they were by their client work. Also, the less psychologists had come to terms with their stressful/traumatic life experiences, the more negatively affected they were by their clients.

Finally, the scatter plots also demonstrated fair individual linear relationships between CF and self distraction, self blame and behavioural disengagement, thereby suggesting that the more the psychologists were suffering from CF, the more they were using self distraction, blaming themselves and behaviourally disengaging (i.e. giving up coping) and vice versa.

H1b): CF will be predicted by i): work factors including experience and trauma client loads and; ii) personal vulnerability factors including: current emotional woundedness; experience; coping strategies; sense of coherence and less social support.

The correlations above have suggested that there was an association between CF and: current emotional woundedness; SOC; overall support; family support; self-distraction; active coping; substance use; behavioural disengagement; venting and self-blame. In order to evaluate which of these combined factors (IV's) best predicted CF (DV), and how well they could account for the overall variance in the CF scores, a multiple regression was used.

Unlike hypothesised, work factors such as experience and higher trauma caseloads had not however been found to be associated with CF in the current study. These latter factors were thus not included in the current multiple regression, as they remained uncorrelated with the DV (CF), and were therefore naturally unable to predict the DV either. In addition, because overall support was highly correlated with family support ($r=.832$, $p<.001$), this former factor was excluded from the multiple regression, in order to exclude multicollinearity, as the regression was most effective if each IV did not too strongly correlate with each other (Howell, 2002).

The following 8 predictors were added into a simultaneously entered multiple regression: SOC; current emotional woundedness; family support; self-distraction; substance use; behavioural disengagement; active coping and self-blame. These factors were chosen as a

predictive model based on previous research, theory and the correlations done above. In addition, current emotional woundedness was also added, to evaluate whether this unexamined factor could add value to the model. All the predictor variables were continuous.

Regression assumptions were examined, including multicolinearity, collinearity, correlation and outlier among residuals, and homoscedasticity (see Appendix 3b). These showed that there were no large correlations between the predictor variables; the residual terms were not correlated (i.e., Durbin-Watson was 1.989); there was no collinearity between predictor variables (i.e., no tolerance scores below 0.658 and VIF scores all below 1.6); and no multicollinearity (i.e., most of the predictors were placed against different dimensions). Also, although 7 residual outliers were found, with only one case exceeding 2.5 (case 51 with a std. residual of 2.514), this was to be expected for a sample size of 112, and thus acceptable (Mayers, 2009). All the above assumptions of multiple regression were therefore met. Some questions were however raised in relation to meeting the assumption of homoscedasticity, as the plots appeared slightly funneled shaped, which suggest linearity, but not full homoscedasticity (see appendix 3b). This would weaken the multiple regression finding and therefore would have to be taken into consideration when interpreting the results.

The main findings of the multiple regression can be found in table 6.3. The adjusted R^2 described the extent to which the predictors as a whole could explain the variance in CF. The beta values (ß) were a measure of how strongly each variable uniquely influenced the

DV (Brace, Kemp and Snelgar, 2003). A positive beta value thus indicated as the value of it increased the value of the outcome variable also increased, while a negative beta value would indicate the opposite. The t-statistics and the p values further gave a rough indication of the impact of each individual predictor variable upon the DV (Brace et al., 2003).

The adjusted R^2 demonstrated that the model altogether explained 40.6 % of the variance in the population estimate of CF. The model was found to significantly predict the CF outcome ($F(8, 101)=10.314$, $p<0.001$). Taken together these factors thus gave a fair to good explanation (Howell, 2002) of the variance in CF. However, only some of the factors significantly contributed to the variance in CF. In fact, only 3 variables, including, higher levels of current emotional woundedness ($t=2.696$, $p<0.01$); lower levels of sense of coherence (SOC) ($t=-2.844$, $p<0.01$), and more use of self distraction when coping with work related difficulties ($t=2.917$, $p<0.01$) all significantly predicted higher levels of CF in the psychologists. Self-blame, behavioural disengagement, family support, substance use and active coping did not however significantly contribute to the prediction of CF.

It was nevertheless initially puzzling that self-blame, which was found to be highly correlated with CF in the correlation matrix ($r=0.390$, $p<0.01$), did not also predict CF. This "mystery" was nevertheless explained by the confidence intervals which crossed 0, which meant that it would be impossible to get a significant contribution from that predictor, due to too much inconsistency (Mayers, 2009).

Table 6.3: Multiple regression analysis of CF

Predictor variable	R^2	AdjR^2	F	p	Constant	ß	t	p(t)	95%CI	
Model	.450	.406	10.314	<0.001	0.879				Upper	Lower
Current Emotional Woundedness						**0.352**	**2.696**	**0.008****	0.093	0.611
SOC						**-0.007**	**-2.844**	**0.005****	-0.012	-0.002
Self distract						**0.038**	**2.917**	**0.004****	0.012	0.063
Self blame						0.014	0.851	0.397	-0.018	0.046
Behavioural Disengagement						0.065	1.855	0.066	-0.005	0.135
Family support						-0.002	-0.357	0.722	-0.010	0.007
Substance use						0.008	0.413	0.681	-0.031	0.048
Active coping						-0.018	-1.318	0.190	-0.044	0.009

**p<0.01.

In sum, the inferential statistics for CF showed the following. First, unlike hypothesised, work factors such as trauma client load and experience were not associated with, nor predicted CF. As such, the current study suggests that neither experience, nor working with trauma clients is associated with CF. Instead, the following individual vulnerability factors predicted CF: sense of coherence; current emotional woundedness and self distraction. In other words, CF was predicted by a weaker sense of coherence, greater woundedness, and greater self distraction as a coping style. The model had to however be interpreted with caution, as the assumption of homoscedacicity had not been adequately met. Additional factors found to be associated with CF, although not predict the construct were: overall support; family support; active coping; substance use; behavioural disengagement; venting; positive reframing, religion and self-blame. These findings have thus highlighted correlates and predictors of a model of CF.

6.1.2 Vicarious posttraumatic growth (VPTG) inferential statistics

A second set of hypotheses evaluated which work and individual characteristics were related to psychologists' positive effects of client work. The positive effects of client work, or rather personal growth from client work, was measured by the vicarious posttraumatic growth construct. The first 3 hypotheses used t-tests in order to evaluate whether according to the hypotheses, there were differences in reported VPTG between the nominal factors: trauma history groups: psychology specialisations and received therapy groups. Also, thereafter, correlations were employed, in order to get a broad understanding of which individual and work factors that were associated with psychologists' VPTG. This was needed to build a model of VPTG. Finally, a multiple regression was run, to determine which combined factors best predicted VPTG and to find how much of the variance of VPTG these variables could explain. The noted inferential statistics will now be evaluated in turn according to the set hypotheses.

H2: Psychologists with a trauma history will report more vicarious posttraumatic growth (VPTG) compared to psychologists who have not got a trauma history

Table 6.4 and 6.5 showed that unlike hypothesised, and despite the trauma group reporting higher VPTG scores (M=50.04, SD=21.302) compared to the non trauma group (M=44.37, SD=18.144), this difference was n-significant ($t(110)=-1.517$, $p>0.05$). This meant that psychologists with a trauma history did not report experiencing significantly more personal growth from their client work compared to psychologists who did not have a trauma history.

Table 6.4: VPTG group statistic differences between trauma and no trauma

VPTG	Trauma	N	Mean	SD	Std. Error Mean
	No	57	44.37	18.144	2.403
	Yes	55	50.04	21.320	2.875

Table 6.5: t-test: no differences in VPTG between trauma and no trauma groups

	t	df	Sig. (2 tailed)	Mean difference	Std Error Difference	95% CI Lower	Upper
VPTG	-1.517	110	0.132	-5.668	3.736	13.072	1.736

H3: Counselling psychologists will report more vicarious posttraumatic growth compared to clinical psychologists

Table 6.6 and 6.7 showed that in line with the set hypothesis, counselling psychologists (M=53.87, SD=19.599) reported significantly more personal growth from giving therapy (VPTG) compared to the clinical psychologists (M=38.82, SD=17.011)(t(110)=4.282, p<0.001). In other words, in comparison to the clinical psychologists, the counselling psychologists felt that they gained more personal growth from their client work.

Table 6.6: VPTG group statistic differences between clinical and counselling Psychologists

VPTG	Specialisation	N	Mean	SD	Std. Error Mean
	Counselling psychologists	62	53.87	19.599	2.489
	Clinical psychologists	50	38.82	17.011	2.406

Table 6.7: t-test: Significant differences in VPTG between clinical and counselling psychologists

	t	df	Sig. (2 tailed)	Mean difference	Std Error difference	95% CI Lower	Upper
VPTG	4.282	110	0.001***	15.051	3.515	8.086	22.016

***p<0.001.

H4: Psychologists who have received psychotherapy will report more vicarious posttraumatic growth compared to those who have not.

The final independent t-test tested differences in personal growth from giving therapy (VPTG) between those psychologists who had received personal therapy and those who had not (see Table 6.8 and 6.9). This found that psychologists who had received psychotherapy reported significantly higher on VPTG scores (M=49.15; SD=19.791) compared to psychologists who had never received any therapy themselves (M=37.37; SD=17.724) (t (110)=2.404, $p<0.05$). Thus psychologists who had received personal therapy were notably more likely to feel like they personally grew from working therapeutically with their clients.

Table 6.8: VPTG group statistic differences between psychologists who have received own therapy and those psychologists who have not.

VPTG	Received own therapy	N	Mean	SD	Std. Error Mean
	Yes	93	49.15	19.791	2.052
	No	19	37.37	17.724	4.066

Table 6.9: t-test: Significant differences in VPTG between psychologists who have received own therapy and those who have not.

	t	df	Sig. (2 tailed)	Mean difference	Std Error difference	95% CI Lower	Upper
VPTG	2.404	110	0.018*	11.782	4.901	2.069	21.495

*p<0.05

Despite the unequal sample sizes used in the current t-test, a compromised G*power analysis showed that when using this sample size (i.e, n1=19 and n2=93) and a medium effect size, a total power statistic of 0.84 was achieved, which was acceptable as discussed in the method section.

H5a): Psychologists' personal growth from therapy work (VPTG) will correlate with: i) work factors including: experience; larger client load and larger trauma client load, and; ii) individual factors including, more social support; CF; current emotional woundedness and coping mechanisms (i.e. positive reinterpretation; acceptance coping; religious coping; problem focused coping; venting and avoidant coping).

The correlations can be seen in tables 6.10 and 6.11. As hypothesised, a medium to large correlation was found between VPTG and positive re-framing ($r=0.384$, $p<0.001$). Moreover, small to medium positive associations were found between VPTG and: CF ($r=0.242$, $p<0.01$); self distraction ($r=0.233$, $p<0.01$); venting ($r=0.239$, $p<0.01$); planning ($r=0.237$, $p<0.01$); acceptance coping ($r=0.301$, $p<0.01$) and religious coping ($r=0.206$, $p<0.05$). The correlations between VPTG and work factors were however n- significant including: experience ($r= -0.093$, $p>0.05$); client load($r=0.034$, $p>0.05$) and trauma client load($r=0.092$, $p>0.05$). Also, the associations between VPTG and individual factors such as, overall social support($r= 0.006$, $p>0.05$); current emotional woundedness ($r=0.134$, $p>0.05$), and the remaining coping variables were very small and n-significant.

The largest correlations (i.e. VPTG and positive re-framing; CF and acceptance coping) were further checked through scatter plots (see Appendix 4b). These confirmed that there was indeed a strong association between positive re-interpretation and VPTG, and a small to medium association between VPTG and acceptance coping. In other words, psychologists who coped with their work by looking for something good in the difficult situations (i.e. positive reinterpretation), and accepted that difficult experiences had

Table 6.10. Vicarious posttraumatic growth (VPTG)significant correlates (N=111)

Variable	CF	Positive reframing	Acceptance	Self distraction	Venting	Planning	Religion	Emotional support
VPTG	0.242**	0.384**	0.301**	0.233**	0.239**	0.237**	0.206*	0.189*

Note. All one tailed Pearson correlations. *p<0.05,**p<0.01.

Table 6.11. Factors that do not correlate with vicarious posttraumatic growth (VPTG) (N=111)

Variable	Current Emotional Woundedness	Trauma clients	Overall clients	Experience	Overall Support	Humour	Active coping	Substance use	Self blame
VPTG	0.134	0.092	0.034	-0.093	0.006	0.101	0.133	-0.011	0.100

Note. All one tailed Pearson correlations.

happened (i.e. acceptance coping) were more likely also see themselves as having personally grown from their client work (VPTG). The small to medium association between VPTG and CF did however remain less convincing through the scatter plots, something which may have been found because of large variance in scores (with some reporting no growth and others reporting a lot of personal growth from their therapy work).

H5b): Psychologists' vicarious posttraumatic growth will be predicted by i) work factors, including: experience; client load and trauma client load, and; ii) by individual factors including: CF; trauma/stressful experience; current emotional woundedness; being a counselling psychologist; social support and coping strategies (i.e. positive reinterpretation coping; acceptance coping; problem focused coping; religious coping; venting and avoidant coping)

The above correlations revealed that VPTG correlated with: CF; self-distraction; positive reframing; planning; acceptance and religious coping. Also, the t-tests found that there were significant VPTG differences reported between clinical and counselling psychologists and between psychologists having received therapy and psychologists never having received their own therapy. These two categorical factors, in addition to the correlated variables noted, were added in a forced multiple regression, in order to determine which factors together best predicted VPTG in the psychologists, and the amount of variance in the VPTG scores these variables could explain. However, prior to this, the categorical variables were re-coded into; 0 or 1, (with 0=counselling

psychologists and 1=clinical psychologists; and 0=have not received therapy, and 1=have received therapy).

Also, before the actual multiple regression findings were interpreted, the regression assumptions were checked (see Appendix 3c). From this, it was discovered in line with the assumptions that the residuals were not correlated (i.e., Durbin-Watson was 2.089, and therefore close to 2) and that there were no collinearity between the predictor variables (i.e., no tolerance scores below 0.631 and no VIF scores above 1.597). Furthermore, although positive re-framing and acceptance were mostly loaded on the same dimension, this was not the case for the remaining variables, in addition to not having any large correlations between predictors, which altogether suggested that the data passed the multicolliearity assumption. Also, although there were 7 outliers among the residuals, (2 of which did exceed 2.5), this was again to be expected for the sample size and thus tolerable (Mayers, 2009). Finally, a scatter plot demonstrated that the data was randomly spread across the plot (see Appendix 3 c), thereby suggesting that the data met the final assumptions of linearity and homoscedasticity.

Table 6.12 further showed that the model as a whole significantly explained 24.7% of the variance in VPTG ($F(8, 102)=5.512$, $p<0.001$). A further look at the statistics however, revealed that the only variable that significantly contributed to the model was positive reframing ($t=2.834$, $p<0.001$). Psychology specialsiation (Clinical or Counselling psychologist) did nevertheless nearly significantly contribute to the model ($t=-1.842$, $p=0.068$, $p>0.05$). Interestingly, when the multiple regression was run without 3 of the

least contributing variables (i.e., self distract, planning and religion), psychology specialisation came out as significantly contributing to the prediction of VPTG (t=-2.142, $p<0.05$) and the Adjusted R^2 increased to 0.259. Thus, in this latter model, the psychology specialisation and positive reframing were able to explain 25.9% of the variance in VPTG.

Table 6.12: Multiple regression analysis of VPTG

Predictor variable	**R^2**	**AdjR^2**	**F**	**p**	**Constant**	**ß**	**t**	**p(t)**	**95%CI**	
Model	0 .302	0.247	5.512	<0.001	12.207				Upper	Lower
CF						8.660	1.180	0.241	0.775	1.290
Self distract						0.907	0.788	0.433	0.777	1.287
Planning						-0.126	-0.090	0.929	0.626	1.597
Religion						0.812	0.741	0.461	0.880	1.137
Have received own therapy or not						-7.501	-1.431	0.156	0.725	1.380
Acceptance						1.368	1.135	0.259	0.704	1.421
Counselling vs Clinical psychologists						-7.679	-1.842	0.068	0.631	1.585
Positive Reframing						**3.875**	**2.834**	**0.006****	**0.714**	**1.401**

** t is significant at the 0.01 level (1-tailed).

The positive beta value for positive reframing meant that the more the psychologists were using positive reframing as a way of coping with their work, the more they would feel that they personally grew and gained from their work. All the remaining variables, including self distraction, planning, religion, acceptance and having received own therapy were n-significant contributors.

6.1.3. The concluding model; correlates and predictors of CF and VPTG in British clinical and counselling psychologists

The results have given rise to a model of correlates and predictors of CF and VPTG in British clinical and counselling psychologists. This has been graphically demonstrated below (see Figure 6.1).

Figure 6.1: A model of psychologists' positive and negative effects of client work: correlates and predictors of CF and VPTG in British clinical and counselling psychologists.

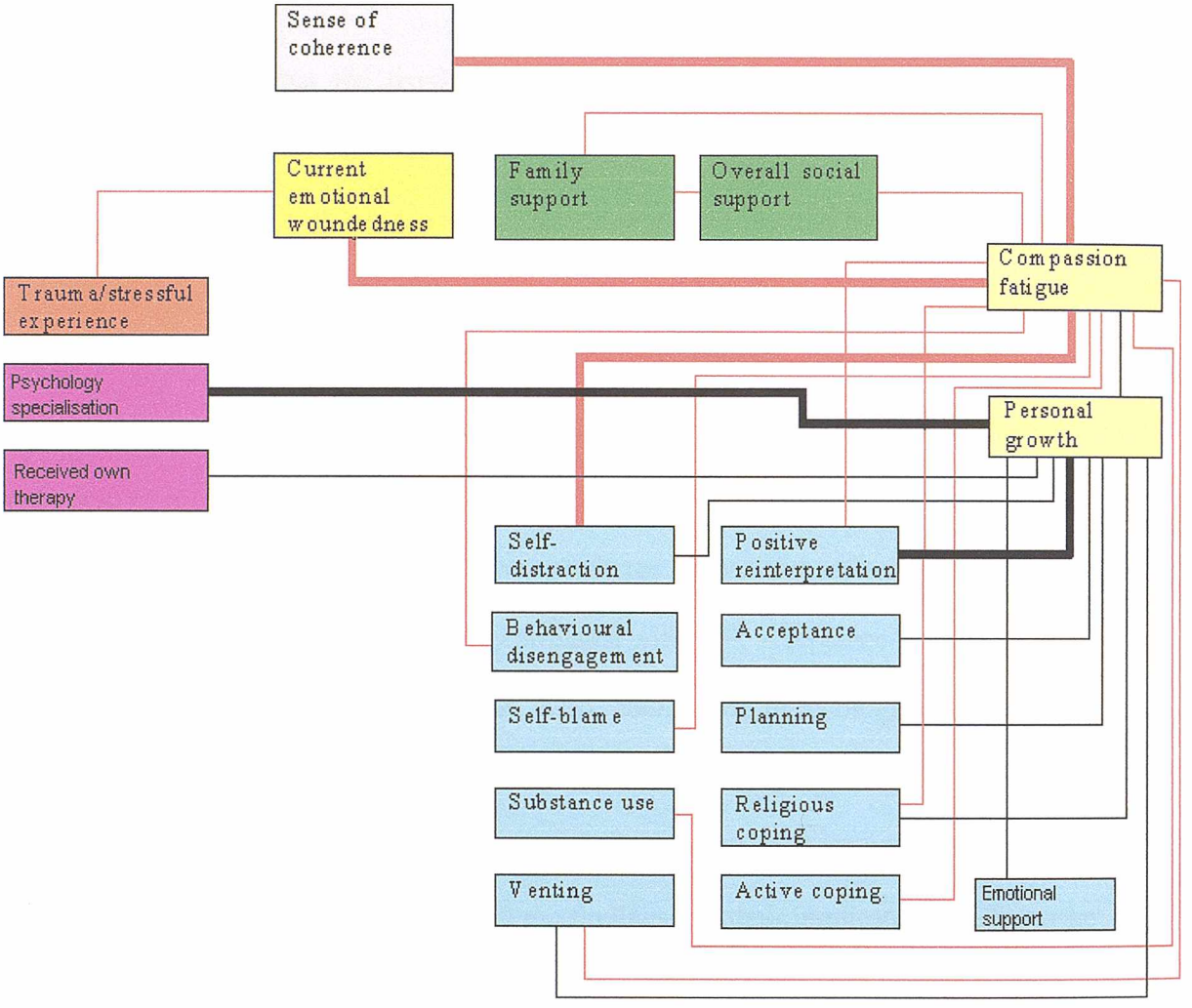


Diagram key

	significant predictors of compassion fatigue
	significant correlates of compassion fatigue
	significant predictors of vicarious posttraumatic growth
	significant correlates of vicarious posttraumatic growth
Turquoise boxes:	significant coping variables
Green boxes:	significant social support variables
Multi coloured boxes:	differing significant individual factors
Beige boxes:	DVs

Part 3: Discussion

7. Discussion

This study revealed that the psychologists' Compassion Fatigue (CF) and vicarious posttraumatic growth (VPTG) was related to individual factors rather than work factors, such as trauma client caseload. A model of psychologists' CF and VPTG was developed. This suggested that psychologists' CF was predicted by: sense of coherence; current emotional woundedness and self-distractive coping. Moreover, CF was positively associated with self-blame; behavioural disengagement; substance use; venting; religion and positive reframing, and negatively associated with family support; overall support and active coping. In addition, VPTG was predicted by positive reframing and being a counselling psychologist, and positively correlated with: CF; acceptance coping; venting; planning; religion and emotional support. Also, counselling psychologists and/or those psychologists who had received their own therapy were significantly more likely to report higher VPTG, when compared to clinical psychologists and/or those psychologists who had never been in therapy themselves. All the findings and their implications will now be discussed in the context of previous research.

7.1 Discussion on the main descriptive findings

7.1.1 Psychologists' trauma and woundedness

The descriptive statistics showed that about half of the psychologists had experienced one or more traumas (according to DSM-IV; APA, 2000). This is comparable to population estimates of trauma exposure that on average suggests that slightly above 50% of

individuals will be exposed to a major life stressor or traumatic event at some point in their lives, with men typically reporting somewhat higher trauma exposure compared to women. (e.g., Breslau et al., 1998; Kessler, Sonnega, Bromet, Hughes & Nelson, 1995).

However, the term trauma is difficult to define. In fact, when the trauma definition was more inclusive, the large majority (91.1%) of the psychologists reported that they had at some point experienced one or more particularly stressful life experiences that involved a trauma, and/or neglect, major losses through death or ending separation of long term relationships, own psychological difficulties or serious physical illness. This suggests that the DSM-IV (APA, 2000) definition of a trauma is too rigid, and that other experiences that are typically not defined as traumatic also can be highly stressful.

Corresponding emotional woundedness after such stressful encounters, meaning the extent to which the individual had come to terms with/learned to cope with the difficult experience, was further found to vary highly among the psychologists. However, the extent of such emotional woundendess was difficult to interpret, as the Current Emotional Woundedness Scale (CEWS) was created for the present study, and as such no norms had been created. Despite this, it could be concluded overall the mean average of the psychologists were only slightly emotionally wounded. Also, the vast majority of the psychologists from the present study appeared to have experienced particularly stressful life event(s).

Many comparable studies have found that therapists typically have experienced painful situations. For example, Way and colleagues (2004) found that 75.8% of their sample of sexual trauma clinicians reported to have had experienced at least one form of childhood maltreatment themselves, with 53.6% of them having had experienced multiple forms of maltreatment as a child. Similarly, Elliot and Guy (1993) also found that psychotherapists reported higher rates of physical abuse, sexual abuse, parental alcoholism, psychiatric hospitalisation of parent, death of a family member, a greater family dysfunction in their family of origins, compared to other professionals not working in mental health. These studies are difficult to compare due to the problems in defining a trauma and the differing aspects of trauma measured (e.g. childhood abuse vs. general trauma). However, the present findings appear to support previous studies that therapists and psychologists have themselves often experienced particularly stressful life experiences. More studies are however needed to confirm such potential high prevalence rate of trauma/stressful incidents in psychologists. The potential implications of psychologists having themselves often experienced stressful experiences will be further explored later in this discussion.

7.1.2 Psychologists' Sense of Coherence (SOC), coping strategies and social support

The psychologists' mean reported sense of coherence (SOC) was above average reported by a community sample (Pallent and Lea, 2001). Despite this, the psychologists' SOC score was below the reported mean score by a British therapist sample (Linley and Joseph, 2007). Nevertheless, taking into consideration reviewed studies using the SOC 13, it could be concluded that the current study, as well as the therapist study together

provided evidence suggesting that psychologists and therapists score relatively high on SOC compared to other populations. Thus, therapists and psychologists typically appear to see their lives as fairly meaningful, comprehensible and manageable.

Moreover, psychologists' reported overall social support (MSPSS) was above that of a student sample (Clara et al., 2003). This suggested that the psychologists on average felt fairly well supported by family, friends and significant others. It was however unknown how much social support the current sample received compared to other psychologist/therapist samples, as no comparable data had been published.

