Vicarious Posttraumatic Growth in the Trauma Therapist: Do organizational factors impact differently on therapists working in private practice compared to therapists employed in clinic/institutional workplaces?

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I declare that this is my own work and that, to the best of my knowledge and belief, it does not contain material from published sources without proper acknowledgement, nor does it contain material which has been accepted for the award of any other higher degree or graduate diploma in any university.

Lydia Francoise Black

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Literature Review

A Discussion of the impact of trauma therapy on the therapist and the personal and organizational variables which may facilitate vicarious posttraumatic growth in the trauma therapist.

Abstract

Following a traumatic event many people experience on-going negative symptoms; in contrast some who survive trauma become stronger or grow from the experience in some way (Tedeschi & Calhoun, 1995, 1996; Linley & Joseph, 2002). In addition to those who experience an event directly, there are those who experience the event indirectly or vicariously (Figley, 1995; Kassam-Adams, 1995; McCann & Pearlman, 1990; Pearlman & Maclan, 1995). Professionals likely to experience a traumatic event vicariously include emergency response workers and police officers. These professionals attend a traumatic event and witness the atrocities occurring; however there may also be a therapist, social worker or a psychologist who hears about the event, days, weeks or even years down the track and who is potentially exposed to similar experiences many times during their career. It is those who have been vicariously exposed to the traumatic experience of others that this literature review is interested in. In particular, it focuses on the consequences for therapists who are vicariously exposed to trauma only via their clients retelling of the event, and the schema transformations they may encounter. A recent shift to positive psychology approaches in research and the therapeutic setting has created a focus on the salutary outcomes of trauma on primary victims, therefore vicarious trauma and/or compassion fatigue in the trauma therapist is reviewed and the occurrence of posttraumatic growth following primary and secondary exposure to trauma is also examined. Of particular interest are the personal and organizational variables which may assist in facilitating vicarious posttraumatic growth for the trauma therapist. In order to accommodate the diverse occupational contexts in which therapists work, this review draws a distinction between and compares the experiences of those who work in a clinic or institutional employment with those who work in private practice.

Much has been written about in the past in regard to the intricacies of the therapeutic relationship during trauma therapy, and the process of therapeutic engagement, transference, and countertransference between the therapists and the survivor client (see, Herman 1992, Pearlman & Saakvitne 1995, Wilson & Lindy 1994). However a focus of one area of the literature is the effect of that therapeutic relationship on the mental health of the treating therapist. As Herman (1992) noted, "Trauma is contagious" (p.140) and research has shown that due to repeated exposure to their clients narrative of the traumatic experience the therapist may be at risk of developing similar symptoms to that of their client, similar symptoms to Post Traumatic Stress Disorder (Kassam-Adams, 1995; McCann & Pearlman, 1990; Pearlman & Maclan, 1995; Schauben & Frazier, 1995). Pearlman and McCann (1990) developed the concept of Vicarious Traumatization to describe this transference process and Charles Figley (1995), coined the term Secondary Traumatic Stress or Compassion Fatigue.

Vicarious Trauma, Compassion Fatigue and Secondary Traumatic Stress

Vicarious Trauma was defined by Pearlman and Maclan (1995), as "the transformation that occurs within the therapist (or other trauma worker) as a result of empathic engagement with the clients' trauma experiences and their sequelae" (p 558). Without intent to cause harm, the trauma-surviving client retells their disturbing experiences and the therapist is exposed to accounts of the shocking events.

Vicarious Trauma is a constructivist model in which the therapist begins to interpret and relate to the world in a new manner as their inner experience is altered by exposure