The descriptive statistics further revealed that the psychologists' most frequently used strategies to cope with work related stress were: active coping (e.g. taking action to change problem); acceptance; emotional support; instrumental support; venting and self-distraction. The least used strategies to cope with work related stress were: behavioural disengagement (e.g. giving up with coping); substance use; religious coping (e.g. praying) and self-blame. In relation to other professions, comparable studies have, for example, suggested that international project managers use more active coping, more instrumental support, more positive reframing and more acceptance in coping with their work related stress when compared to the current sample (Aitken & Crawford, 2007). Moreover, it appears that project managers make less use of typically "negatively" seen coping strategies, such as self distraction and substance use than the psychologists, although more use of self-blame and behavioural disengagement. Altogether these findings suggest that psychologists are using less "positive" coping and more "avoidant" coping when compared to project managers. It was however possible that the project

managers were a relative highly functioning group, and as such, if the psychologists had been compared to a community or student sample, their relative use of coping mechanisms would not have been seen as negative. In addition, it was difficult to estimate how the psychologists coped in comparison to other therapist samples, as few such studies had been done. Therefore, as no such samples or norms of the Brief Cope had been published, this remained unknown.

7.1.3 Prevalence of CF

In comparison to norm statistics, the prevalence of CF in the current sample was below average (Stamm, 2005). These mean scores were nevertheless comparable to mean CF scores in a recent study of British therapists (Linley and Joseph, 2007). Moreover, according to the cut scores, 17.86 % of the psychologists from the current sample scored high (17 and above), 45.54% scored moderately (8-17), whereas 36.60 % scored low (7 and below) on CF. This indicated that about 18 % of the psychologists felt particularly effected by their client work, about 45% felt moderately effected, and finally about 37% did generally not feel effected by their client work. Thus, a whole 63.4 % of the psychologists felt moderately or severely affected by working with distressed individuals. This evidence clearly implied that psychologists with a more general caseload (rather than specialising in trauma clients) can also be negatively affected by their clients. This finding, therefore, disputed previous claims/findings (e.g. Stamm, 1999) that CF is specifically caused by trauma work. This was particularly evident considering that only 6 out of the 112 psychologists defined themselves as trauma specialists. Moreover, overall, the trauma specialists scored less on CF than the remaining psychologists who were not

trauma specialists. These findings suggested that CF is not caused by trauma work, after all (unlike what has been theorised; e.g. Figley, 2002), but that psychologists with more general caseloads can also be negatively affected by their client work (i.e. CF).

This prevalence rate of CF in the psychologists was comparable to other therapist studies. For example, Steed and Bicknell (2001) found that almost half (46.2%) of their sample of Australian sexual offenders therapists was at moderate or higher risk of CF. Moreover, Ennis and Horne (2003) described that 20% of their sample of American sexual offender therapists reported having moderately, seriously or extremely problematic PTSD related difficulties.

Other comparable studies have nevertheless found even higher prevalence rates of PTSD like symptoms in therapists. For example, both Kassam-Adams (1995) and Way and colleagues (2004) found that about half of their samples of sexual abuse therapists scored high on the clinical, patient range using the Impact of Event Scale (IES; Harrowitz et al., 1979). Although it remains difficult to compare these findings with the current study, due to use of differing CF measurements, it can still be suggested that the current sample did not overall, report to be suffering from such high levels of CF. Thus, taken together it appears that CF prevalence rates can vary greatly from sample to sample. Moreover, the current findings suggested that CF was not an exclusive effect of trauma work, but that psychologists with more general caseloads could also be effected by their client work. Indeed, 63.4 % of the British psychologists were found to be moderately or severely affected by their clients, thereby suggesting that CF is a rather common consequence of

such work. It was however unknown what moderate or severe CF scores meant for each individual, and how much this negatively influenced the psychologists' and their work abilities. Such clinical implications of CF will be discussed in the implications section.

7.1.4 Prevalence of VPTG

The psychologists scored somewhat less on reported VPTG compared to a British therapist sample (Linley and Joseph's, 2007). This may have been explained by the type of approach used and trained in, with many of the therapists having been trained in humanistic/existential and transpersonal schools of psychology, that have an emphasis on growth. The psychologists from the present study were rather trained in multiple psychological approaches, with the majority claiming to work from an eclectic/ integrative approach (i.e., 65 %). The psychologists' beliefs may therefore not have been grounded in positive psychology to the same extent as the therapists.

Nevertheless, when the psychologists were further separated by psychology specialisation this revealed that counselling psychologists scored higher on the PTGI when compared to the clinical psychologists. The potential significance of such differences in reported VPTG and the potential reasons for this were further examined in the discussion of inferential statistics section below. The descriptive statistics could nevertheless conclude that individuals working therapeutically did indeed experience some amount of personal growth from their work, although the exact prevalence may vary among samples.

But how did the psychologists personal growth findings compare to PTG from primary traumas and other vicariously acquired PTG? As expected, it appeared that individuals

watching particularly horrifying scenes from a differing country on TV (i.e. British watching 9/11 terrorist attack), experienced low degrees of personal growth from this (Linley et al., 2003) when compared to all other PTG data. Despite this, PTG acquired vicariously through therapy does not seem to be of less strength compared to PTG following some primary traumas. For example, Weiss (2003) found that breast cancer sufferers and their husbands reported similar mean PTG scores as the therapists and the psychologists respectively. Altogether, it can thus be concluded that the clinical psychologists reported fair levels of personal growth from their therapy work, whereas the counselling psychologists reported moderate to high levels of VPTG. Potential reasons for this difference in reported growth between the psychology professions were discussed in the inferential statistics discussion.

7.2 Discussion on the main findings from the inferential statistics

The main findings from the inferential statistics will now be discussed in accordance with the aims, set hypotheses and the relating existing research and theories.

7.2.1 Discussion on correlates and predictors of CF

i) Associations between CF: work and/or individual characteristics

Pearson's r correlations first revealed in line with the hypothesis, a large negative correlation between Sense Of Coherence score (SOC) and CF. Thus, the less the psychologists felt their lives were meaningless, comprehensible and manageable, the more they were distressed by their client work. This result was consistent with Ortlepp and Friedman's (2002) and Linley and Joseph's (2007) findings in therapists. Together

these results thus suggested that psychologists' overall SOC was highly associated with CF.

Second, the Pearson's r correlations demonstrated a strong positive relationship between current emotional woundedness and CF. In other words, the more psychologists currently felt like they had not come to terms with their painful life experiences, the more they were negatively influenced by their clients' difficulties. The current study thus provided evidence that psychologists who have not come to terms with own painful life events were more likely to also be distressed by their client work. However, as this was the first study of it's kind, further evidence was needed to confirm such potential findings.

This discovery was nevertheless not surprising. In fact, various theorists have emphasised the importance of clinicians' self awareness and ways of coming to terms with their own issues through, for example, receiving their own psychotherapy (e.g. Jung, 1961; Guy, 1987; Pearlman and Saakvitne, 1995; see chapter 3 for further information on this connection). This is important because, as Sedgwick (1994) describes: projections from clients can "hook onto therapists' wounds", which can make the therapist feel particularly vulnerable to stress such as CF. This strong association between current emotional woundedness and CF may have been the missing link that explains the inconsistent findings between trauma and CF.

These findings that CF is associated with therapist emotional woundeness were in line with Cognitive Behavioural Therapy (CBT; e.g., Beck, Shaw, Rush and Emery, 1979). From a CBT perspective a psychologists' core beliefs (i.e., deep set, rigid unconditional beliefs about the self, others and the world such as; 'I am a failure'; 'others will criticise me and reject me'), and/ or dysfunctional assumptions (i.e., conditional, if, then... rules, such as 'if I do not get things right, then I'm a failure') developed from difficult childhood experiences (e.g., having a critical, abusive, high achieving parent) could be triggered by any events fitting with his/her beliefs (e.g., a critical client that does not get better), and highly influences how the individual appraises the situation (e.g., I am not a good enough therapist'; 'the client will criticise me'; 'I cannot handle listening to their story'), how they feel (e.g., down, anxious) and how they see themselves (e.g., a failure that cannot cope). This way, a psychologist's own 'wounds' could be triggered by working with clients, thereby potentially making it more likely to be effected by CF.

Third, also as hypothesised, the Pearson r-correlations further exposed various associations between ways of coping with work related distress and CF. For example, medium to large positive associations were found between self-distraction and CF; behavioural disengagement and CF; and self blame and CF. Thus the more the psychologists made use of self distraction and blaming themselves, or even giving up trying to cope with the work related stress, the more upset they were by their client work.

Moreover, medium positive correlations were recorded between substance use and CF; and venting and CF, and small positive associations were found between CF and positive

reinterpretation; and CF and religious coping. Finally, active coping was discovered to have a small negative correlation with CF. This meant that the more a psychologist drank alcohol, or vented their distress in order to try to cope with their stress at work, the more strained they felt about their client work. Also, the stronger their CF, the more they used religious coping (e.g., prayer) or tried to see the best in the situation (i.e., positive reinterpretation). On the other hand, the less the psychologists actively tried to cope at work, the more the psychologists also felt negatively influenced by their clients' distress and vice versa. In other words, more active coping was associated with less distress from client work. These findings were again consistent with Way et al.'s (2004) results and Schauben and Frazier (1995) findings of positive associations between avoidant coping strategies (e.g. behavioural disengagement) and CF; and negative associations between active coping and CF. Also, these findings were in line with mainstream psychology studies, which have linked avoidant coping with most emotional disorders such as anxiety and depression (e.g., Foa and Kozak, 1986).

Fourth, the Pearsons r correlation revealed that there were small to medium negative associations between CF and overall social support and CF and family support. The less overall support and the less family support received by the psychologists was therefore linked with being more distress by one's client work. This finding was consistent with Ortlepp and Friedman's (2002) finding of CF being associated with perceived social support. Also, it was consistent with theories of stress (e.g., Lazarus & Folkman, 1984) and previous research linking low social support with high psychological distress (e.g., Grassi et al., 2000).

Finally, unlike hypothesised, there were found no associations between the level of CF and; the amount of trauma clients seen in a week; or the total amount of clients seen in a week; or years of practicing as a psychologist. This former finding suggested that CF was not specific to trauma work, but that psychologists with more general caseloads could also be distressed by their client work. This was supported by Kadambi and Truscott's (2004) and Minnen and Kejsers's (2000) conclusions, although inconsistent with CF theorists' (e.g. Stamm, 1999; Figley, 1995; 2002) claims suggesting that CF is a result of the particular stressful aspect of trauma work e.g., listening to a client's experiences of abuse. Thus, the more recent studies proposed that negative effects of client work, such as CF, is not specific to trauma work, but that it can also influence therapists/psychologists who see non-trauma clients (e.g. anxiety, depression).

In short, the findings from these correlations suggested that psychologists' distress from client work was not associated with work factors, such as the amount of trauma clients or overall clients seen a week, but rather psychologists' individual vulnerability, including: current emotional woundedness; sense of coherence; coping and the social support received. In other words, in line with cognitive behavioural theories (e.g., Beck, Rush, Shaw and Emery, 1979) and transactional models of stress (e.g., Lazarus and Folkman, 1984), the psychologists did not get stressed by their work experiences as such, but rather by how they perceived their work experiences (e.g., if they found life meaningful, could cope with it and how wounded they were).

ii) Predictors of CF; individual and occupational factors

A multiple regression revealed that the strongest predictors of distress from client work were SOC overall, current emotional woundedness and self distraction. This was in line with the hypothesis. Thus, the less the psychologists felt like their lives were meaningful, comprehensible and manageable; the more they felt they had not come to terms with their difficult life experiences; and the more self distraction they used to cope with work related stress; the more predictive this was of psychologists also being negatively influenced by their client work. Taken together these factors gave a fairly good explanation of the variance in CF (40.6%). The remaining variables entered where however n-significant.

SOC's predictive value of CF was consistent with Linley and Joseph's (2007) findings and a host of studies strongly linking SOC to psychological distress in general (e.g., Erikson & Lindstrom, 2007). No other known studies, other than Linley and Joseph (2007) have however looked at SOC as a predictor of CF.

Moreover, the finding that current emotional woundedness has a strong predictive value of CF was not surprising. It would make intuitive sense that psychologists who were themselves still struggling with coming to terms with/coping with their own painful life events would be more susceptible to be effected by clients' distress. The finding from this study thus further supported the correlations in suggesting that current emotional woundedness may account for the missing link of the inconsistent results relating trauma to CF.

Finally, the discovery that avoidant coping, such as, self distraction predicted CF, was in line with previous findings. For example, Schauben and Frasier found behavioural disengagement to be associated with CF, while Way et al (2004) also found that avoidant coping strategies such as substance abuse predicted CF. Together these results thus suggested that avoidant coping is associated with and can even predict CF. Again, this related back to mainstream psychology research findings, which have found strong associations between avoidant coping and emotional distress (e.g., Foa & Kozac, 1986).

To sum up, these findings further put CF theory into question, as CF was not predicted by trauma client load, nor even associated with trauma client load. Instead, the current study suggested that individual vulnerability, including SOC, current emotional woundedness and distractive coping predicted CF. This was again in line with Cognitive Behavioural Theories (e.g., Beck, Rush, Shaw and Emery, 1979) and Transactional models of stress and coping (Lazarus and Folkman, 1984), in that stress does not necessarily result from experiencing stressful incidents per ce, but rather from how the individual interprets and then copes with the event.

7.2.2 Discussion on factors related to VPTG

7.2.2.1 Main findings from tests of difference

i) Differences in VPTG between psychologists with and without a trauma history.

Unlike hypothesised, there were found no significant differences in VPTG between traumatised psychologists and non-traumatised psychologists. This finding indicated that

psychologists with a trauma history did not report experiencing significantly more growth following their therapy work compared to psychologists who had never gone through a trauma. This contradicted Linley and Joseph's (2007) findings.

This result may have been due to how trauma had been defined according to the DSM-IV (APA, 2000) (e.g., not very inclusive) and to the fact that the large majority (91.1%) of the psychologists reported that they had at some point experienced some sort of particularly stressful life experiences (e.g., trauma, and/or neglect, major losses through death or ending separation of long term relationships, their own psychological difficulties or serious physical illness), that they could have grown from. This therefore again supported noted findings throughout this study that were in line with cognitive behavioural theories (e.g., Beck, Rush, Shaw and Emery, 1979) and transactional models of stress (Lazarus and Folkman, 1984), that it is not necessarily about whether one experiences a traumatic situation or not, but rather how an individual interprets that situation (e.g., whether one feels one grows from this or not).

ii) Differences in VPTG between clinical and counselling psychologists

Counselling psychologists reporting significantly more VPTG as a result of their client work, compared to clinical psychologists. This was thus consistent with a PTG model from primary trauma (Calhoun and Tadeschi, 2006), and empirical research from primary PTG, which has, for example, found that breast cancer sufferers who knows others who also report growth following stressful events; also tend to themselves report experiencing

more PTG (Weiss, 2002). This thus supports the notion of PTG being related to proximal culture.

On top of this, the current finding was also consistent with Linley and Joseph's (2007) study, which found that therapists with a more transpersonal and client centred way of working, were more likely to report growth from their therapy, compared to, for example, those therapists mainly having practiced in a cognitive behavioural orientation. This finding was corresponding to counselling psychology being firmly rooted in a humanistic philosophy (e.g., Rogers, 1961). In other words, it appeared that the counselling psychologists also saw their own potential for personal growth, perhaps from having had a firm grounding in humanistic therapy from their training. This suggested that therapeutic training (i.e. proximal culture) matters for whether psychologists feel they achieve personal growth from their client work or not. This finding has clear implications for training. This will be described in the implications part.

It remained unknown, however, whether it was the actual philosophical training in the psychology specialisation/training concerned, or whether particular individuals would be attracted to a particular psychology specialisation/training because of the philosophical underpinning that specialisation is grounded in. Scragg, Bor and Watts (1999) findings suggested that different personalities are indeed attracted to different theoretical orientations. It may then be that the individual clinician would initially be attracted to a specialisation/training that fitted his/her beliefs, and that this view would probably be reinforced throughout the training.

The current evidence therefore suggests that counselling psychologists are more likely to report growth following therapy work compared to clinical psychologists. However, as this is only a preliminary finding linking proximal culture to VPTG following therapy work, further studies are needed to confirm this association.

iii) Differences in reported VPTG between psychologists who have received psychotherapy compared to those who have not

In line with the set hypothesis, significant differences in reported personal growth following therapy work were found through an independent t-test. Those psychologists who had themselves received personal therapy were significantly more likely to report higher VPTG scores, compared to psychologists who had never received personal therapy. This was consistent with Linley and Joseph's (2007) finding from British therapists. Together these two studies thus suggested that personal therapy can be an activator for growth following therapy work. It may be that personal growth and a heightened sense of self-awareness achieved through personal therapy can also continue to be cultivated through clinicians' client work. This highlighted that personal therapy may be an important part of training to ensure therapists are protected from CF, whilst also encouraging personal growth. However, if clinicians have never looked into their own issues (i.e. never had therapy), it may also be natural that the clinician concerned would neither be as self aware of their own psychological concerns when working with their clients, thereby not achieving as much growth following their therapy efforts.

In short, the current findings thus proposed that psychologists' receiving psychotherapy should be encouraged, as this is not only helpful in bringing self-awareness to help prevent current emotional woundedness (and CF), but can also encourage personal growth from own client work.

7.2.2.2 Main findings from correlates and predictors of VPTG

i) Correlates of VPTG

First, as hypothesised, there was found a medium to large association between positive-reinterpretation and VPTG. This finding was the strongest association found between VPTG and another factor, and indicated that the more the psychologists coped with their work related stress by attempting to look for something good in what had happened, the more they also felt they had personally grown from their client work and vice versa. This result was consistent with primary posttraumatic growth theories holding that positive reappraisal coping is critical and a pre-requisite for personal growth to occur (e.g. Calhoun & Tedeschi, 1998). Moreover, this finding was further consistent with primary stress related growth having been found to be associated with positive-reinterpretation in a college sample (Park et al. 1996). The current study thus gave preliminary evidence for positive reinterpretation also being highly associated with psychologists' personal growth from client work.

Second, a medium association was found between VPTG and acceptance coping. Thus, the more the psychologists were coping with work related stress by accepting what had happened, the more they also felt that they positively grew from working with their

clients. Again, this was consistent with primary stress-related growth findings (e.g. Armeli et al. 2001) and general positive psychology which has linked acceptance to well being (e.g., compassionate mind training; Gilbert and Proctor, 2006). Altogether, these findings thus suggested that psychologists' positive reappraisal and acceptance coping were associated with personally growing from client work.

However, it was not only "positive" coping that correlated with VPTG. Self-distraction was also found to have a small to medium association with VPTG. In other words, the more the psychologists used self distraction in attempting to cope with their work related stress, the more they felt they personally grew from their client work. Again, this was consistent with primary stress-related growth findings, where a variety of avoidant coping strategies including self distraction have been found to be associated with PTG (e.g. Best et al., 2001). PTG theorists and researchers have however argued over the potential meaning of such an association. For example, some primary PTG theorists have suggested that this may mean that PTG may have an illusionary/ avoidant side (i.e. Zoellner and Maercker, 2006). Other PTG theorists (e.g. Tedeschi and Calhoun, 2004) have implied that it would be natural that avoidant coping would be linked to PTG, as struggling with a difficulty is naturally associated with avoidance, and such struggle with in turn result in stress related growth. These latter theorists have stressed however that this does not mean that there is an illusionary side to PTG. Rather, they have argued that well-being and PTG are distinct constructs and therefore should not necessarily have to be associated with each other.

This argument was further relevant to the current study which also found CF to have a small to medium association with VPTG. Thus, the more the psychologists felt distressed by their client work, the more they also felt like they had grown from it. This further brought up questions whether VPTG, like primary stress-related growth, was associated with distress, rather than well being, and whether this meant that VPTG, like PTG could be an illusionary way of attempting to avoid discomfort. These findings may however not be as extraordinary as they seem. In fact, it may be that VPTG is related to distress in the short run, as stress related growth by name has derived from the distress itself. Moreover, it may be that VPTG is related to well being in the long run. Empirical research of primary PTG has suggested that this may be the case, with most longitudinal studies of PTG finding the construct to be related to wellbeing in the long run (see Zoellner and Maercker, 2006 for a review). Further research is however needed to evaluate whether psychologists' VPTG may also be related to long term well-being. Nevertheless, the findings from the current study proposed that psychologists' distress from client related work was associated with growth following client sessions. Moreover this association meant that VPTG was not necessarily *vicarious* growth from client work; but learning about self through one's own distress when seeing clients.

Other coping strategies that were also found to have a small to medium positive associations with VPTG were venting; planning; emotional support and religious coping. This meant that the more the psychologists used venting, planning, religious coping such as praying and/or were seeking emotional support from others, in order to deal with work related stress, the more they felt they positively grew from their sessions with clients.

This was again consistent with findings from primary PTG. For example, Pargament et al. (1998; 2000) found religious coping to be associated with PTG; Koenig et al., (2001) found problem focused coping, (a coping strategy that could be argued to be similar to planning) to be associated with PTG; and finally Park and Fenster (2004) found that PTG was strongly associated with both venting and social support. Thus, the current study also found preliminary evidence for the more a clinician makes use of venting, planning, emotional support and religious coping, the more he/she personally grows from their therapist efforts.

It is worth noting, however that the associations between experience (years of practicing as psychologist) and CF and client load and CF were found to be n-significant by the current study. This contradicted Linley and Joseph's (2007) findings. The result that trauma client load was not associated with CF implied that personal growth following therapy was not specific to trauma therapy, and that therapists and psychologists with more general caseloads also can experience personal growth from working with their clients.

Finally, unlike hypothesised, the current study found no associations between psychologists' current emotional woundedness and VPTG. It may be that current emotional woundedness indirectly influenced VPTG through CF. Or it could be that VPTG would be more related to the amount of struggle a clinician has ever gone through (e.g. perceived threat at the time), in attempting to come to terms with a stressful life event. In other words, VPTG may have been associated to the extent of emotional

woundedness at the height of the stressful experience, rather than the current emotional woundedness. This is because some clinicians may have gone through particularly difficult life events that they really struggled with, but now have come to terms with, but nevertheless have personally grown extensively from. Further studies are thus needed to evaluate the potential association between VPTG and psychologists' woundedness.

Overall the current study, therefore, found some preliminary evidence for various individual coping mechanisms and client work related distress (CF) being associated with growth following client work. Such growth was however not found to be associated with any occupational factors such as size of client load, nor years of practicing as a psychologist.

ii) Predictors of psychologists' VPTG

A multiple regression revealed that the strongest predictor of personal growth from client work was positive reframing, and when re-run with less factors; psychology specialisation. All the remaining factors were n-significant. These findings were nevertheless consistent with primary PTG theory and empirical results. For example, as stated above, PTG theorists such as Calhoun & Tedeschi (1998) and Janoff-Bullman (1992) have all stressed that positive reappraisal coping (e.g., to look for something good in what has happened) is critical and a pre-requisite for personal growth to occur. Moreover this has further been supported by primary PTG empirical research such as for example Sears et al.'s (2003) finding that positive reappraisal coping at 3 months predicted PTG at 12 months thereafter in a sample of females with breast cancer. It was

also supported by Park et al.,'s (1996) finding that positive reinterpretation was a highly significant predictor of growth in college students. In fact, positive reinterpretation and acceptance has now even been embedded in Cognitive Behavioural Therapies, such as, Compassionate Mind Training (Gilbert & Proctor, 2006), in order to encourage positive mental health. The current study thus added to these findings and suggested that psychologists' use of positive reinterpretation in coping with work related stress was a strong predictor of their personal growth from their therapy work.

Moreover, the finding that being a counselling psychologist was a predictor of psychologists' VPTG was consistent with a PTG model suggesting that socio-cultural features can be another influential factor on the development of PTG (Calhoun and Tedeschi, 2006). It was also consistent with findings relating proximal culture to PTG following primary trauma (e.g. Weiss, 2004). The potential reasons for the predictive value of being a counselling psychologist on the VPTG scores sas been discussed above. These findings thus provide preliminary supporting evidence that VPTG can be partly predicted by psychology specialisation/therapy training. The implications this has on training will be described in the implications part.

Together these variables significantly explained 24.7% of the variance in the VPTG scores, a score which meant that the combined factors had a rather poor combined predictive value of psychologists' personal growth. Nevertheless, such a poorly explained variance is not unheard of in general PTG research. In fact, most PTG studies using multiple regression have found that factors have similar poor predictive value of PTG

following primary trauma, as found in the current study (e.g. see Linley and Joseph, 2004). This suggested that PTG research and theory development is still in its infancy, and that further research and theory development is needed to get a fuller and better understanding of PTG. This clearly also accounted for VPTG research, even more so, with only a couple of studies to date having attempted to examine clinicians' personal growth following therapy work. Still, it is hoped that the current study and resulting model shed some preliminary light on some factors related to the development of psychologists' VPTG; including positive reinterpretation; psychology specialisation and distress from client work (CF). Further studies are however needed to confirm these findings.

7.2.3 Conclusion on findings

'Without a bit of sadness
A beautiful samba cannot be made'.
-Vinicius de Morais and Baden Powell-
'Samba de Bencao' translation

The current study has developed a model of psychologists' positive and negative effects of client work (see Figure 6.1). This has shed light on a variety of factors associated with psychologists' compassion fatigue (CF) and vicarious posttraumatic growth (VPTG) and demonstrated that psychologists can be both positively and negatively influenced by their clients. In fact, the more a psychologist is distressed by one's client work, the more one is also likely to grow from it. In other words, psychologists' client work could be both enriching and cost-full, which implies that suffering and growth can go hand in hand and therefore need to be evaluated together.

The model has further suggested that CF and VPTG are associated with and predicted by individual vulnerability factors, rather than work factors. Thus, unlike previously suggested (e.g., Pearlman, and MacIan, 1995) CF was not associated with trauma work. Instead, CF could affect psychologists working with any type and any number of clients. CF was rather found to be predicted by: sense of coherence; current emotional woundedness and self-distractive coping, and to be positively associated with self-blame; behavioural disengagement; substance use; venting; religion and positive reframing, and to be negatively associated with family support; overall support and active coping. In addition, VPTG was predicted by positive reframing and being a counselling psychologist, and positively correlated with: CF; acceptance coping; venting; planning; religion and emotional support. On top of this, counselling psychologists and/or psychologists who had received their own therapy were significantly more likely to report higher VPTG, when compared to clinical psychologists and/or psychologists who had never received therapy.

The findings that psychologists' individual vulnerability factors were associated with and predicted VPTG and CF, rather than work factors, were in line with views of psychological distress advocated for by Transactional models of stress (Lazarus and Folkman, 1984), Antonovsky (1979) and Cognitive Behavioural Theories (e.g., Beck, Rush, Shaw and Emery, 1979). These theories have proposed that a stress/growth response is not related to having experienced a particular stressful situation per se (e.g., having a large caseload, or seeing many trauma clients), but rather how the individual

psychologist interprets that situation (e.g., 'this feels unmanageable.....but I can learn something from this') and consequently copes with it (avoidance, then acceptance).

Perhaps most importantly, this model has for the first time shed light on how psychologists' current emotional woundedness (whether they have come to terms with and learned to cope with their own past stressful experiences) is highly predictive of CF. This may explain the inconsistency in previous findings when linking CF with trauma (e.g., Pearlman, and MacIan, 1995: Way et al., 2004). The current emotional woundedness construct could thus potentially continue to clarify the link between trauma and CF in future studies. This link between current emotional woundeness and CF has a number of implications for clinically working psychologists. These will be discussed below.

The noted model could be the start of theory development for the positive and negative effects of psychologists' clinical work. A better understanding of this could help the NHS (and other organisations where psychologists work), supervisors and individual psychologists maximise their potential for personal growth from their client work, and to minimise the negative effects of such clinical sessions.

It has to be noted, however, that this is a preliminary model of psychologists' stress and growth from client work, and that further studies are needed to test this model. It remains uncertain at this stage, whether the model fully encompasses all the potential aspects of costs and growth resulting from client work, and whether other potential constructs, such

as for example, burnout and vicarious trauma also need to be accounted for in the model, in order to get a full understanding of the stresses and benefits involved in psychologists' client work. Further qualitative and quantitative studies of the costs and benefits of psychologists' client work are thus needed.

7.3. Implications of findings

The theoretical and clinical implications of the current findings will be discussed in turn.

7.3.1 Theoretical implications

The theoretical implications from the current findings include a needed revision of CF theory, as it has been found to unspecific to trauma work. Also, there is a need to include current emotional woundedness in CF theory. Finally, as CF and VPTG have been shown to be associated, the current study suggests a holistic model of both negative and positive effects of client work. This will now be discussed.

The current findings indicated that psychologists can be both positively and negatively affected by their client work. However, unlike previously theorised (e.g. Stamm, 1999; Figley, 1995; 2003) this study suggested that CF *is not specific to trauma* work, but that clinicians with a more general caseload can also be distressed by their client work. Thus, this study proposed that it is not the particular aspects of psychologists' job of listening to traumatised clients that result in CF. Instead, CF is predicted by individual vulnerability such as SOC (i.e. seeing life as meaningless, non-comprehensible and unmanageable), current emotional woundedness and self-distraction. The previously unstudied construct of current emotional woundedness was further proposed to account for the discrepancies

in previous findings in whether CF is related to clinicians' own trauma or not. Altogether, the evidence from the current study thus implied a need for CF theory revision, in particular in relation to the construct not being specific to trauma work, and in including current emotional woundedness to account for psychologists' negative effects of client work. This fitted with a Cognitive Behavioural perspective, or more specifically Cognitive Theory that has proposed that it is the meaning making (i.e., how an individual interprets a situation) that determines the type of emotional response felt (e.g., Beck, Shaw, Rush and Emery, 1979). In other words, if a psychologist interpreted the world as incomprehensible, unmanageable and meaningless (SOC) and felt like they had not come to terms with their own stressful experiences (i.e., still felt emotionally wounded), the individual would also be more likely to be negatively affected by their clients (i.e., CF).

Finally, the current findings further suggested that a theoretical model of psychologists' effects of client work needs to be holistic and account for both clinicians' positive and negative effects. This was because the potential effects of client work (i.e., VPTG and CF) were associated with each other. The current research has consequently proposed a model that details correlates and predicters of both VPTG and CF. However, as the combined VPTG predictors accounted for a small variance of VPTG, this implied that little is still known about personal growth from therapy work. The VPTG part of the model, in particular, therefore needed to be developed through further research, in order to test additional factors which may be involved in predicting VPTG.

Again, this also related to recent developments in mainstream psychological theories that are now finally realising the importance of tapping into individuals' strength and positive well-being in order to combat stress. Indeed, positive psychology, as it is called, is steadily growing, and many psychological therapists are now incorporating this into their therapy. For example, some CBT therapists both target the negative thoughts and unhelpful behaviours, in addition to identifying, building and strengthening resilience (e.g., identifying a previous experience when he/she has overcome a difficulty and apply the same skills to the current problem) (Padesky and Moorey, 2006), and/or developing acceptance and compassion to combat self-criticism (e.g., Gilbert & Proctor, 2006). Examples such as these show the importance therefore of accounting for both negative and positive thoughts, feelings and processes when promoting individual well-being. In line with this, the current findings proposed that both stresses and gains from client work needed to be to be taken into account when assessing the effects of client sessions on psychologists.

7.3.2 Clinical implications

The findings from the current study have a variety of clinical implications. These will be evaluated in turn

7.3.2.1 Clinical implications of CF and what to do about it

It is particularly important to assess the potential negative effects of therapy on British psychologists at this point of time, because of the government's large investment of money into talking therapies (e.g., Improving Access to Psychological Therapies; IAPT).

This may put a lot of pressure upon psychologists, and as such make them more vulnerable to CF.

This study found that 18% of the psychologists were highly negatively affected by their client work (CF), and that a further 45.54% were moderately affected. The significance of this and what it means for the wellbeing of the psychologists concerned and their ability to work with their clients will now be explored.

In line with Motta and colleagues' (1997) propositions, it could be that the practitioners with higher CF scores faced medium levels of distress only (e.g., intermediate levels of anxiety), rather than full blown PTSD symptoms, as suffered by some primary traumatised individuals. Indeed, although a proportion of the psychologists scored high on CF, all still remained in their jobs and they appeared to at least to attempt to cope with the work related stress, although avoidant coping only seemed to make the CF worse. The exact subjective level of client work related distress some of the psychologists suffered from did however remain unknown, and as such, the effects of the CF on the individual psychologist's wellbeing and their intension to quit their work warranted further research.

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Questions remains however, as to the effect such *high* levels of CF could have on the psychologists' ability to work therapeutically and to attend to their clients. This would clearly depend on the subjective view of how much each psychologist could still attend to the client without being all consumed by their distress, as also noted by a variety of wounded healer theorists (Jung, 1961; Guy, 1987). If theorists such as Motta et al., (1997)

and Figley (1995) are right in suggesting that CF generally involves, for example, intermediate levels of anxiety that have a fairly fast recovery rate in comparison to burnout, one would think that most psychologists would still be able to attend to their clients, whilst at the same time being self-aware of own distress. If it is not the case however, that such "high" levels of CF only involve intermediate distress, CF could theoretically have clear implications for a psychologists' ability to attend to the therapeutic relationship. This is of particular concern to counselling psychologists, whose core underlying focus remains on the therapeutic relationship, as it is seen as the significant variable in facilitating change in the client (Woolfe, 1990). Further studies are thus needed to evaluate how much effect such "high" levels of CF could have on psychologists' ability to attend to their clients. Moreover, in accordance with the wounded healer paradigm, it remained unknown whether psychologists' wounds could be empathy enhancing, and therefore beneficial to the client, rather than depleting to the therapeutic relationship. This clearly also warrants further research.

Moreover, this study emphasised the importance of psychologists' self-awareness. CF was found to be predicted by the extent to which a psychologist has come to terms with his/her own painful life experiences (i.e., emotional woundedness). In other words, CF may be somewhat prevented, if a psychologist comes to terms with his/her own difficulties. Clearly then, it would be vital for psychologists to look into their own issues, like for example through attending their own therapy. Moreover, the current study further implied that self awareness from psychologists receiving their own therapy can further

encourage personal growth from their therapy work. Receiving therapy can then not only prevent CF, but also promote VPTG.

This section has so far evaluated the implications of CF findings on psychologists' wellbeing and their ability to attend to their clients. However, this puts into question whether CF is only the responsibility of each individual psychologist, or whether employers should also have a responsibility to help tackle CF. As noted above, each psychologist should not only look into their own issues through, for example, attending therapy. This study has also shown that active coping rather than avoidant coping is helpful in dealing with work related stress. Each individual psychologist, therefore, has an individual obligation to help themselves, as well as improving their emotional well being for their clients. After all, the psychologist's use of self is a fundamental ingredient for any client work.

Having said that, employers such as the National Health Service (NHS) trusts could help normalising CF effects of client work by organising educational workshops on the matter and encouraging self care and self awareness by, for example, offering training courses such as mindfulness programmes for psychologists. But perhaps most of all, if clinical supervisors were more informed on CF (e.g. through workshops), they could approach their supervisees with a more helpful, normalising stance. If they were trained to recognise and acknowledge the potential negative effects of client work, they would better allow clinicians to discuss their feelings, fears and regrets in a safe and supportive environment. Moreover, the supervisors would then be able to advise on what to do if the

clinician was, in the worst case scenario, not able to fully attend to their client. The supervisor and the supervisee could then discuss and come to an agreement about helpful measures, additional supportive supervision; and/or own therapy; and/or potentially limit work hours for the psychologist concerned (e.g., maybe they could be in need of a holiday), so that he/she could re-gain their strength. This way, supervisors that were updated on CF could potentially minimise psychologists' adverse effects of working with clients. This would not only benefit the well being of the clinicians, but also their clients. Furthermore, supervision would not only have to be limited to one-to one supervision formats, but could also take place in peer supervision groups, in which psychologists could share their experiences and provide mutual support, that could potentially minimise the likelihood and severity of CF from developing.

Moreover, as the current study suggested that current emotional woundedness predicts CF, the encouragement of psychologists' self awareness through, for example, receiving own therapy is crucial. Also, as shown through this study, encouraging psychologists to receive therapy is equally important for prompting psychologists' personal growth from client work. Psychology training programmes could have a role in this, as shown by counselling psychology programmes that include psychologists' own therapy as a compulsory part of the curriculum. Clinical psychology courses could also promote the importance of self awareness through bringing one's own therapy into the clinical training. After all, the current study clearly showed that clinical psychologists were no less emotionally wounded, nor CF free than counselling psychologists. Hence, altogether this demonstrates that individual psychologists, as well as employers (e.g. NHS),

supervisors and training programmes can together help prevent psychologists' negative effects of their therapy work.

Ideas such as these can only be achieved through a normalising, respectful dialogue about CF, that does not disgrace clinicians if they feel effected by CF. After all, as this study has shown, the large majority of psychologists do have some sorts of "wounds", and whether "raw/open" or not, it is inevitable that some clients will touch on psychologists' own difficulties at times in their careers.

7.3.2.2 Clinical Implications of VPTG findings

Clients do not, however, only have negative effects on psychologists. Indeed the current study found that clinical psychologists report fair levels and counselling psychologists report medium- high levels of personal growth from client work.

In order to encourage more personal growth from client work, these findings suggested that psychologists should try to cope with work related stress by looking for something good in the stressful situation (i.e. positive reinterpretation) and accept that the stressful situation has occurred (i.e. acceptance coping). Moreover, receiving one's own psychological therapy can be growth enhancing, perhaps by encouraging self-awareness that can be further fostered through client work.

In addition, as counselling psychologists reported significantly higher VPTG scores from their work, in comparison to clinical psychologists, a higher emphasis on positive

psychology and personal growth as a part of clinical psychology training could potentially also make clinical psychologists more aware of their own gains from their client work. In addition, the introduction of compulsory attendance to one's own therapy, as already exists as a part of counselling psychology courses, could possibly also be introduced in clinical psychology training, again, in order to try to enhance clinical psychologists' VPTG from their client sessions.

Finally, the current findings further suggested that personal growth from therapy is positively associated with CF. Thus psychologists who are more negatively influenced by their clients, are also more likely to grow personally from their client work. Clinician's client related stress can therefore also be growth enhancing.

Together these findings showed that psychology can be a particularly growth enhancing profession, something which has been largely overlooked both empirically and theoretically. Moreover, psychologists can maximise their personal growth from client work by receiving their own therapy and coping with work related stress through positive reinterpretation and acceptance. The findings reaffirm the significance of compulsory therapy in counselling psychology training and its applicability for other specialisations.

7.4 Limitations of study

7.4.1 Methodological limitations

In summary, the methodological limitations of this study include the employed recruitment strategy, the unknown representativeness of the postal survey, the uncertain ecological validity of the study, the non-experimental design and the materials/questionnaires used.

First, the exclusion criteria for psychologists employed in academia could be considered as flawed, because many clinical and counselling psychologists who are employed in academia also work clinically. Thus, the recruitment strategy used for the current study was biased, which meant that the findings could only be generalised to British psychotherapeutically working clinical and counselling psychologists who did not do any academic work.

Second, the use of a postal survey made it difficult to know how representative the sample was, as the response rate was only about 40%. The response rate was thus below 50 %, which is typically seen as unacceptable (Bryman, 2004). A major implication of this was sample bias (i.e., a sample of the population in which some members are less likely to be included than others; Howell, 2002). In other words, it may be possible that those psychologists who felt more negatively affected by their client work saw the study as a burden and reminder of not being able to cope with their work, and consequently did not complete the questionnaires. On the other hand, it may be that the psychologists who felt more distressed by their work, were more likely to take part, because they saw it as

useful. It was thus difficult to know whether there was a difference between the responding and the non-responding psychologists. If there was a difference, the findings were not representative of clinically working clinical and counselling psychologists in the UK, thereby reducing the generelisability and validity of this study (i.e., the conclusions made from the study would be inappropriate and less meaningful). Due to the time and money restraints on completing this study however, the researcher was unable to do a further study which checked whether there in fact were any differences between the non responsive psychologists and the participating psychologists (e.g., comparing responses from the non-responders with the old sample, by re-contacting the non-responders and asking them to take part). Previous studies which have attempted to assess such comparisons between responders and non responders in mental health care professionals have nevertheless found minimal sample bias in surveys (e.g., Thomsen, 2000). Also, as the study assessed both positive and negative effects of client work, therapists who saw their work as either growth enhancing and/or stress inducing may have been inclined to take part, thereby perhaps getting a more balanced representative sample. Nevertheless, the low response rate and thus potentially low generalisability of this study had to be taken into account when interpreting these findings. All of the findings therefore needed to be interpreted with caution.

Third, and similarly, it was uncertain whether the findings reflected the psychologists' everyday 'real world' CF and VPTG. In other words, the ecological validity of the study was unknown. For example, it could have been that some participants were not responding truthfully, due to stigma attached to CF and/or found it hard to quantify their experience, and/or gave the responses they would like to think happens (e.g., higher

personal growth; VPTG scores). It was therefore uncertain whether the findings from the current study could be generalised to clinicians real life experience of positive and negative effects of their client work.

A fourth methodological limitation of the current study was that the design used was non-experimental. This design enabled a study of the relationships between correlates and predictors (IV's) of psychologists' positive and negative effects of therapy work (DV's). However, as the design was non-experimental, conclusions regarding the causality of these factors were uncertain. For example, potential confounding variables may have also had an effect on the levels of growth or stress from work the therapists' experienced. Nevertheless, given the practical and ethical difficulties and considerations of the current research topic, the current study provided the most feasible method for researching this area.

Fifth, there were concerns over the psychometric properties of some of the self-report questionnaires used. Self-report measures are by definition somewhat biased, as they rely on the subjective accounts of respondents. Moreover, there were some concerns over the CEWS, which was created by the researcher for the current study, and as such, was not a standardised questionnaire. Whilst the CEWS showed good internal reliability, appeared to measure what it was supposed to measure (i.e. good face validity) and was able to predict the expected outcome of CF (i.e. good criterion validity), it was also acknowledged that the scale only consisted of 4 items, which may have meant that the scale did not take into account the current emotional woundedness construct as a whole

(i.e. it may have had low content validity). Further studies are thus needed to evaluate the potential usefulness of CEWS and its psychometric properties.

Moreover, a second scale made use of in the current study; the Posttraumatic Growth Inventory (PTGI, Tedeschi and Calhoun, 1996), was originally designed to measure PTG following primary trauma and not vicariously related personal growth. Although, the wording was changed to fit the psychologist sample, and the PTGI had been used in the very same capacity in another study of personal growth from client work (i.e. Linley and Joseph, 2007), the vicarious growth research was still in its infancy, and so it was uncertain whether the growth aspects measured from the PTGI also were relevant to and covered all aspects of personal growth following client work. Further theory development and research of both qualitative and quantitative nature, needs to evaluate, therefore, whether personal growth following client work is growth of a similar nature to stress related growth from primary trauma.

Finally, the use of a third scale, the Brief COPE (Carver, 1997) had a low variation in response because it was based on too few items. This meant that the current study had to discard the denial scale from the Brief Cope, which may have been highly related to particularly the CF construct. Moreover, the Brief COPE had only been demonstrated to have adequate reliability statistics (e.g. Carver, 1997). Despite such concerns, scales from the Brief COPE made meaningful predictions in relation to both personal growth and CF (i.e. good criterion validity). Nevertheless, the Brief COPE's slightly weak psychometric properties needed to be considered when interpreting the findings from the current study.

To sum up, this study unfortunately suffered from similar pitfalls as already criticised in previous CF and VPTG research (e.g., the uncertainty of the representativeness of the sample and the use of non-standardised measures). There were various reasons for these continuing difficulties. For example, the use of non-standardised measures (e.g., CEWS) in research of CF and VPTG was inevitable, as the topic remained mostly unexamined, and so no standardised measures had been developed. It was nevertheless hoped that the exploratory nature of this study was helpful to get some preliminary insight into CF and VPTG in clinically working British psychologists. Further research of this topic, including development of such specialised standardised scales (e.g., on emotional woundedness) is nevertheless needed to fully be able to draw conclusions from this area of research.

A second reason for this study suffering from the same pitfall of potential non-representativeness as other studies was due to the use of postal surveys, because of the sensitive nature of the topic. The fact that the subject matter could be delicate to many (e.g., if effected by CF), meant that the researcher wanted the study to be done in a confidential environment, which enabled the participants to answer truthfully, without worrying about being judged. This was therefore the reason for making use of a postal survey, rather than, for example, a telephone survey, which typically gets higher response rates. The researcher suspected that this was the reason why previous studies had also made use of postal surveys. Another reason for not gaining a larger sample size was that the researcher had budget and time restraints. Future studies could nevertheless

potentially try to improve the response rate by doing electronic confidential questionnaires sent via e-mails that may be quicker and also save costs. This would enable multiple reminders to be sent to the participants, which could potentially improve future response rates.

7.4.2 Statistical limitations

The statistical limitations of the current study were: that structural equation modeling could have been used instead of the statistical tests employed and an increased sample size would have increased the power of the tests. These will now be discussed in turn.

First, in order to get a fuller understanding of the mediating processes and variables contributing towards negative and positive effects of psychologists' client work, structural equation modeling could have been used. This would have enabled a more sophisticated understanding of the connected relationships between IV's and DV's. Nevertheless, as the combined positive and negative influences of client work chiefly remains unstudied and un-theorised (as one theory), it would have been difficult to hypothesise the differing potential relationships between IV's and DV/s in a structural equation model. Therefore, it was more appropriate to develop the current model by other approaches. Indeed, the use of correlations, t-test and multiple regressions enabled the researcher to establish the statistical strength of a wide range of factors. This was necessary as a part of the initial stages of developing a model for understanding what factors correlate and predict CF and VPTG. Nevertheless, the use of structural equation modeling could be beneficial in future research in developing this model further.

A second statistical limitation of the current study was that a larger sample size would have gained more power, i.e. more likelihood of finding a difference if the null hypotheses were false. Whilst a priori tests had found acceptable power statistics of above 0.80 in relation to the sample sizes used for the present analyses, it was nevertheless acknowledged that this made it a 20 % chance of making a Type II Error (i.e. of not finding a difference that was there). For example, it would be expected from previous empirical findings and PTG theory that growth following client work would be related to psychologists' experiences of trauma /stressful situations and the resulting current emotional woundendess. This hypothesised n-significant finding thus may have been due to too much variation, given the smallish sample size. Alternatively, it may be that VPTG is more complex, and that measures of emotional woundedness at the height of distress may be associated with VPTG (i.e., meaning that there is an n-significant relationship between *current* emotional woundedness and VPTG). Future studies could thus use a larger sample size and measures of emotional woundendess at the height of the individual's distress, in order to reassess the significance of the potential relationships between woundendness and VPTG.

Third, and finally, the apparent lack of homoscedasticity met for the multiple regression that assessed the predictors of CF, meant that these findings could be somewhat misleading. Some argue however, that a lack of homoscedasticity is only a problem when the sample size is very small, as when the sample size increases, so does the robustness of psychometric tests (e.g., Rasmussen, 1989). The lack of the homoscededasticity found in

the CF multiple regression may thus have been acceptable. All the above statistical limitations nevertheless needed to be kept in mind when interpreting the findings from this study.

7.4.3 Theoretical limitations

Leading on from the statistical limitation of the non-use of structural equation modelling, the suggested combined model of CF and VPTG could consequently say nothing about the mediating and moderating relationships between the variables included.

Moreover, whilst theoretically related CF and VPTG variables were attempted to be accounted for in the above suggested model, it was acknowledged that some variables from theories had not been included in the model. The model could therefore not fully explain how negative and positive effects from client work such as CF and VPTG occur (i.e. its aetiology). For example, the theorised and empirically researched PTG related process rumination, could also be associated with, or even predict VPTG, but had nevertheless not been accounted for in the current study. Similarly, appraisal of stressful situation/trauma at the time of occurrence (e.g. threat; like emotional woundedness at the time) was neither accounted for by the current study, despite having been found to be associated with PTG from primary trauma. Altogether, this meant that the suggested model of negative and positive effects of client work (see Table 5), was not a fully explaining aetiological model.

Finally, it was acknowledged that the current study only assessed one specific aspect of stress-related difficulties from client work. As noted earlier, other similar constructs such as burnout or VT have also attempted to account for psychologists stress, but where nevertheless not assessed in the current study. All these theoretical limitations thus needed to be taken into account when interpreting the results from the current study

7.5 Future directions

In short, the findings from the current study propose that psychologists' client work can be both cost-full and enriching. Further studies on stress and growth from psychologists' therapy are however needed to replicate the findings from the current model. Moreover, a further understanding of the relationship between psychologists' current emotional woundedness and CF is warranted. Finally, in order to get a better understanding of CF and the extent of distress involved, CF could be evaluated in relation to intension to quit work.

In terms of positive effects of client work, the current model has found some correlates and predictors of VPTG. However, still very little is known about VPTG, as suggested by the small variance of VPTG that the predictors could explain. Further empirical studies of, for example, the potential relationship between rumination and VPTG are thus needed, as well as replications of the current relations between coping factors; psychology training; CF and VPTG.

7.6 Conclusion

"This reminds us that...forces of the positive and the negative, loss and fulfilment, suffering and growth may often go hand in hand "(Joseph and Linley, 2006, p. 1050).

The current study has found that psychologists' client work can be both cost-full (CF) and personally growth enhancing (VPTG). More specifically, 17% and 45% of the psychologists reported high and moderate levels of CF respectively. Also, the clinical psychologists reported fair amounts of mean levels of VPTG following their client work, whilst the counselling psychologists reported moderate to high amounts of mean levels of VPTG from their psychotherapeutic efforts.

Overall, this study has built upon previous findings by developing a comprehensive, holistic model of correlates and predictors of psychologists' potential positive (VPTG) and negative effects (CF) of client work. This has shown that psychologists' VPTG and CF are not related to occupational factors such as trauma work, hours of work, nor client load. Instead, the extent to which psychologists feel their client sessions are growth enhancing and/or stress inducing have been found to be predicted by psychologists' vulnerability/individuality. This study further advances on previous findings, by discovering that CF is partly predicted by the extent to which the clinician has *not come to terms with their painful life events* (i.e. current emotional woundedness). This could explain inconsistent previous findings in relating therapists' own experiences of trauma to CF. Also; the current study has shed light on factors relating to psychologists' positive effects of client work (VPTG), such as positive reinterpretation and acceptance coping. In

addition, the finding that personal growth from therapy is associated with psychologists' CF, further suggests that the positive and negative effects of client work needs to be explained by a combined, holistic model.

Finally, in terms of implications, this study has first elucidated unhelpful (e.g. self distraction; self blame; substance use) and helpful (e.g. positive reinterpretation; acceptance coping) ways of coping with work related stress. Such latter ways of coping have been found to strengthen CF and personal growth from client work respectively. Knowledge about these positive and negative ways of coping could be useful in helping clinicians to better cope with work related stress and to enhance personal growth from client work. Second, this study has emphasised the importance of psychologists receiving their own therapy, for looking into and dealing with their own potential current emotional woundendess. This could help prevent CF and also prompt psychologists' personal growth from working with clients. This finding has major implications, and boosts the call for all psychology specialisations to emphasise the importance and necessity of clinicians' receiving their own therapy. Clinical psychology training institutes, therefore, may consider revising their policies when it comes to trainees' self reflection, personal growth and receiving compulsory therapy. Finally, this study's emphasis on maximising psychologists' well-being is particularly relevant today, with the many pressures put upon British psychologists, in the context of the UK's government's recent large investment into psychological talking therapies (IAPT).

7.7 Reflective analysis

I first got interested in the CF literature when I was completing an MSc in Psychology in Copenhagen. Talks among trauma clinicians there awakened my curiosity in CF, and consequently led me to choose to do my MSc thesis on the matter among Danish trauma specialists. However, although this topic was still of interest to me when searching for a doctorate research subject, I could not help but reflect on my own experiences of client work and both the stresses and gains from my sessions with clients. I also felt that only looking at the potential clinician stresses would not reflect the whole picture and that this would neglect all the personal growth and learning that I personally felt from my own clinical work.

On top of this, I also recognised that ever since I started working as a clinician, I had always wondered how my own baggage, or emotional woundedness may have been a hinder and/or a strength when working with clients. I always saw myself as a pretty anxious personality who could often feel quite vulnerable. I suffered from panic disorder in my early 20s (something I managed to treat by myself with CBT, although I did also receive therapy). I relate the panic to my sheltered and fairly over protected background and to moving to a new country by myself when I was 19 (hence feeling very vulnerable) and to experiences of childhood illness (when I was 12 my appendix burst, was operated, but left with infections, so that I had to have several new operations and periods of stay in hospital). For the most part, I feel that my own experience of panic has helped me to understand and empathise with others' pain (i.e., put myself in my 'clients' shoes'). I also feel that I have learned a lot from listening to my clients' stories and their incredible

courage. But, I can also particularly remember how my own 'wounds' interfered, when I was at the start of my counselling psychology training, and I was to complete a hyperventilating experiment with a young panic client. I remember noticing the panic raising in me, particularly the nausea, and I ended up making an excuse and going to the toilet and throw up. In other words, I was unable to attend to the client's panic, because of my own panic, and felt like a complete failure as a therapist. I did nevertheless manage to go back and finish the session. In fact, the client ended up improving pretty rapidly (CBT really does work wonders for panic). I did never tell anybody about this incident, as I felt too ashamed (surely this must mean I am not fit to be a psychologist!). Nevertheless, in later years, I became more accepting towards myself and realised that my colleagues could also become distressed and/or feel enriched by their clients. Together, therefore, my own experiences and talks with colleagues awakened my curiosity on how psychologists may be affected by their clients, and thus lead me to choose this as a subject matter for my doctorate.

I feel the completion of this study has been exciting and stressful at times, but nevertheless a journey of personal growth. I have struggled, yet through this struggling I have also learned to rely on myself more and trust my own opinions. In particular, my struggle has involved doubts as to whether I can actually ever finish this doctorate and whether it will be good enough. My own self doubts have certainly come to the surface (e.g., 'I am not intelligent enough'), yet made me more determined to complete the doctorate and to spend countless hours writing. And whilst I have felt incredibly stuck at

times, I have also shown myself that I do get there in the end. My own experience tells me that stress does indeed coincide with growth.

This study has further been an eye opener for me in making me more aware of personal aspects of growth from my own client work. For example, the other day after having seen an asylum seeker client, who has gone through an incredible hard life, I started reflecting on the clients' unbelievable strength, yet vulnerability, and found myself seeing these human sides in myself, as well. It also made me think about how incredibly lucky I am, for still having supportive family and friends, and appreciate life for what really matters (e.g., no, I do not really need to buy those Topshop shoes).

It has also made me more open to exploring positive psychological approaches to my clients' difficulties (e.g., compassionate mind; Gilbert & Proctor, 2006), so that clients can develop their positive attributes, rather than only countering negative thoughts, behaviours and core beliefs (e.g., Beck et al., 1979). In addition, the findings have strengthened my belief that I need to be self-aware of my own personal woundedness. This has prompted me to approach ways of which to do so, by checking into myself (mindfulness), taking care of myself (e.g., exercise, sleep) and discussing any difficulties with my supervisor, colleagues and family. I would also like to go back to receive some more psychological therapy in the future. I further hope studies such as this can help other psychologists becoming more self aware of their own woundeness, how it affects them and their work, and how they can help themselves work through this. Clearly this study shows that psychologists are themselves often emotionally wounded and are

consequently more likely to also be negatively influenced by their clients' distress. This thus suggests that a respectful dialogue about psychologists' potential positive and negative effects of client work is needed. Hopefully, this study can be part of that.

Finally, the findings of this study will be fed back to the psychologists who showed interest in receiving the outcome. Also, the findings could potentially be published in a journal or The Psychologist, if possible, so that the conclusions can reach a fuller audience of psychologists, in order for them to make use of the conclusions made. This is important, particularly in the current work climate, where pressures on performing are high (e.g., IAPT). For their own and their clients' benefits therefore, psychologists need to reflect on how they can personally be influenced by their clients, both through enrichment and distress. For as Kottler (2003) concludes: 'our clients do indeed change us almost as much as we change them. Even though we... guard against infection by clients...we cannot remain completely unaffected...at the same time as we are touched by their goodness and the joy and privilege we feel in being allowed to get so close to a human soul' (p.265).

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Appendix 1: Questionnaire package

Psychotherapeutic work; enriching and/or cost-full?

Dear Colleague, *09/09/07*

My name is Malin Oyen and I am writing to ask if you can kindly take part in my research on **psychologists' stress and personal growth** as a part of my Doctorate in Counselling Psychology at London Metropolitan University. I am supervised by Dr Gella Richards and got your address from the BPS Directory of Charted Psychologists.

Jung (1966) described that working with mentally ill clients can lead to "unconscious infection", yet others have described our work as very rewarding. **What do you think? Is there a cost to caring for you, and/or is your work a source of personal growth?**

Participating involves completing the brief attached questionnaires and a demographic info sheet that will altogether **only take about 15 min** to fill in. Questions from the Professional Quality of life scale (Stamm, 1997) will for example, concern compassion satisfaction, burnout and CF. Other questions will relate to your personal growth (PTGI: Tedeschi & Calhoun, 1996), social support (MSPSS; Zimet et al., 1988), sense of coherence (SOC-13; Antonovsky, 1987) and ways of coping (Brief COPE; Carver, 1997). Please return the completed questionnaires using the stamped addressed envelope provided.

I would like to stress that participation is voluntary and you can withdraw from the study at any time. In addition, the information provided will remain **strictly anonymous and confidential** on a pass worded computer. The data **will not include any identifiable characteristics** of the participants and will be destroyed once it has been analysed. The return of the questionnaires will be considered as consent for wanting to take part in this study.

If you have any questions or would like to receive information regarding the findings of this study, please do not hesitate to contact me on; **oyenmalin@hotmail.com**, or my supervisor Dr. Richards on **Gella.Richards@.londonmet.ac.uk**. A summary of the results will be available upon request after February 2008.

Although I do acknowledge that it may be uncomfortable for some to complete a few of the questions included, it may also help you to assess your own personal and professional development.

Thank you very much if you do decide to take part in this study! It is much appreciated!!!
Warm regards,

Malin Oyen

Demographic Questionnaire

1) Gender: Male ☐ Female ☐

2) Age; _____years

3) Marital status

a) Married or living with partner ☐

b) Single..... ☐

c) Separated/divorced..... ☐

d) Widowed..... ☐

4) Ethnicity

a) White..... ☐

b) Mixed..... ☐

c) Asian or Asian British..... ☐

d) Black or Black British..... ☐

e) Chinese..... ☐

f) Other..... ☐

5) Psychology area specialised in

a) Counselling Psych ☐

b) Clinical Psych ☐

c) Other (please state) ☐

_____

6) Type of employment

a) Private practice..... ☐

Private organisation..... ☐

c) Public (e.g NHS, prison)..... ☐

d) Teaching/researching..... ☐

6) Number of years having practiced as a psychologist?_____years

7) Approximate number of hours of client work a week _____hrs
(i.e., how many combined individual client and group slots)

8) Approximate number of overall hours of work a week (including overtime)**?**_____hrs

9) <u>Main</u> theoretical approach practiced:

Integrative/eclectic ☐ Psychoanalytic/dynamic ☐ CBT ☐ Systemic ☐ Humanistic ☐
Other_____

10) Client population served:

a) Age group; Children ☐ Adults ☐ Older adults (above 65) ☐ All ages ☐

b) Severity of <u>typically</u> presenting problems:

- General mental health (e.g., depression and anxiety disorders)..... ☐
- Severe/ more chronic mental health (e.g., psychosis, personality disorders).... ☐
- A mixture of general and severe mental health difficulties..... ☐

c) Specialisation (please choose one group you specialise in treating)

a) General Adult mental health..... ☐

b) Severe adult mental health-enduring/ chronic conditions ☐

c) Children/adolescent /families..... ☐

d) Forensic..... ☐

e) Trauma..... ☐

f) Learning Disability..... ☐

g) Substance use and addictive beh. ☐

h) Older adults..... ☐

i) Other..... ☐

(please state):_____

11) Do you receive regular clinical supervision?

Yes ☐ No ☐

12) Do you regularly supervise others?

Yes ☐ No ☐

13) How much can you rely on your clinical *supervisor* to support you when you experience work-related difficulties? (Tick N/A if you do not have a supervisor)

Not at all	Slightly	Moderately	Quite a lot	Fully	N/A
0	1	2	3	4	5

14) How much can you rely on your colleagues to support you when you experience work-related difficulties? (Tick N/A if you are self employed/do not have colleagues)

Not at all	Slightly	Moderately	Quite a lot	Fully	N/A
0	1	2	3	4	5

15) Have you ever received psychotherapy yourself?

Yes, for a short period ☐ Yes, over a longer period/ several ☐ times ☐

No

A trauma has been defined as experiencing, witnessing or confronting event(s) "that involved actual or threatened death or serious injury, or a threat to the physical integrity of self and others" and that "the person's response involved intense fear, helplessness or horror" (perhaps expressed as disorganized or agitated behaviour in children)[APA, 2000].

16) Does your work ever involve counselling traumatised clients? If so, approximately how many hours of your clinical work are spent with trauma clients a week? _____sessions

17) Have you got any personal experience of trauma?

No, never ☐ Yes, once ☐ Yes, more than once ☐

18) Have you experienced a trauma over the last 6 months?

Yes ☐ No ☐

19) Have you ever gone through a particularly stressful life experience? (e.g., experience of trauma and/or neglect, major losses through death or ending/separation of long term relationships, own psychological difficulties or serious physical illness)?

Yes ☐ No ☐

If you have experienced several particularly stressful experiences, please refer to the most stressful incident.

a) If so, how stressful was this for you at the time?

1	2	3	4	5
Not at all stressful	not very stressful	somewhat stressful		Extremely stressful

b) How stressful is it for you to think about this incident now?

1	2	3	4	5
Not at all stressful	not very stressful	somewhat stressful		Extremely stressful

c) To what extent would you say you have come to terms with this experience?

1	2	3	4	5
Not at all	A little bit	Somewhat		Fully

d) To what extent would you say you have learned to cope with this experience?

1	2	3	4	5
Not at all	A little bit	Somewhat		Fully

e) To what extent do you feel this personal experience has aided your work with clients?

1	2	3	4	5
Not at all	A little bit	Somewhat		A lot

f) To what extent do you feel this personal experience has impeded your work with clients?

1	2	3	4	5
Not at all	A little bit	Somewhat		A lot

ProQOL - R –IV PROFESSIONAL QUALITY OF LIFE

Compassion Satisfaction and Fatigue Subscales – Revision IV

Helping people puts you in direct contact with their lives. As you probably have experienced, your compassion for those you help has both positive and negative aspects. We would like to ask you questions about your experiences, both positive and negative, as a helper. Consider each of the following questions about you and your current situation. Select the number that honestly reflects how frequently you experienced these characteristics ***in the last 30 days***.

0=Never 1=Rarely 2=A Few Times 3=Somewhat Often 4=Often 5=Very Often

_____1. I am happy.
_____2. I am preoccupied with more than one person I help.
_____3. I get satisfaction from being able to help people.
_____4. I feel connected to others.
_____5. I jump or am startled by unexpected sounds.
_____6. I feel invigorated after working with those I help.
_____7. I find it difficult to separate my personal life from my life as a helper.
_____8. I am losing sleep over experiences of a person I help.
_____9. I think that I might have been "infected" by the stress of those I help.
_____10. I feel trapped by my work as a helper.
_____11. Because of my helping, I have felt "on edge" about various things.
_____12. I like my work as a helper.
_____13. I feel depressed as a result of my work as a helper.
_____14. I feel as though I am experiencing the trauma of someone I have helped.
_____15. I have beliefs that sustain me.
_____16. I am pleased with how I am able to keep up with helping techniques and protocols.
_____17. I am the person I always wanted to be.
_____18. My work makes me feel satisfied.
_____19. Because of my work as a helper, I feel exhausted.
_____20. I have happy thoughts and feelings about those I help and how I could help them.
_____21. I feel overwhelmed by the amount of work or the size of my caseload I have to deal with.
_____22. I believe I can make a difference through my work.
_____23. I avoid certain activities or situations because they remind me of frightening experiences of the people I help.
_____24. I am proud of what I can do to help.
_____25. As a result of my helping, I have intrusive, frightening thoughts.
_____26. I feel "bogged down" by the system.
_____27. I have thoughts that I am a "success" as a helper.
_____28. I can't recall important parts of my work with clients.
_____29. I am a very sensitive person.
_____30. I am happy that I chose to do this work.

PTGI (Tedeschi & Calhoun,1996)

Indicate for each statement below the degree to which **this change has occurred in your life as a result of your therapy work**, using the following scale.

0= I **have not** experienced this change as a result of my therapy work
1= I have experienced this change to a **very small degree** as a result of my therapy work
2= I have experienced this change to a **small degree** as a result of my therapy work
3= I have experienced this change to a **moderate degree** as a result of my therapy work
4= I have experienced this change to a **great degree** as a result of my therapy work
5= I have experienced this change to a **very great degree** as a result of my therapy work

_____ 1. I have changed my priorities about what is important in life
_____ 2. I have a greater appreciation for the value of my own life
_____ 3. I have developed new interests
_____ 4. I have a greater feeling of self-reliance
_____ 5. I have a better understanding of spiritual matters
_____ 6. I more clearly see that I can count on people in times of trouble
_____ 7. I have established a new path for my life
_____ 8. I have a greater sense of closeness to others
_____ 9. I am more willing to express my emotions
_____ 10. I know better that I can handle difficulties
_____ 11. I am able to do better things with my life
_____ 12. I am better able to accept the way things work out
_____ 13. I can better appreciate each day
_____ 14. New opportunities are available which wouldn't have been otherwise
_____ 15. I have more compassion for others
_____ 16. I put more efforts into my relationships
_____ 17. I am more likely to try to change things which need changing
_____ 18. I have a stronger religious faith
_____ 19. I have discovered that I am stronger than I thought I was
_____ 20. I have learned a great deal about how wonderful people are
_____ 21. I better accept needing others

Brief COPE (Carver,1997).

These items deal with ways you've been coping with **work related stress over the last 12 months**. There are many ways to try to deal with problems. These items ask what you've been doing to cope with something that has been stressful for you. Obviously, different people deal with things in different ways, but I'm interested in how you've tried to deal with it. Each item says something about a particular way of coping. I want to know to what extent you've been doing what the item says. How much, or how frequently. Don't answer on the basis of whether it seems to be working or not—just whether or not you're doing it. Use these response choices. Try to rate each item separately in your mind from the others. Make your answers as true for you as you can.

1 = I haven't been doing this at all
2 = I've been doing this a little bit
3 = I've been doing this a medium amount
4 = I've been doing this a lot

____1. I've been turning to other activities to take my mind off things.
____2. I've been concentrating my efforts on doing something about the situation I'm in.
____3. I've been saying to myself "this isn't real.".
____4. I've been using alcohol or other drugs to make myself feel better.
____5. I've been getting emotional support from others.
____6. I've been giving up trying to deal with it.
____7. I've been taking action to try to make the situation better.
____8. I've been refusing to believe that it has happened.
____9. I've been saying things to let my unpleasant feelings escape.
____10. I've been getting help and advice from other people.
____11. I've been using alcohol or other drugs to help me get through it.
____12. I've been trying to see it in a different light, to make it seem more positive.
____13. I've been criticizing myself.
____14. I've been trying to come up with a strategy about what to do.
____15. I've been getting comfort and understanding from someone.
____16. I've been giving up the attempt to cope.
____17. I've been looking for something good in what is happening.
____18. I've been making jokes about it.
____19. I've been doing something to think about it less, such as going to movies, watching TV, reading, daydreaming, sleeping, or shopping.
____20. I've been accepting the reality of the fact that it has happened.
____21. I've been expressing my negative feelings.
____22. I've been trying to find comfort in my religion or spiritual beliefs.
____23. I've been trying to get advice or help from other people about what to do.
____24. I've been learning to live with it.
____25. I've been thinking hard about what steps to take.
____26. I've been blaming myself for things that happened.
____27. I've been praying or meditating.
____28. I've been making fun of the situation.

SOC orientation to life questionnaire (Antonovsky, 1987)

Please circle the number that best describes you.

01. Do you have the feeling that you don't really care about what goes on around you?	Very seldom or never						Very often
	1	2	3	4	5	6	7
02. Has it happened in the past that you were surprised by the behaviour of people whom you thought you knew well?	Never happened						Always happened
	1	2	3	4	5	6	7
03. Has it happened that people whom you counted on disappointed you?	Never happened						Always happened
	1	2	3	4	5	6	7
04. Until now your life has had:	No clear goals or purpose at all						very clear goals and purpose
	1	2	3	4	5	6	7
05. Do you have the feeling that you're being treated unfairly?	Very often						very seldom or never
	1	2	3	4	5	6	7
06. Do you have the feeling that you are in an unfamiliar situation and don't know what to do?	Very often						very seldom or never
	1	2	3	4	5	6	7
07. Doing the things you do every day is:	A source of deep pleasure and satisfaction						a source of pain and boredom
	1	2	3	4	5	6	7
08. Do you have very mixed-up feelings and ideas?	Very often						very seldom or never
	1	2	3	4	5	6	7
09. Does it happen that you have feelings inside that you would rather not feel?	Very often						very seldom or never
	1	2	3	4	5	6	7
10. Many people - even those with a strong character - sometimes feel like losers in certain situations. How often have you felt this way in the past?	Never						Very often
	1	2	3	4	5	6	7
11. When something happened, have you generally found that:	You overestimated or underestimated its importance						you saw things in the right proportion
	1	2	3	4	5	6	7
12. How often do you have the feeling that there's little meaning in the things you do in your daily life?	Very often						very seldom or never
	1	2	3	4	5	6	7
13. How often do you have feelings that you're not sure you can keep under control?	Very often						very seldom or never
	1	2	3	4	5	6	7

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

Instructions: Please read carefully and 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**

	Very Strongly Disagree 1	Strongly Disagree 2	Mildly Disagree 3	Neutral 4	Mildly Agree 5	Strongly Agree 6	Very Strongly Agree 7	
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

If you feel effected by any of the issues raised in this study, and would like to know more about the potential effects of therapy, or where to get support, please see the following links:

- The International Society for Traumatic Stress Studies; **http://www.istss.org/resources/indirect_trauma.cfm**
- **BPS**

In addition, you can self assess your burnout, CF and work satisfaction from the Professional Quality of life scale (Stamm, H.B., 2005) by going to:

- *http://www.isu.edu/~bhstamm.*

Otherwise it is always good to talk to a colleague, supervisor, friend or significant other to gain support/plan how to better balance work, play and rest.

Thank you very much for taking part in this study!!!

Best wishes, Malin Oyen

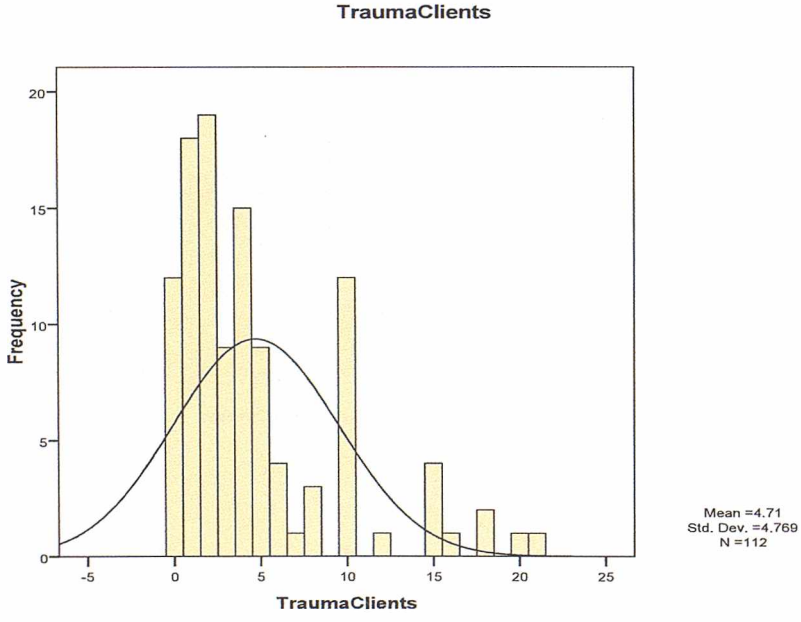
Appendix 2: normal distribution and outlier checks

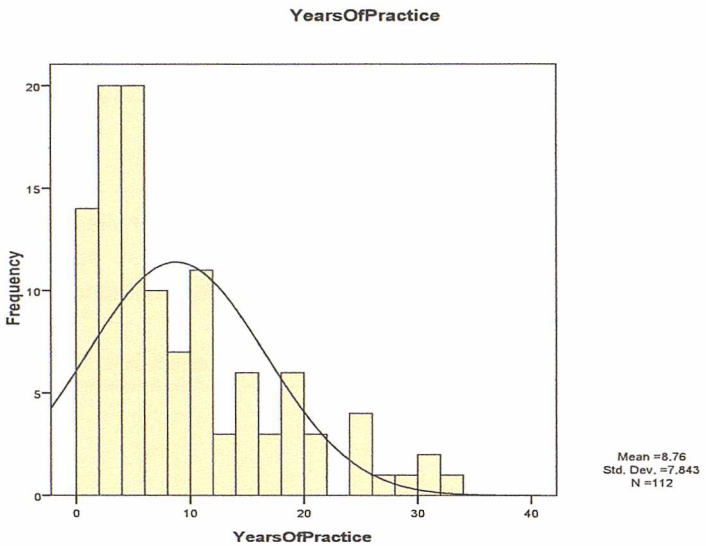
2a) Normal distribution checks for years of experience, trauma client load and overall client load

Skewness and Kurtosis Statistics for trauma clients, years of practice and hours of client work a week.

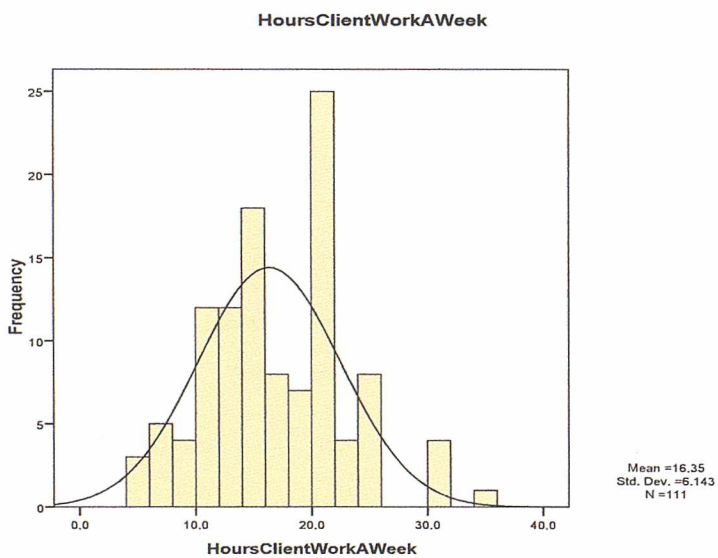
		Trauma Clients	Years Of Practice	Hours Client Work A Week
N	Valid	112	112	111
	Missing	0	0	1
Mean		4.71	8.76	16.351
Std. Deviation		4.769	7.843	6.1432
Skewness		**1.526**	**1.228**	**.318**
Std. Error of Skewness		**.228**	**.228**	**.229**
Kurtosis		**1.903**	**.790**	**.070**
Std. Error of Kurtosis		**.453**	**.453**	**.455**

Histograms of trauma client and years of practice variables before transformation





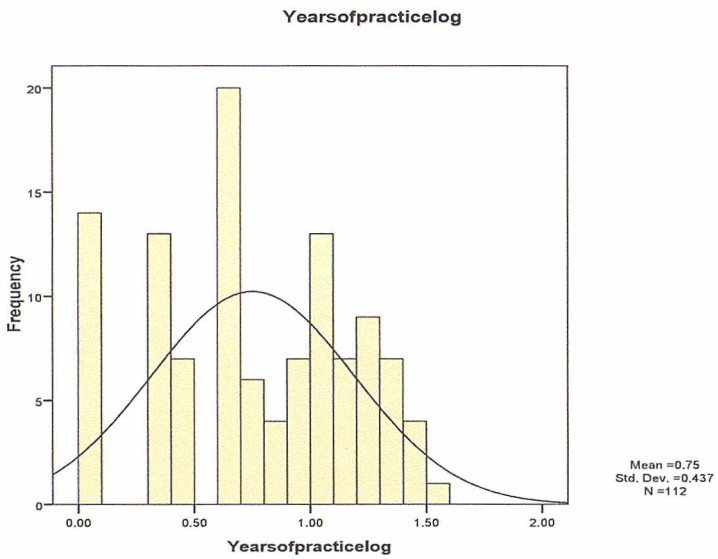
Histogram of hours of client work a week

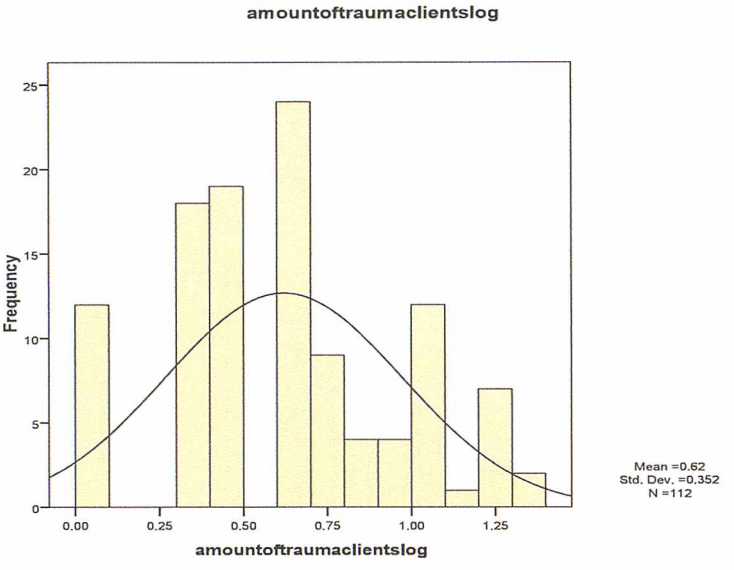


Skewness and Kurtosis Statistics for trauma clients, years of practice after transformation (log).

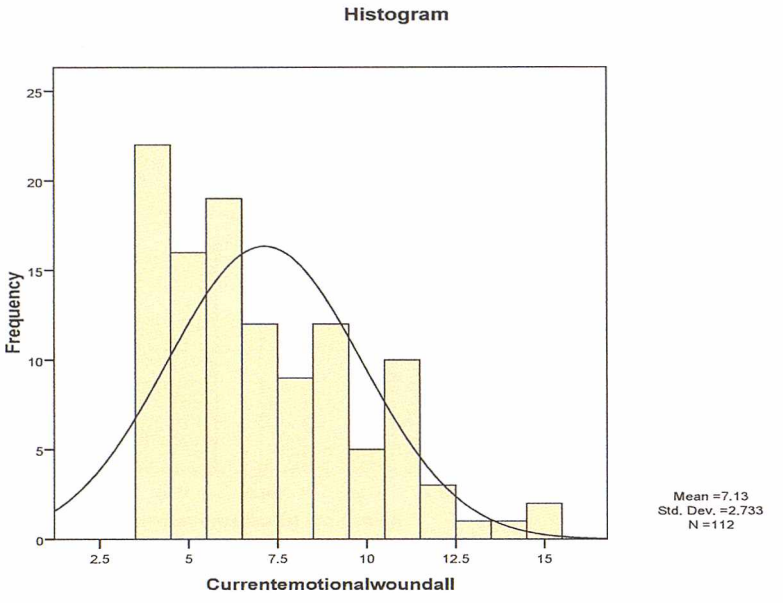
		amountoftraumaclientslog	Yearsofpracticelog
N	Valid	112	112
	Missing	0	0
Mean		.6198	.7522
Std. Deviation		.35217	.43656
Skewness		**.015**	**-.215**
Std. Error of Skewness		**.228**	**.228**
Kurtosis		**-.633**	**-.922**
Std. Error of Kurtosis		**.453**	**.453**

Histograms of years of practice and amount of trauma clients after logs




amountoftraumaclientslog
Frequency
25
20
15
10
5
0
0.00
0.25
0.50
0.75
1.00
1.25
amountoftraumaclientslog
Mean =0.62
Std. Dev. =0.352
N =112

2b) Normal distribution checks for the Current emotional woundedness scores



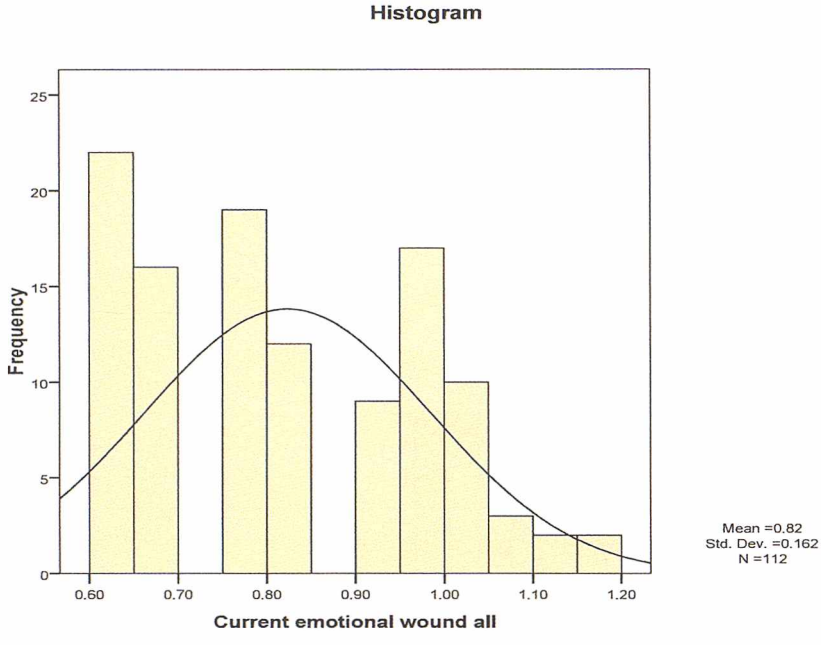
Skewness and Kurtosis Statistics for Current Emotional Woundedness

N	Valid	112
	Missing	0
Skewness		.793
Std. Error of Skewness		.228
Kurtosis		-.022
Std. Error of Kurtosis		.453

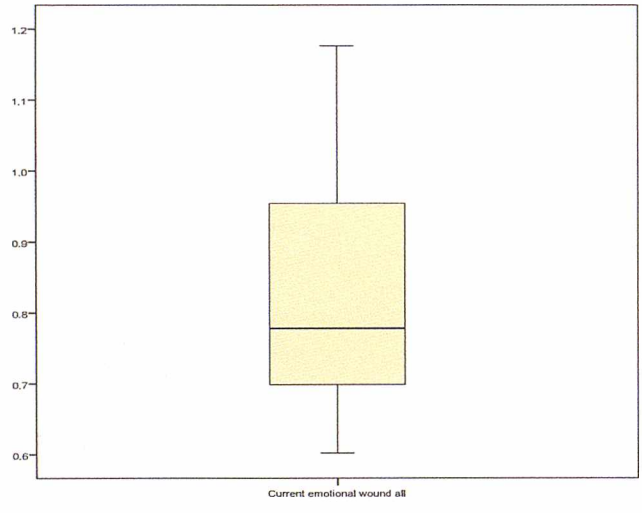
Skewness and Kurtosis Statistics for Current Emotional Woundedness after transformation

N	Valid	112
	Missing	0
Skewness		.195
Std. Error of Skewness		.228
Kurtosis		-.991
Std. Error of Kurtosis		.453

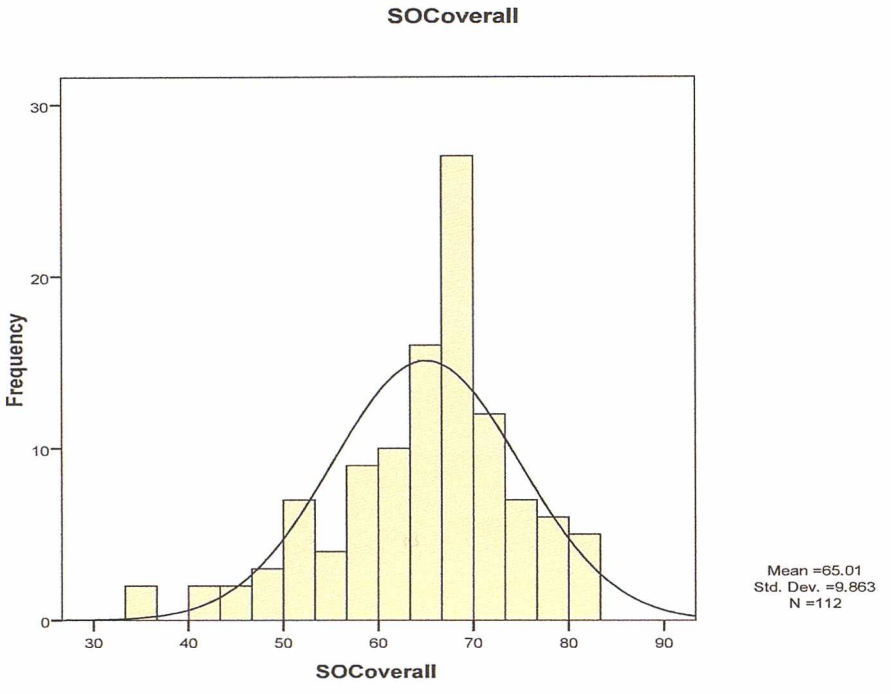
Current Emotional Woundedness after transformation (Log)



No outliers for current emotional woundedness



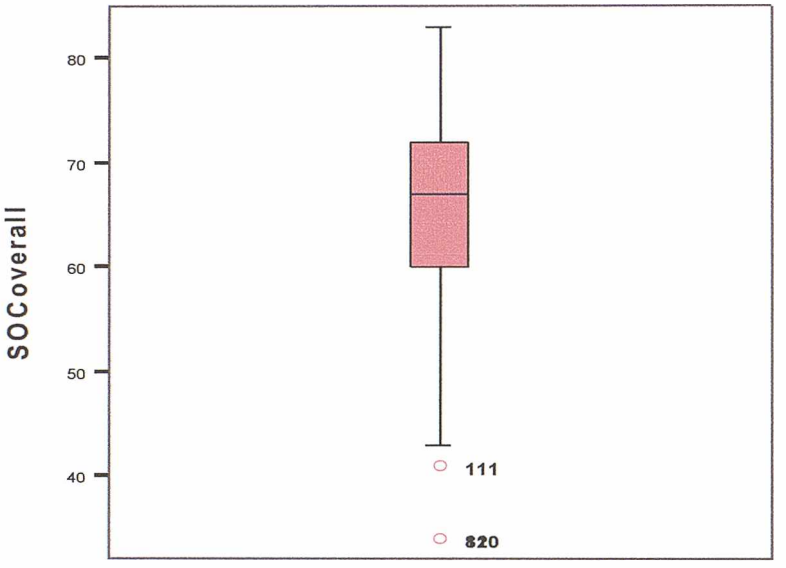
2c) Normal distribution checks for the Sense of Coherence (SOC) scores



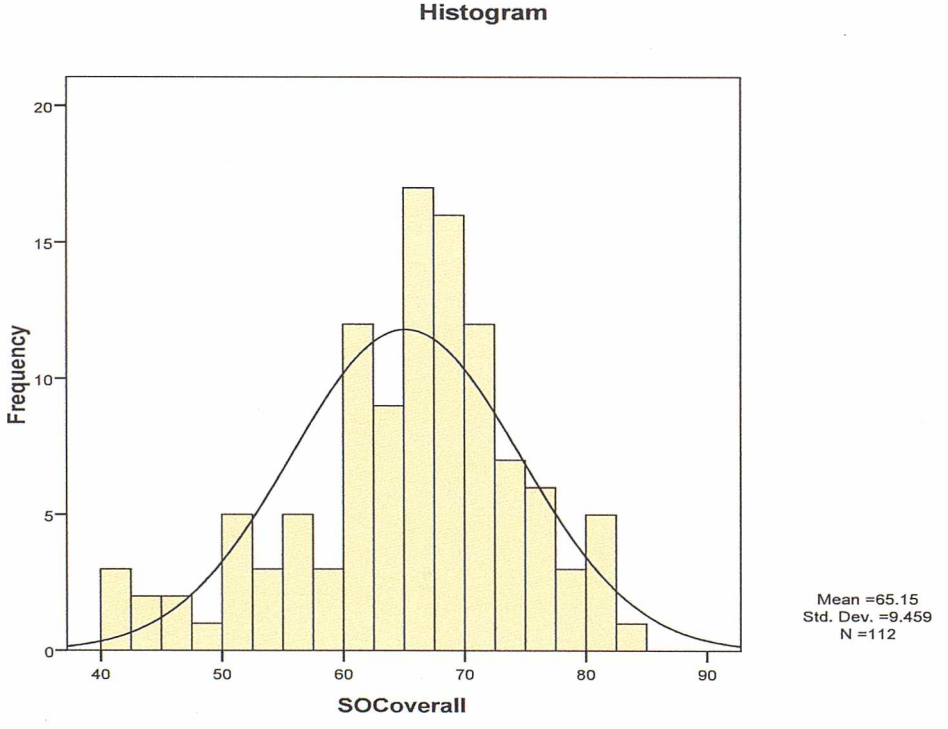
Skewness and Kurtosis Statistics for SOC

N	Valid	112
	Missing	0
Mean		65.01
Median		67.00
Mode		69
Std. Deviation		9.863
Variance		97.288
Skewness		-.800
Std. Error of Skewness		.228
Kurtosis		.925
Std. Error of Kurtosis		.453
Percentiles	25	60.00
	50	67.00
	75	72.00

Sense of Coherence (SOC) scores: 3 outliers



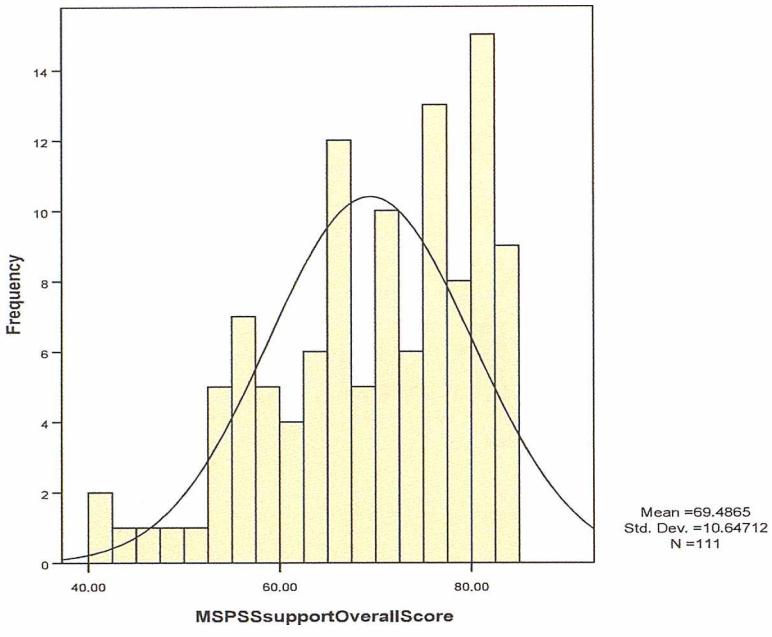
SOC normal distribution after changing scores of 2 outliers

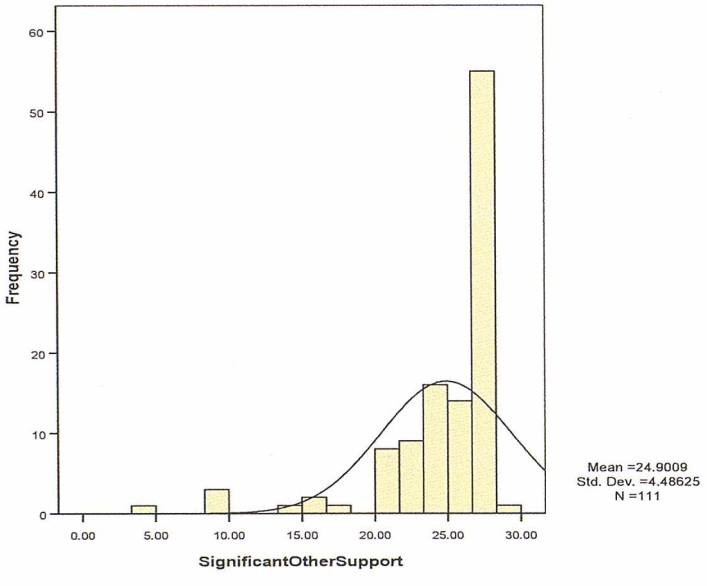


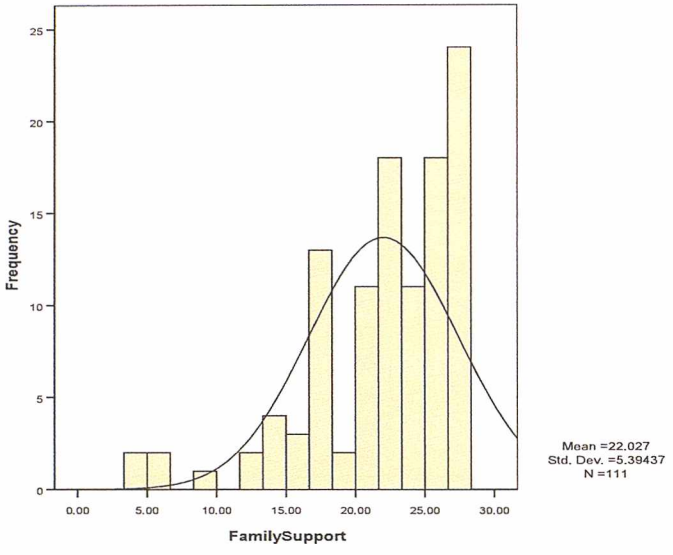
Descriptives for SOC after changing scores of 2 outliers

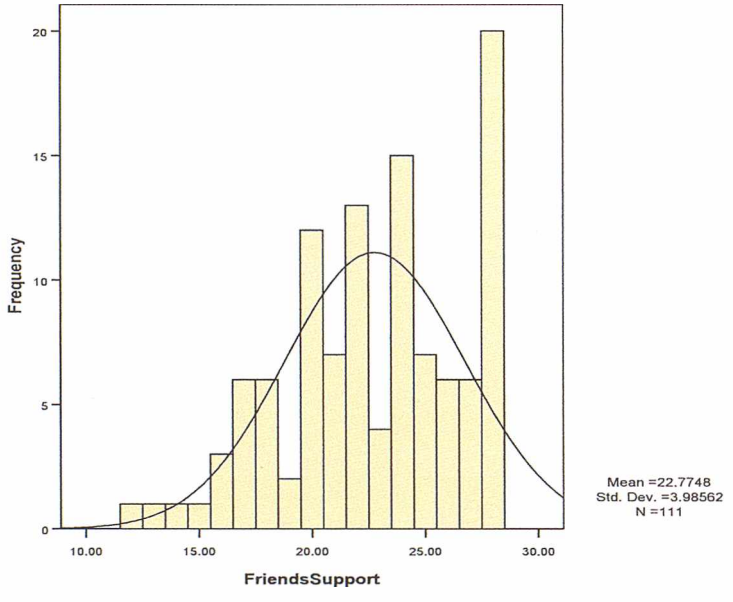
			Statistic	Std. Error
SOCoverall	Mean		65.15	.894
	95% Confidence Interval for Mean	Lower Bound	63.38	
		Upper Bound	66.92	
	5% Trimmed Mean		65.47	
	Median		67.00	
	Variance		89.481	
	Std. Deviation		9.459	
	Minimum		41	
	Maximum		83	
	Range		42	
	Interquartile Range		12	
	Skewness		**-.571**	**.228**
	Kurtosis		**.159**	**.453**

2d) Normal distribution checks for the Social support variables





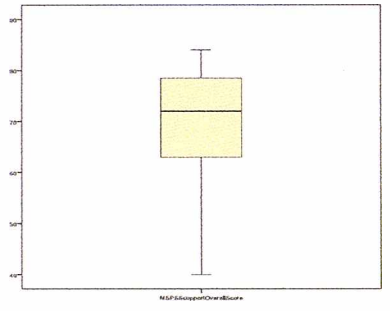

Frequency
25
20
15
10
5
0
0.00
5.00
10.00
15.00
20.00
25.00
30.00
FamilySupport
Mean =22.027
Std. Dev. =5.39437
N =111


Frequency
20
15
10
5
0
10.00
15.00
20.00
25.00
30.00
FriendsSupport
Mean =22.7748
Std. Dev. =3.98562
N =111

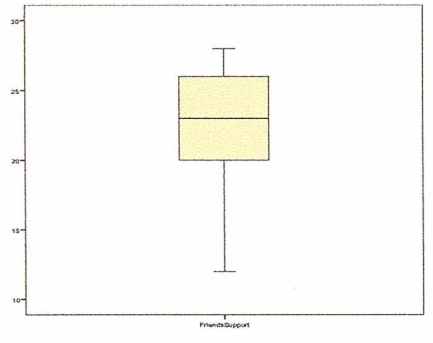
Statistics Social Support

		MSPSS Support Overall Score	Significant Other Support	Family Support	Friends Support
N	Valid	111	111	111	111
	Missing	1	1	1	1
Mean		69.4865	24.9009	22.0270	22.7748
Median		72.0000	27.0000	23.0000	23.0000
Mode		76.00	28.00	28.00	28.00
Std. Deviation		10.64712	4.48625	5.39437	3.98562
Variance		113.361	20.126	29.099	15.885
Skewness		**-.648**	**-2.282**	**-1.274**	**-.420**
Std. Error of Skewness		**.229**	**.229**	**.229**	**.229**
Kurtosis		**-.224**	**6.199**	**1.722**	**-.528**
Std. Error of Kurtosis		**.455**	**.455**	**.455**	**.455**
Range		44.00	25.00	24.00	16.00

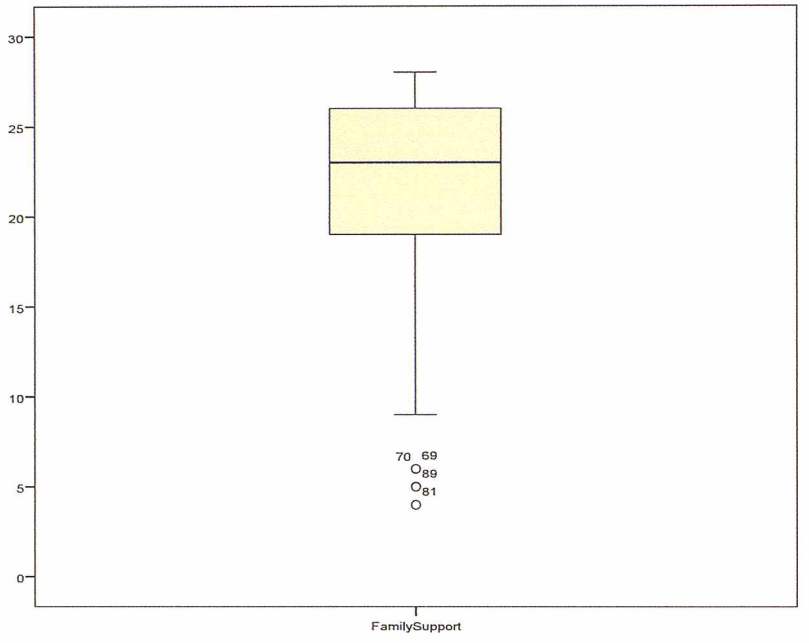
Overall social support: no outliers



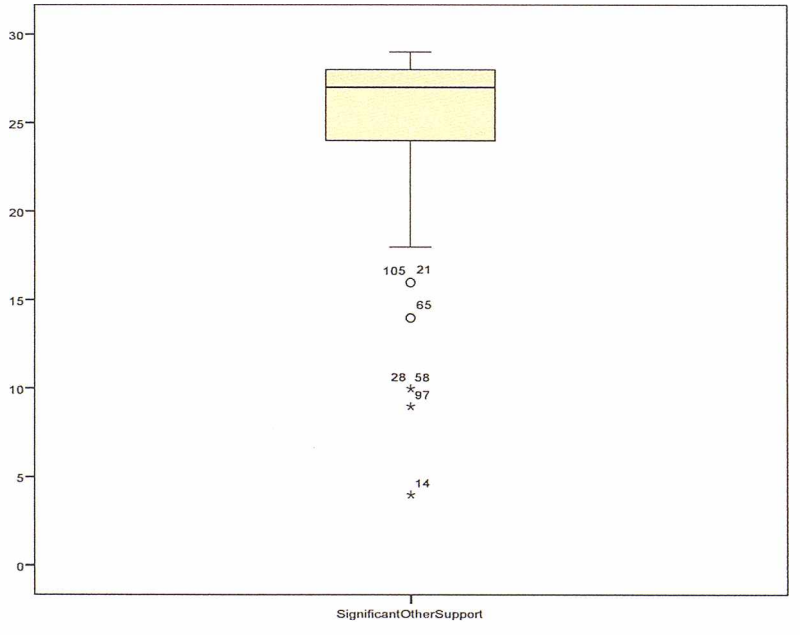
Friends support: no outliers



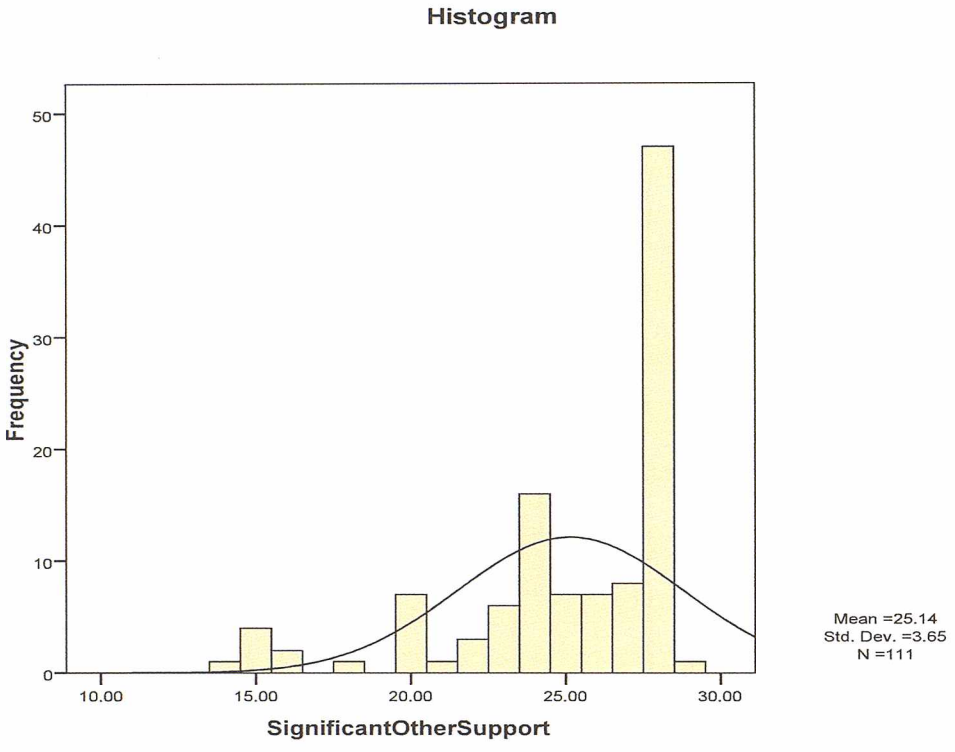
Family support: 4 outliers



Significant Other support: 3 ouliers and 4 extreme scores



Significant other support histogram after the change of the 4 extreme scores

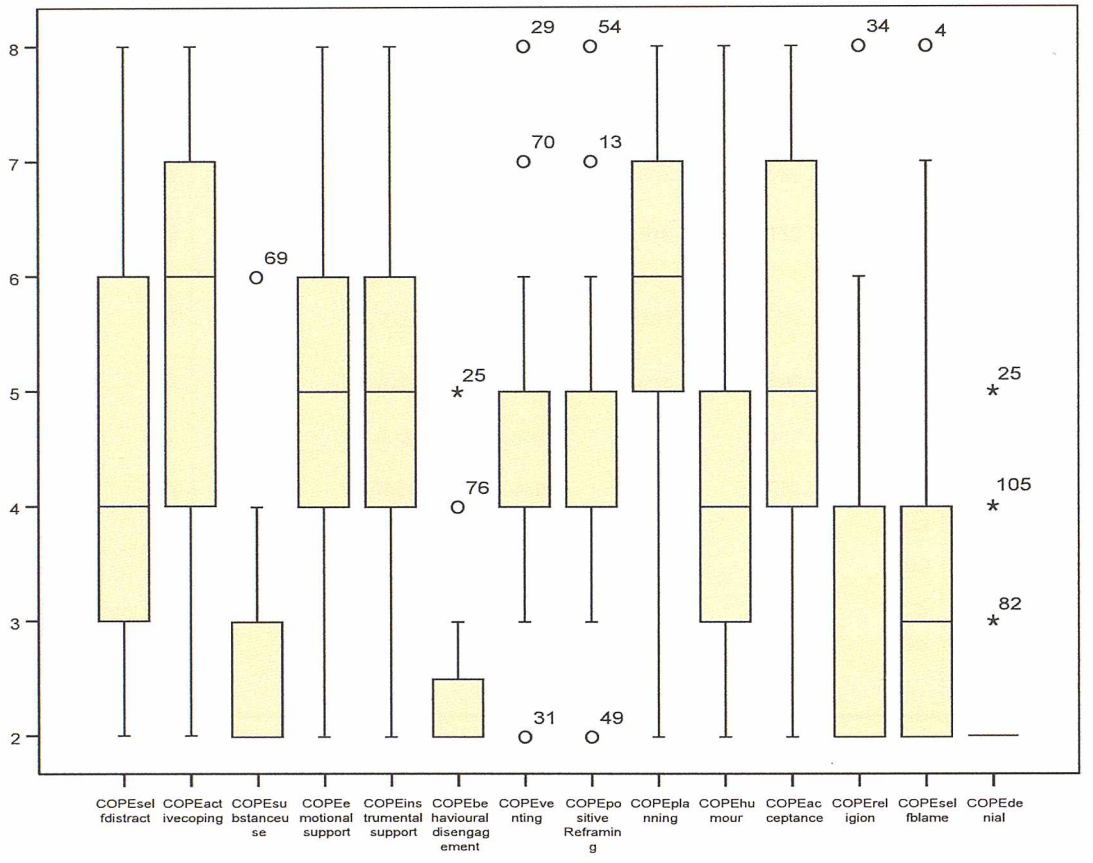


Descriptive Statistics for Significant Other support after the change in extreme scores

	N	Minimum	Maximum	Mean	Std. Deviation	Skewness		Kurtosis	
	Statistic	Statistic	Statistic	Statistic	Statistic	Statistic	Std. Error	Statistic	Std. Error
SignificantOtherSupport	111	14.00	29.00	25.1441	3.65027	-1.417	.229	1.429	.455
Valid N (listwise)	111								

2e) Normal distribution checks for the coping variables (COPE).

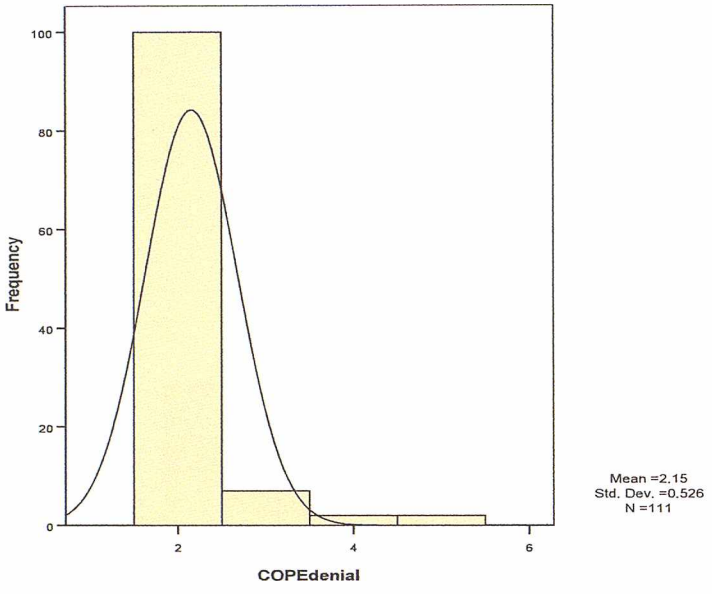
Outliers and extreme scores for the COPE variables

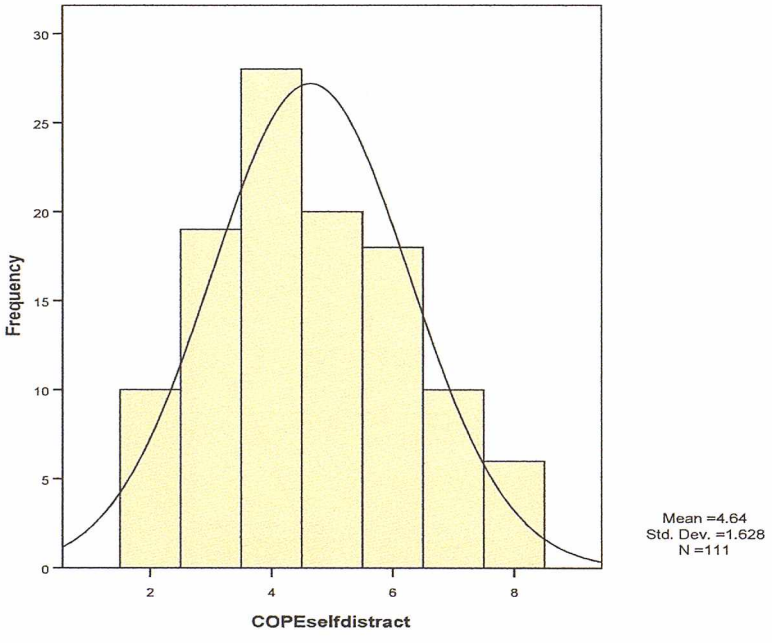


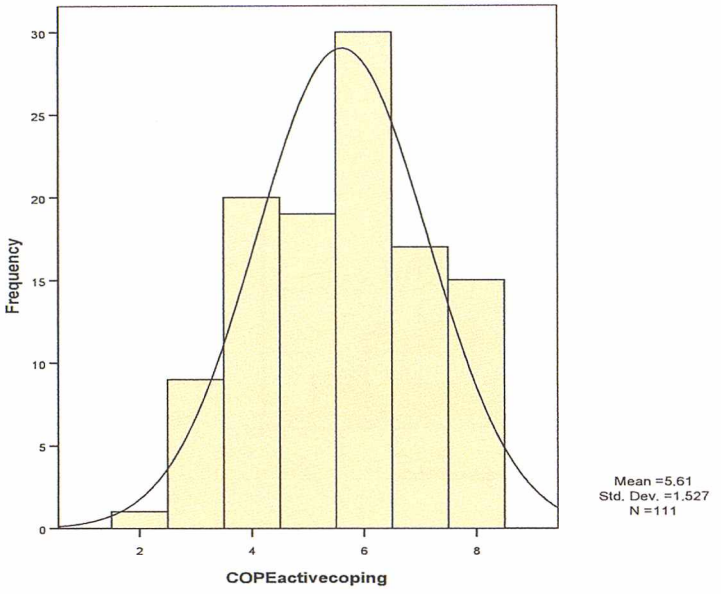
Descriptive Statistics for the COPE variables

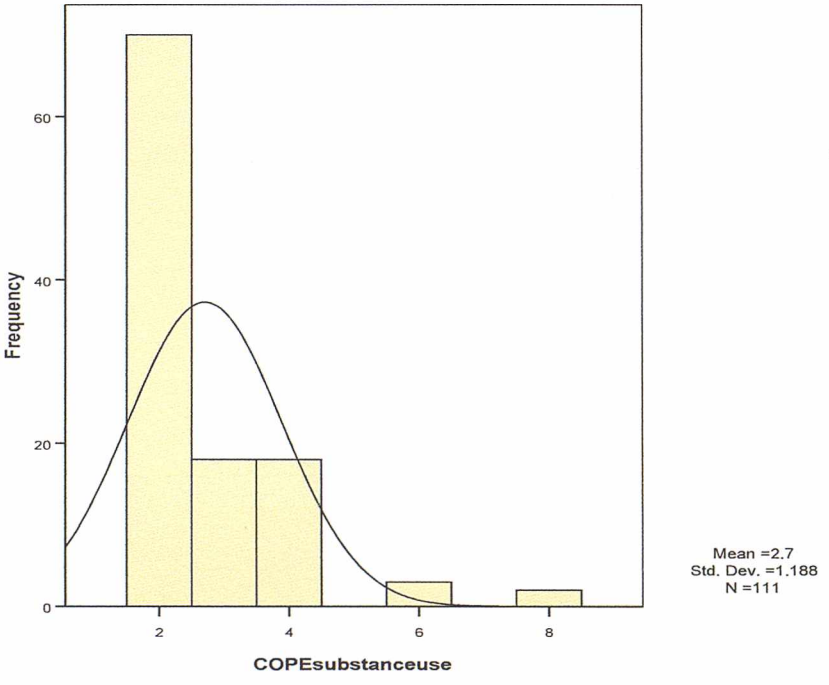
	N	Minimum	Maximum	Mean	Std. Deviation	Variance	Skewness		Kurtosis	
	N	Statistic	Statistic	Statistic	Statistic	Statistic	Statistic	Std. Error	Statistic	Std. Error
Self distract	111	2	8	4.64	1.628	2.651	.280	.229	-.672	.455
Active coping	111	2	8	5.61	1.527	2.330	-.116	.229	-.823	.455
Denial	110	2	5	2.14	.497	.247	4.384	.230	20.770	.457
Substance use	111	2	6	2.67	1.047	1.097	1.674	.229	2.407	.455
Emotional support	111	2	8	5.35	1.529	2.339	-.085	.229	-.548	.455
Instrumental support	111	2	8	4.94	1.370	1.878	.116	.229	-.028	.455
Behavioural disengagement	111	2	5	2.32	.620	.385	1.980	.229	3.651	.455
Venting	111	2	8	4.65	1.405	1.975	.590	.229	.146	.455
Positive Reframing	111	2	8	4.59	1.430	2.045	.347	.229	.109	.455
Planning	111	2	8	5.64	1.482	2.196	-.039	.229	-.508	.455
Humour	111	2	8	3.94	1.586	2.514	.663	.229	-.085	.455
Acceptance	111	2	8	5.37	1.634	2.671	-.030	.229	-.803	.455
Religion	111	2	8	3.23	1.725	2.976	1.397	.229	1.095	.455
Selfblame	111	2	8	3.55	1.500	2.250	1.170	.229	1.038	.455
Valid N (listwise)	110									

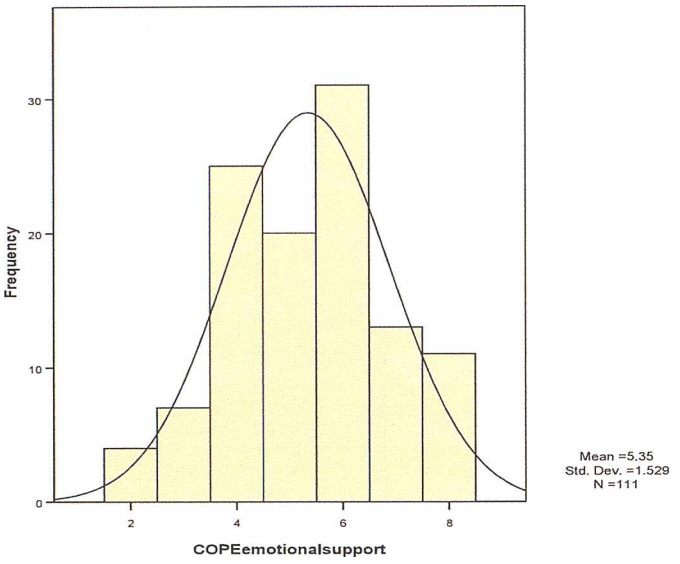
Histograms of the COPE variables

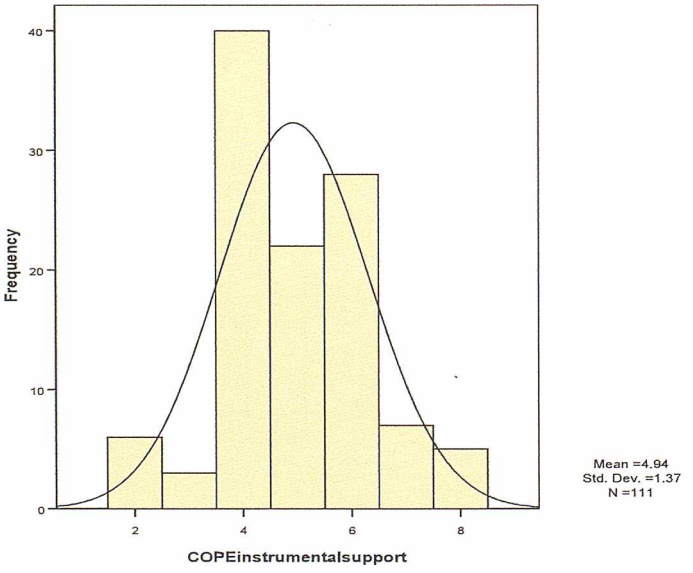


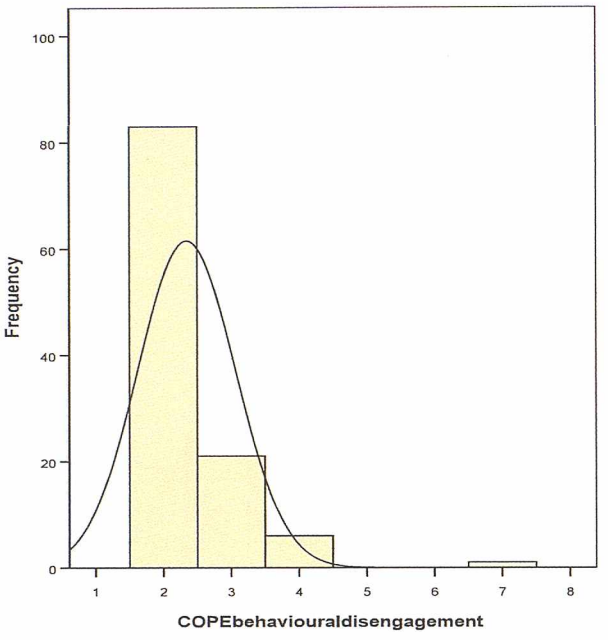


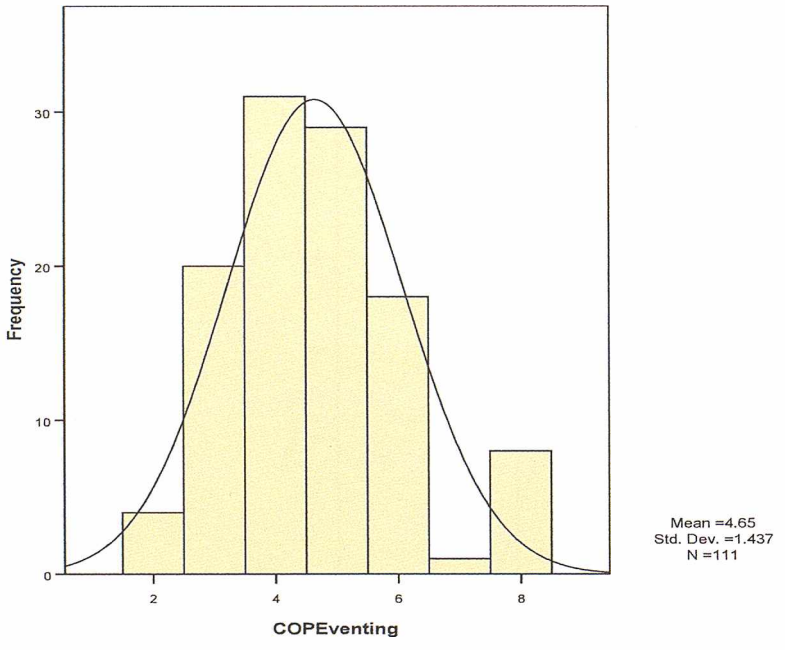

Frequency
30
25
20
15
10
5
0
2
4
6
8
COPEactivecoping
Mean =5.61
Std. Dev. =1.527
N =111

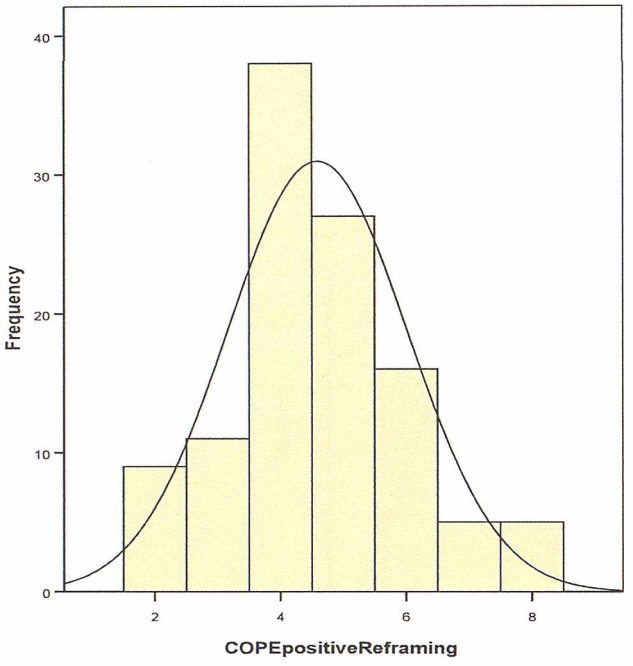

Frequency
60
40
20
0
2
4
6
8
COPEsubstanceuse
Mean =2.7
Std. Dev. =1.188
N =111

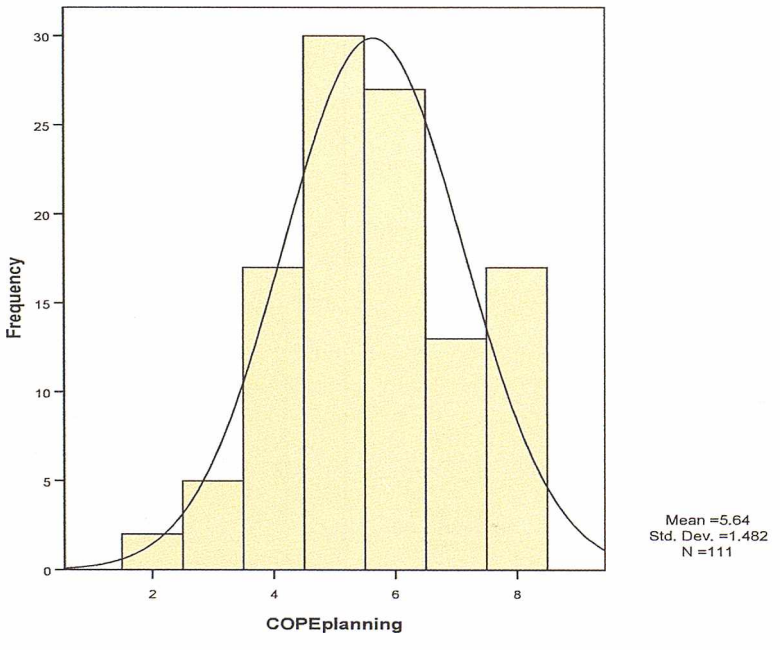

Frequency
30
20
10
0
2
4
6
8
COPEemotionalsupport
Mean =5.35
Std. Dev. =1.529
N =111

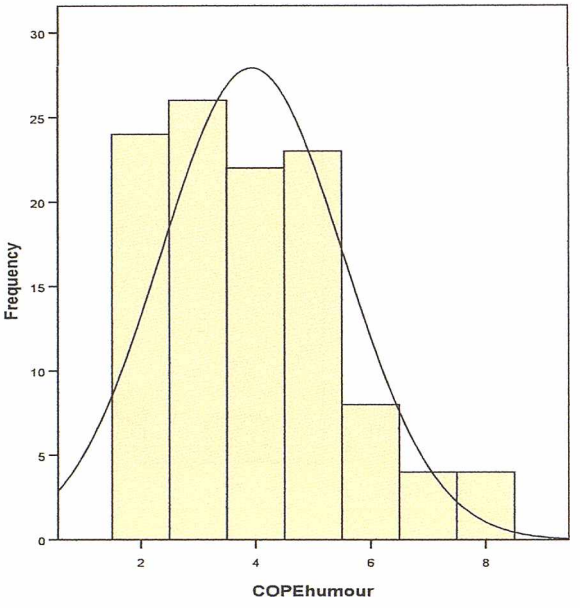

Frequency
40
30
20
10
0
2
4
6
8
COPEinstrumentalsupport
Mean =4.94
Std. Dev. =1.37
N =111

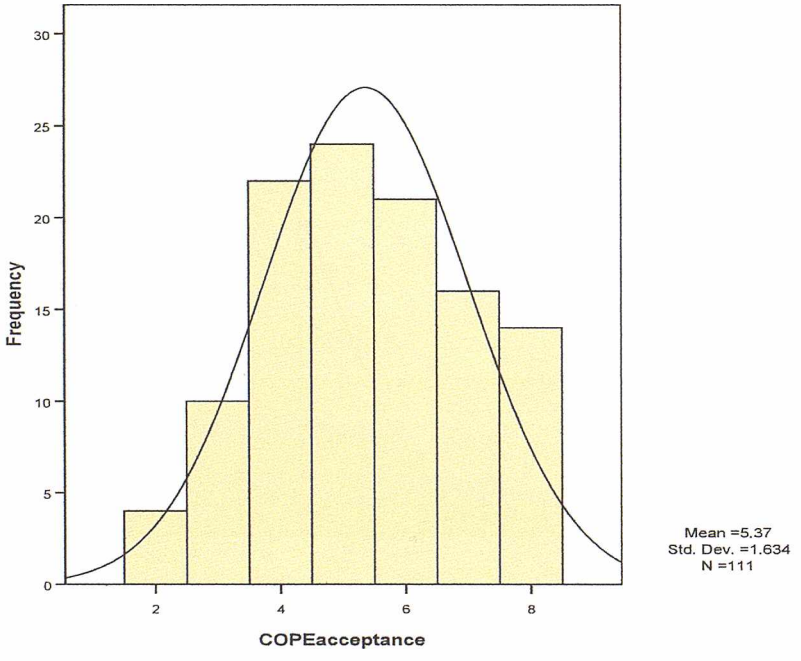

100
80
60
40
20
0
Frequency
1
2
3
4
5
6
7
8
COPEbehaviouraldisengagement
Mean =2.34
Std. Dev. =0.72
N =111

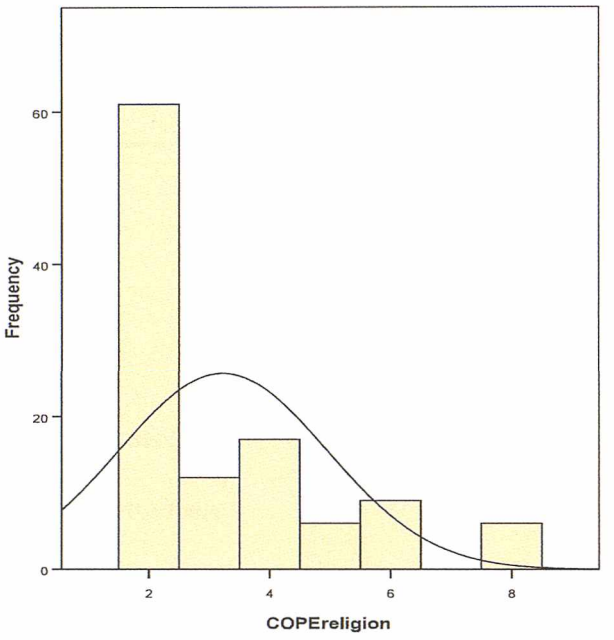

30
20
10
0
Frequency
2
4
6
8
COPEventing
Mean =4.65
Std. Dev. =1.437
N =111

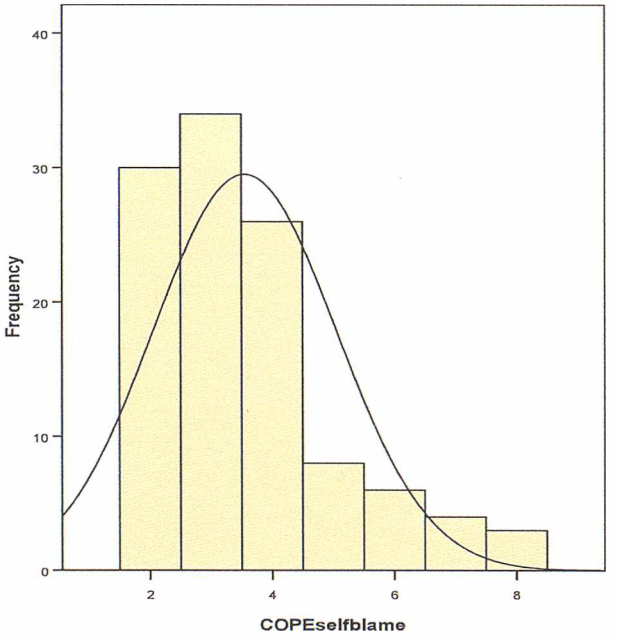

Frequency
40
30
20
10
0
2
4
6
8
COPEpositiveReframing
Mean =4.59
Std. Dev. =1.43
N =111


Frequency
30
25
20
15
10
5
0
2
4
6
8
COPEplanning
Mean =5.64
Std. Dev. =1.482
N =111


Frequency
30
25
20
15
10
5
0
2
4
6
8
COPEhumour
Mean =3.94
Std. Dev. =1.586
N =111


Frequency
30
25
20
15
10
5
0
2
4
6
8
COPEacceptance
Mean =5.37
Std. Dev. =1.634
N =111


Frequency
60
40
20
0
2
4
6
8
COPEreligion
Mean =3.23
Std. Dev. =1.725
N =111

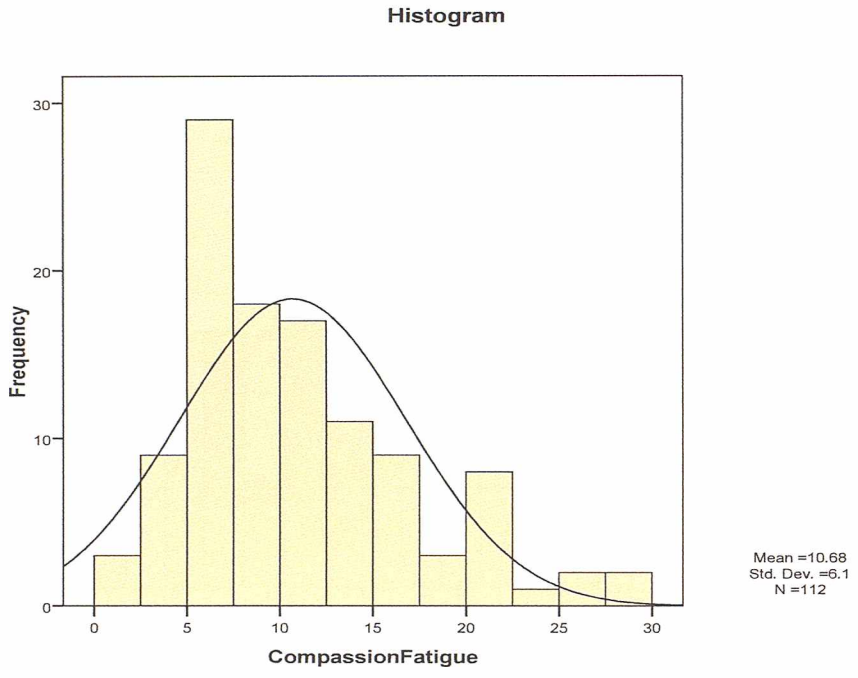

Frequency
40
30
20
10
0
2
4
6
8
COPEselfblame
Mean =3.55
Std. Dev. =1.5
N =111

Kurtosis and Skewness statistics after having removed some outliers and an extreme score

		Substance use	Behavioural disengagement	Religion	Self blame
N	Valid	111	111	111	111
	Missing	1	1	1	1
Mean		2.67	2.32	3.18	3.54
Median		2.00	2.00	2.00	3.00
Mode		2	2	2	3
Std. Deviation		1.047	.587	1.608	1.476
Variance		1.097	.345	2.585	2.178
Skewness		**1.674**	**1.717**	**1.197**	**1.112**
Std. Error of Skewness		**.229**	**.229**	**.229**	**.229**
Kurtosis		**2.407**	**1.899**	**.313**	**.835**
Std. Error of Kurtosis		**.455**	**.455**	**.455**	**.455**
Range		4	2	6	6

2f) Normal distribution checks for CF

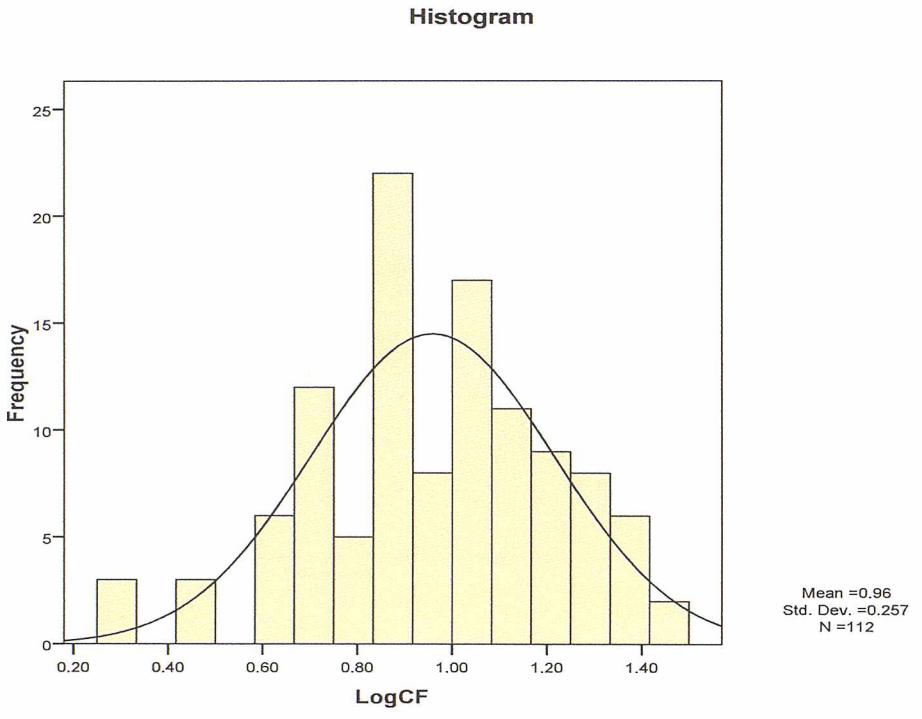
Histogram before transformation



Descriptives for CF before transformation

			Statistic	Std. Error
CompassionFatigue	Mean		10.68	.576
	95% Confidence Interval for Mean	Lower Bound	9.54	
		Upper Bound	11.82	
	5% Trimmed Mean		10.30	
	Median		9.00	
	Variance		37.211	
	Std. Deviation		6.100	
	Minimum		1	
	Maximum		29	
	Range		28	
	Interquartile Range		8	
	Skewness		**.982**	**.228**
	Kurtosis		.514	.453

Histogram of transformed CF



Skew and kurtosis statistics for CF(CF) after transformation

LogCF

N	Valid	112
	Missing	0
Mean		.9582
Std. Deviation		.25677
Variance		.066
Skewness		-.284
Std. Error of Skewness		.228
Kurtosis		-.161
Std. Error of Kurtosis		.453

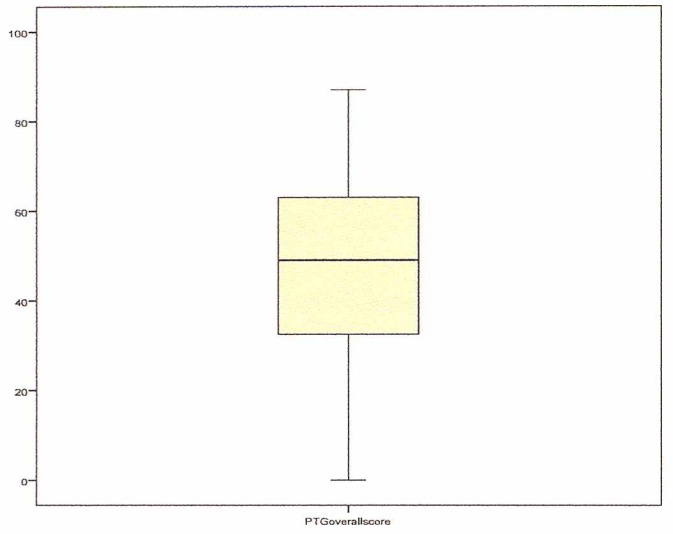
Tests of Normality after transformation

	Kolmogorov-Smirnov(a)			Shapiro-Wilk		
	Statistic	df	Sig.	Statistic	df	Sig.
LogCF	.071	112	**.200(*)**	.981	112	.119

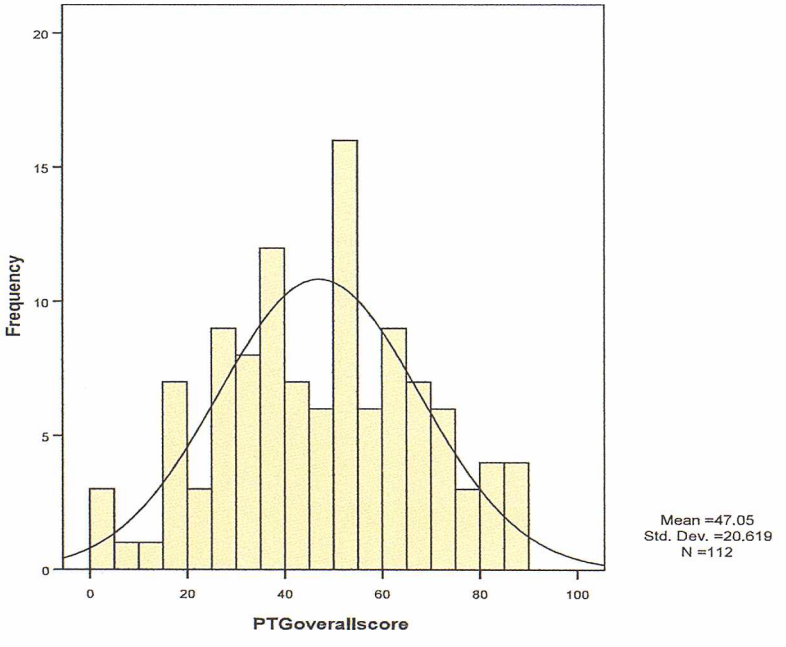
* This is a lower bound of the true significance.
a Lilliefors Significance Correction

2g) Normal distribution, homogeneity of variance and box-plot checks for VPTG

No outliers for VPTG overall



Histogram of VPTG



Skew and Kurtosis statistics for VPTG

			Statistic	Std. Error
PTGoverallscore	Mean		47.17	1.882
	95% Confidence Interval for Mean	Lower Bound	43.44	
		Upper Bound	50.90	
	5% Trimmed Mean		47.25	
	Median		49.00	
	Variance		396.719	
	Std. Deviation		19.918	
	Minimum		0	
	Maximum		87	
	Range		87	
	Interquartile Range		31	
	Skewness		**-.062**	**.228**
	Kurtosis		**-.544**	**.453**

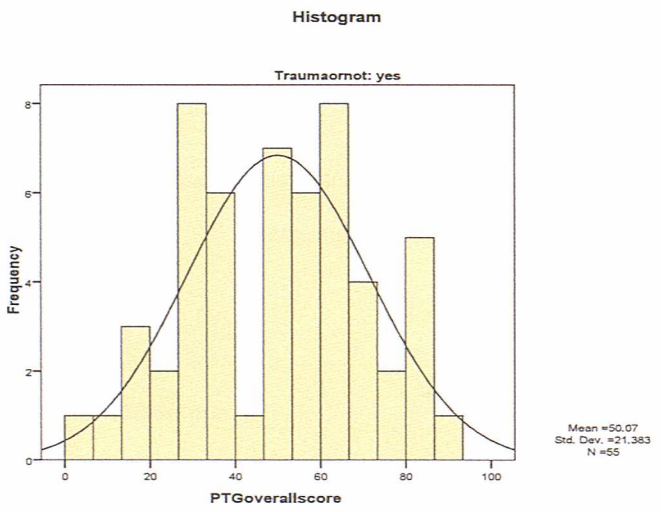
Tests of Normality for VPTG

	Kolmogorov-Smirnov(a)			Shapiro-Wilk		
	Statistic	df	Sig.	Statistic	df	Sig.
PTGoverallscore	.061	112	**.200(*)**	.988	112	.403

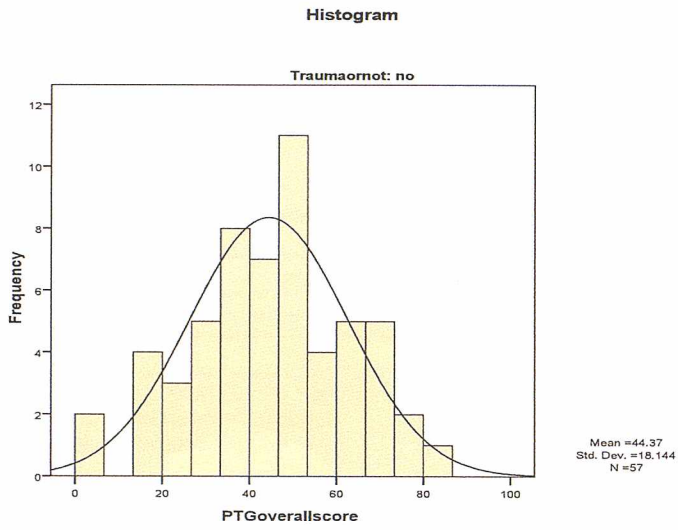
* This is a lower bound of the true significance.
a Lilliefors Significance Correction

Normality checks for split files

Histogram of VPTG split file; trauma group



Histogram of VPTG split file; no trauma group



Skew and Kurtosis Statistics for no trauma group VPTG

PTGoverallscore

N	Valid	57
	Missing	0
Mean		44.37
Std. Deviation		18.144
Variance		329.201
Skewness		-.207
Std. Error of Skewness		.316
Kurtosis		-.154
Std. Error of Kurtosis		.623

a Traumaornot = no

Skew and Kurtosis Statistics for trauma group VPTG

PTGoverallscore

N	Valid	55
	Missing	0
Mean		50.07
Std. Deviation		21.383
Variance		457.217
Skewness		-.093
Std. Error of Skewness		.322
Kurtosis		-.871
Std. Error of Kurtosis		.634

a Traumaornot = yes

Trauma Group Tests of Normality: Significant

	Kolmogorov-Smirnov(a)			Shapiro-Wilk		
	Statistic	df	Sig.	Statistic	df	Sig.
PTGoverallscore	.099	55	**.200(*)**	.970	55	.192

* This is a lower bound of the true significance.
a Lilliefors Significance Correction
b Traumaornot = yes

No trauma group Tests of Normality: Significant

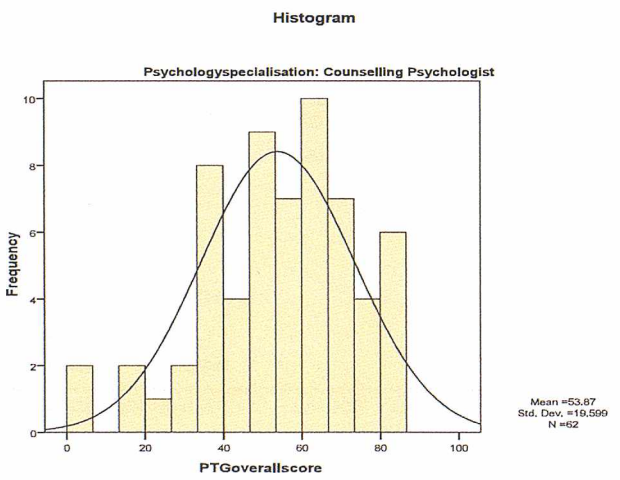
	Kolmogorov-Smirnov(a)			Shapiro-Wilk		
	Statistic	df	Sig.	Statistic	df	Sig.
PTGoverallscore	.049	57	**.200(*)**	.989	57	.875

* This is a lower bound of the true significance.
a Lilliefors Significance Correction
b Traumaornot = no

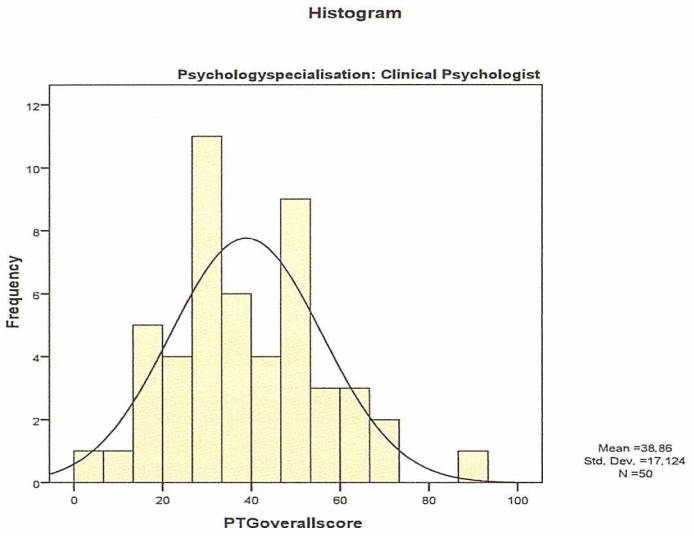
Test of Homogeneity of Variance trauma vs no trauma

		Levene Statistic	df1	df2	Sig.
PTGoverallscore	Based on Mean	2.650	1	110	**.106**
	Based on Median	2.423	1	110	.122
	Based on Median and with adjusted df	2.423	1	109.341	.122
	Based on trimmed mean	2.615	1	110	.109

Histogram of slit file for VPTG; Counselling Psychologists



Histogram of split file for VPTG: Clinical Psychologists



Skew and kurtosis statistics for VPTG for counseling psychologists

PTGoverallscore

N	Valid	62
	Missing	0
Mean		53.87
Variance		384.114
Skewness		**-.566**
Std. Error of Skewness		**.304**
Kurtosis		**.092**
Std. Error of Kurtosis		**.599**

a Psychologyspecialisation = Counselling Psychologist

Skew and kurtosis statistics for VPTG for Clinical psychologists

PTGoverallscore

N	Valid	50
	Missing	0
Mean		38.86
Variance		293.225
Skewness		**.402**
Std. Error of Skewness		**.337**
Kurtosis		**.245**
Std. Error of Kurtosis		**.662**

a Psychologyspecialisation = Clinical Psychologist

Split File Tests of Normality for VPTG in Counselling Psychologists

	Kolmogorov-Smirnov(a)			Shapiro-Wilk		
	Statistic	df	Sig.	Statistic	df	Sig.
PTGoverallscore	.087	62	**.200(*)**	.969	62	.121

* This is a lower bound of the true significance.
a Lilliefors Significance Correction
b Psychologyspecialisation = Counselling Psychologist

Split file Tests of Normality for VPTG in Clinical Psychologists

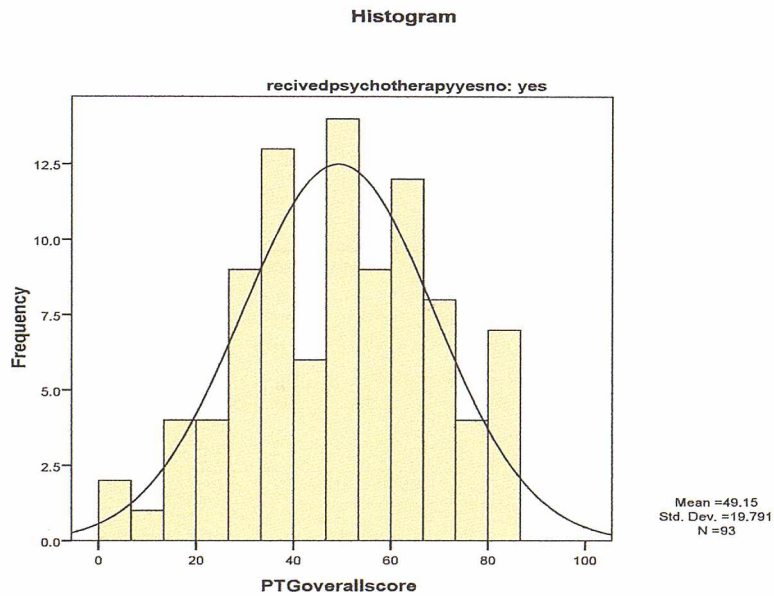
	Kolmogorov-Smirnov(a)			Shapiro-Wilk		
	Statistic	df	Sig.	Statistic	df	Sig.
PTGoverallscore	.089	50	**.200(*)**	.982	50	.637

* This is a lower bound of the true significance.
a Lilliefors Significance Correction
b Psychologyspecialisation = Clinical Psychologist

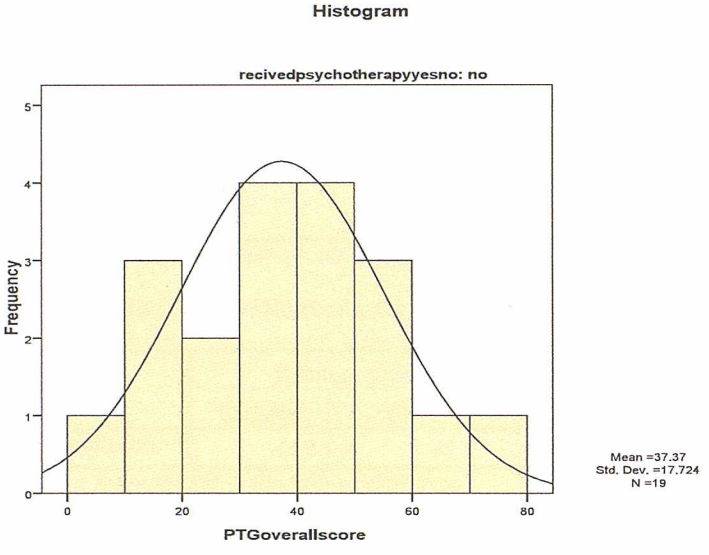
Test of Homogeneity of Variance for psychology specialisation

		Levene Statistic	df1	df2	Sig.
PTGoverallscore	Based on Mean	.753	1	110	**.387**
	Based on Median	.748	1	110	.389
	Based on Median and with adjusted df	.748	1	107.815	.389
	Based on trimmed mean	.749	1	110	.389

Histogram of split file for VPTG: have received own therapy



Histogram of split file for VPTG: have not received own therapy



Skew and kurtosis statistics for VPTG for psychologists who have received therapy

PTGoverallscore

N	Valid	93
	Missing	0
Mean		49.15
Std. Deviation		19.791
Variance		391.694
Skewness		**-.121**
Std. Error of Skewness		**.250**
Kurtosis		**-.592**
Std. Error of Kurtosis		**.495**

a recivedpsychotherapyyesno = yes

Skew and kurtosis statistics for VPTG for psychologists who have not received therapy

PTGoverallscore

N	Valid	19
	Missing	0
Mean		37.37
Std. Deviation		17.724
Variance		314.135
Skewness		**-.103**
Std. Error of Skewness		**.524**
Kurtosis		**-.117**
Std. Error of Kurtosis		**1.014**

a recivedpsychotherapyyesno = no

Split file Tests of Normality for VPTG in psychologists who have received therapy

	Kolmogorov-Smirnov(a)			Shapiro-Wilk		
	Statistic	df	Sig.	Statistic	df	Sig.
PTGoverallscore	.068	93	**.200(*)**	.985	93	.342

* This is a lower bound of the true significance.
a Lilliefors Significance Correction
b recivedpsychotherapyyesno = yes

Split file Tests of Normality for VPTG in psychologists who have not received therapy

	Kolmogorov-Smirnov(a)			Shapiro-Wilk		
	Statistic	df	Sig.	Statistic	df	Sig.
PTGoverallscore	.093	19	.200(*)	.988	19	.994

* This is a lower bound of the true significance.
a Lilliefors Significance Correction
b recivedpsychotherapyyesno = no

Test of Homogeneity of Variance for received psychotherapy or not

		Levene Statistic	df1	df2	Sig.
PTGoverallscore	Based on Mean	.594	1	110	**.442**
	Based on Median	.552	1	110	.459
	Based on Median and with adjusted df	.552	1	109.437	.459
	Based on trimmed mean	.587	1	110	.445

Appendix 3: SPPS outputs for inferential statistics

Appendix 3a: Multiple regression assumption checks for the prediction of CF.

No large correlations between the predictors (i.e., no multicollinearity)

		Compassion Fatigue	Current emotional wound	SOC	Self distract	Self blame	Behavioural disengagement	Family Support	Substance use	Active coping
Pearson Correlation	Compassion Fatigue	1.000	.430	-.528	.397	.388	.353	-.239	.242	-.187
	Current emotional wound all	.430	1.000	-.297	.186	.263	.255	-.146	.279	-.128
	SOC	-.528	-.297	1.000	-.292	-.485	-.326	.348	-.238	.178
	Self distract	.397	.186	-.292	1.000	.376	.109	-.108	.122	.138
	Self blame	.388	.263	-.485	.376	1.000	.120	-.197	.307	.020
	Behavioural disengagement	.353	.255	-.326	.109	.120	1.000	-.083	.041	-.196
	Family Support	-.239	-.146	.348	-.108	-.197	-.083	1.000	-.252	.214
	Substance use	.242	.279	-.238	.122	.307	.041	-.252	1.000	-.156
	Active coping	-.187	-.128	.178	.138	.020	-.196	.214	-.156	1.000
Sig. (1-tailed)	Compassion Fatigue	.	.000	.000	.000	.000	.000	.006	.005	.025

Durbin-Watson is close to 2, suggesting that residual terms do not correlate with each other.

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	**Durbin-Watson**
1	.671(a)	.450	.406	.19762	**1.989**

a Predictors: (Constant), COPEactivecoping, COPEselfblame, COPEbehaviouraldisengagement, FamilySupport, Current emotional wound all, COPEselfdistract, COPEsubstanceuse, SOCoverall
b Dependent Variable: CompassionFatigueTransformed

Collinearity Diagnostics

Model	Dimension	Eigenvalue	Condition Index	Variance Proportions								
		(Constant)	Current emotional wound all	SOCoverall	COPEselfdistract	COPEselfblame	COPEbehaviouraldisengagement	FamilySupport	COPEsubstanceuse	COPEactivecoping	(Constant)	Current emotional wound all
1	1	8.463	1.000	.00	.00	.00	.00	.00	.00	.00	.00	.00
	2	.179	6.867	.00	.00	.01	.02	.18	.00	.03	.13	.03
	3	.115	8.574	.00	.00	.00	.21	.12	.00	.00	.47	.03
	4	.077	10.510	.00	.02	.00	.00	.00	.37	.00	.14	.21
	5	.071	10.880	.00	.00	.00	**.67**	**.50**	.00	.01	.07	.01
	6	.040	14.549	.00	.00	.01	.06	.03	.22	.29	.01	**.63**
	7	.029	16.968	.00	**.64**	.01	.01	.01	.24	.18	.15	.00
	8	.021	20.190	.02	.23	.27	.00	.05	.00	**.47**	.02	.08
	9	.004	46.631	**.97**	.11	.69	.02	.11	.17	.01	.02	.01

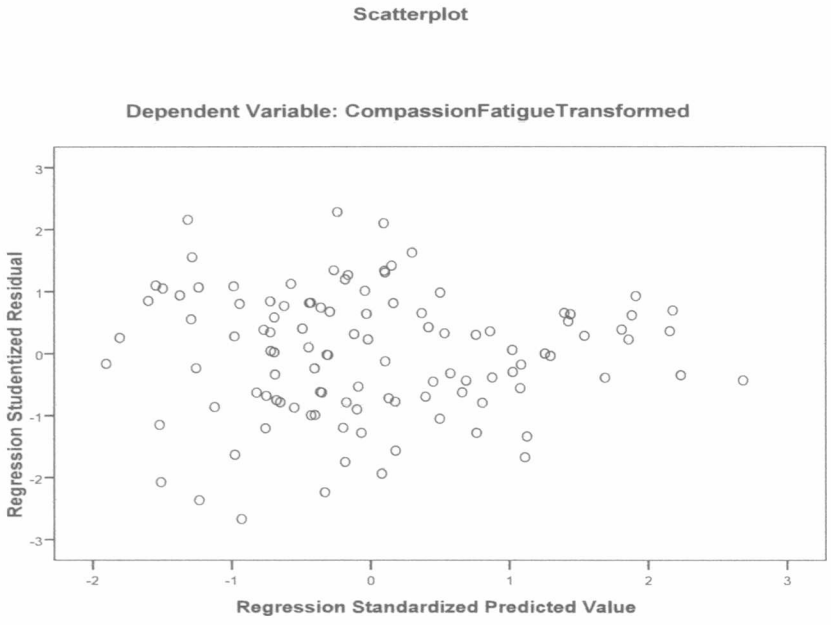
a Dependent Variable: CompassionFatigueTransformed

Residual outliers

Case Number	Std. Residual	CompassionFatigueTransformed	Predicted Value	Residual
30	2.124	1.15	.7265	.41967
37	-2.011	.30	.6985	-.39749
39	-2.315	.30	.7575	-.45749
50	2.036	1.38	.9779	.40234
51	-2.514	.30	.7978	-.49680
66	-2.129	.48	.8979	-.42078
91	2.134	1.34	.9207	.42175

a Dependent Variable: CompassionFatigueTransformed

Test for linearity and homoscedasticity



Appendix 3b: Multiple regression assumption checks for the prediction of VPTG.

A Durbin-Watson score close to 2, indicating residual terms do not correlate with each other.

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Durbin-Watson
1	.549(a)	.302	.247	17.328	**2.098**

a Predictors: (Constant), yes vs no, COPEacceptance, CompassionFatigueTransformed, COPEreligion, COPEpositiveReframing, COPEselfdistract, counselling vs clnical psychologists, COPEplanning
b Dependent Variable: PTGoverallscore

No colliearity

Model		Collinearity Statistics	
		Tolerance	VIF
1			
	Compassion Fatigue	.775	1.290
	Self distract	.777	1.287
	Positive Reframing	.714	1.401
	Planning	.626	1.597
	Acceptance	.704	1.421
	Religion	.880	1.137
	counselling vs clnical psychologist	.631	1.585
	yes vs no own therapy	.725	1.380

a Dependent Variable: PTGoverallscore

No multicollinearity, with most predictors most highly loaded on different dimension, except for positive re-framing and acceptance.

Model	Dimension	Variance Proportions							
		CF	Self distract	Positive Reframing C	planning	acceptance	religion	counselling vs clnical psychologists	Received therapy
1	1	.00	.00	.00	.00	.00	.00	.00	.00
	2	.00	.00	.00	.00	.00	.01	.09	.38
	3	.00	.00	.00	.00	.00	.01	.55	**.49**
	4	.00	.00	.03	.02	.01	**.83**	.01	.00
	5	.07	**.49**	.04	.04	.06	.05	.03	.02
	6	.06	.07	**.50**	.00	**.45**	.00	.01	.00
	7	**.56**	.43	.16	.01	.01	.04	.10	.10
	8	.01	.00	.27	**.54**	.45	.01	.02	.00
	9	.29	.00	.00	.39	.01	.06	.17	.00

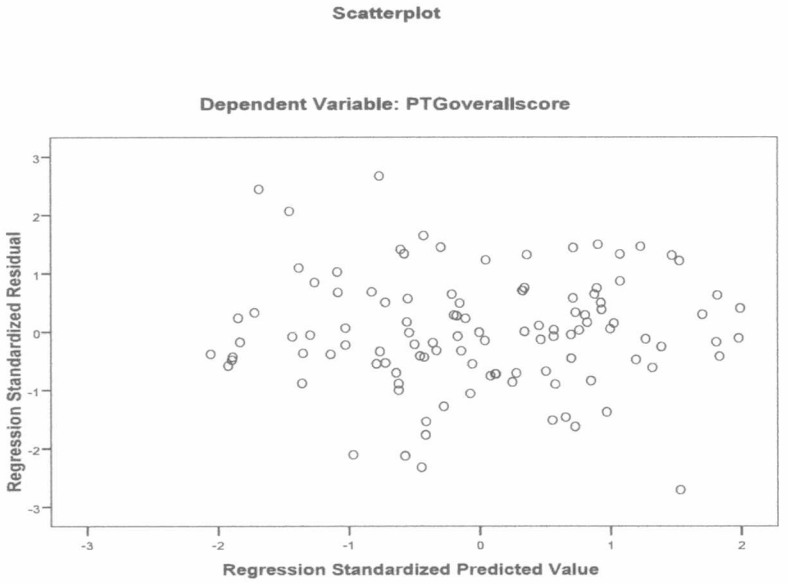
a Dependent Variable: PTGoverallscore

7 outliers among the residuals, with 2 of them exceeding 2.5. Ok for sample of 111.

Case Number	Std. Residual	VPTG	Predicted Value	Residual
1	-2.126	4	40.84	-36.839
18	-2.105	0	36.48	-36.482
22	-2.321	2	42.21	-40.211
38	2.069	67	31.16	35.845
48	2.672	85	38.70	46.303
54	-2.708	17	63.92	-46.919
75	2.447	71	28.61	42.392

a Dependent Variable: PTGoverallscore

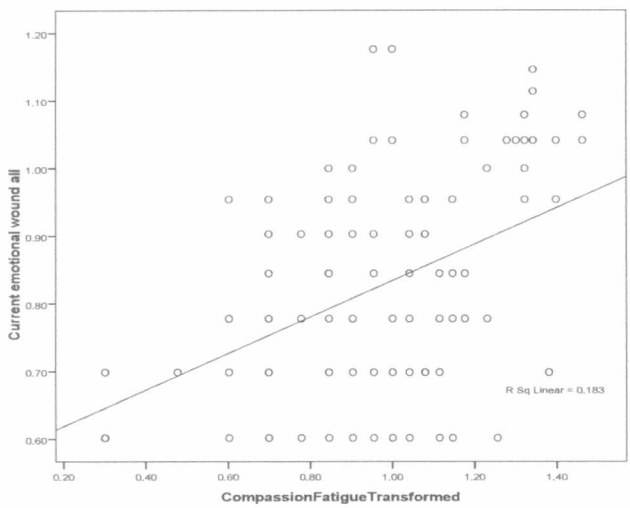
Scatter-plot showing both linearity and homoscedasticity



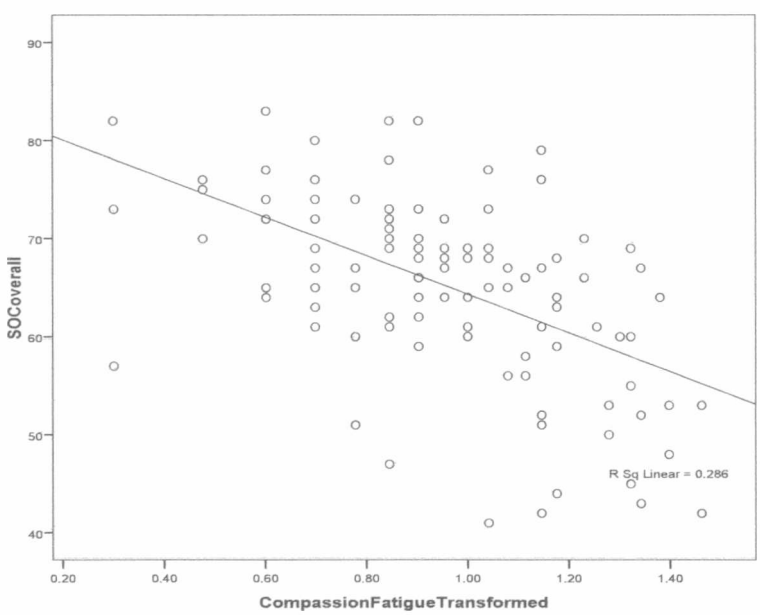
Appendix 4: Scatterplots

4a) Scatter plots showing associations between STS and vulnerability factors

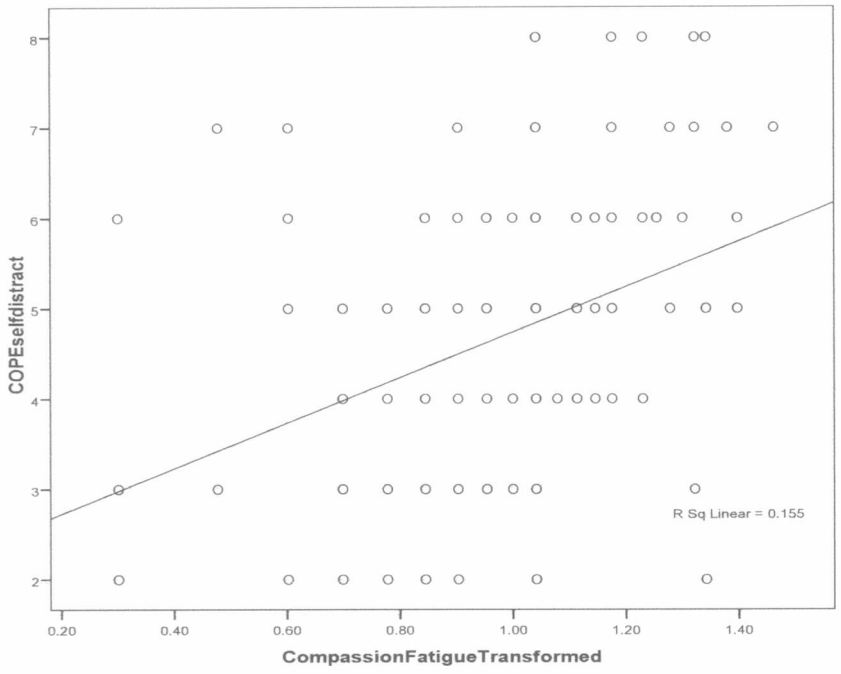
A positive association between current emotional woundendess and CF



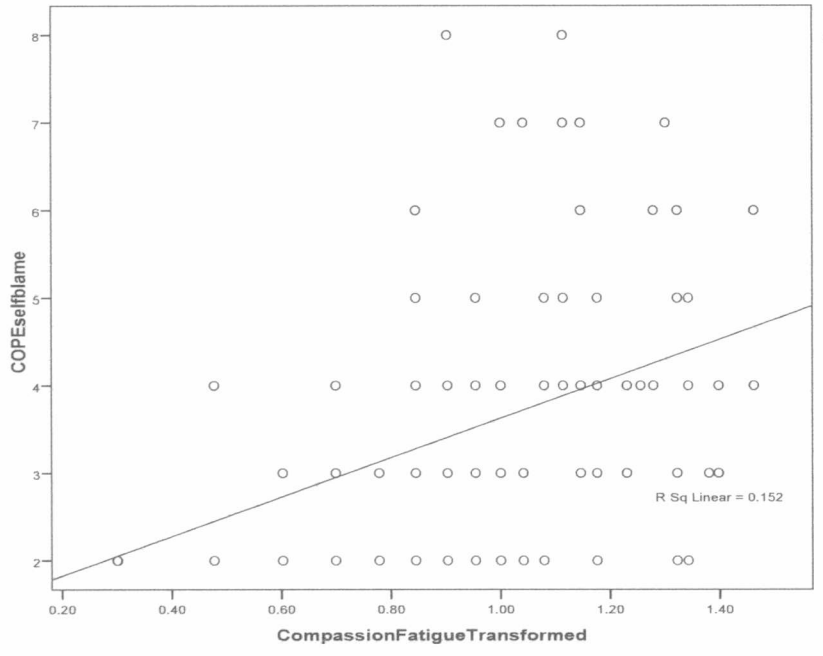
A negative association between CF and Sense of Coherence



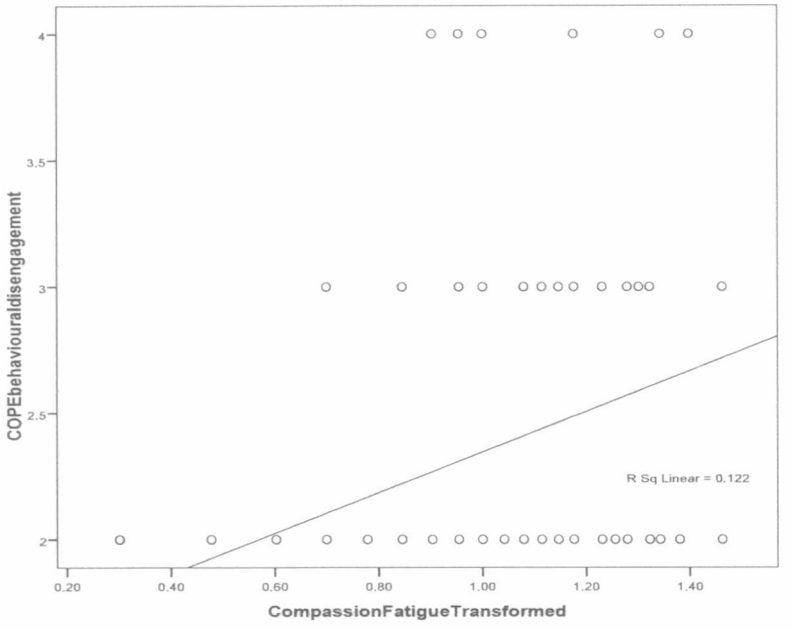
A positive association between self distraction and CF



A positive association between self-blame and CF

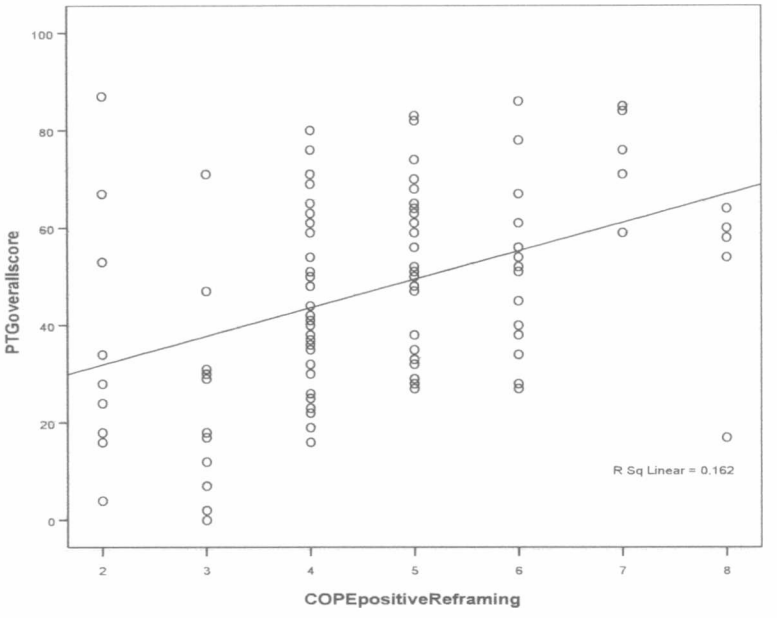


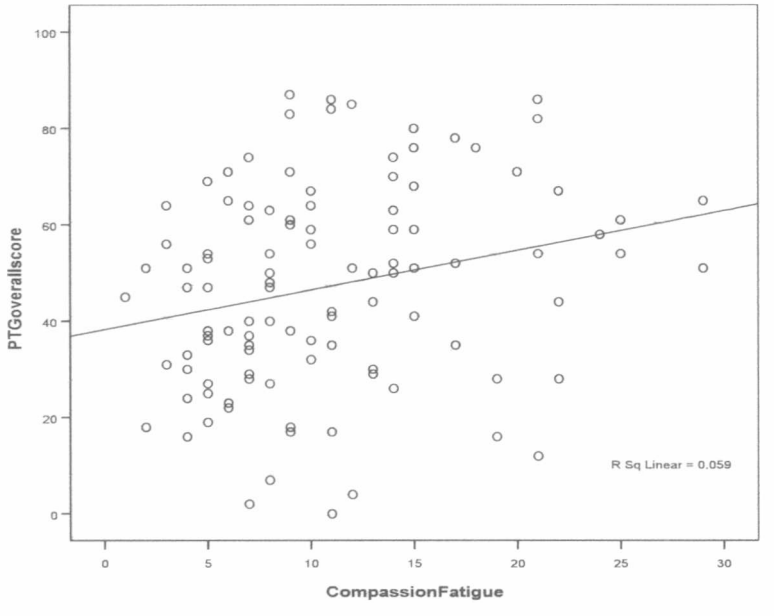
A positive association between behavioural disengagement and CF



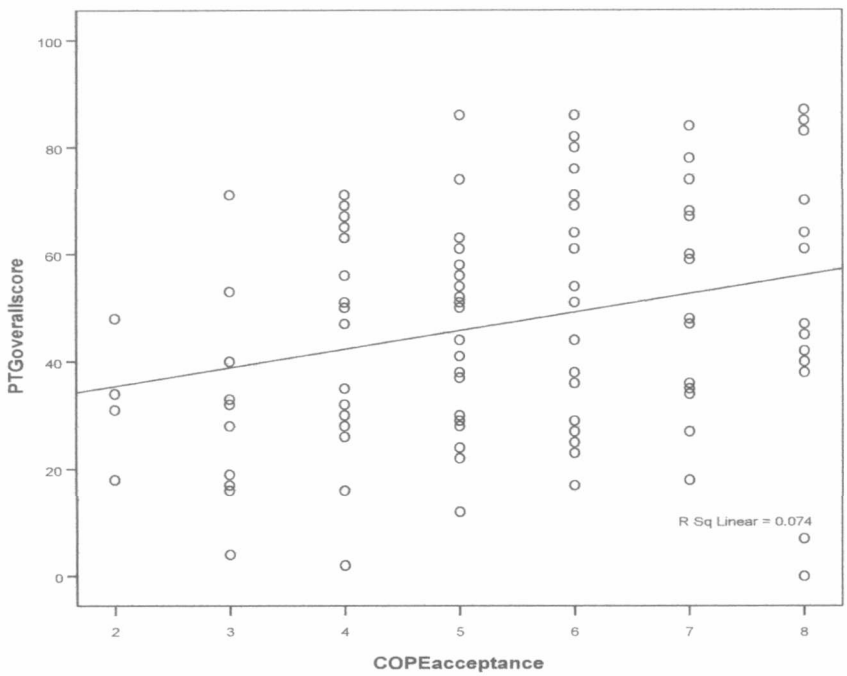
Appendix 4b: Scatter plots showing associations between VPTG and positive reframing, CF and acceptance.

A positive association between positive reframing and VPTG





A positive association between VPTG and CF



A positive association between acceptance and VPTG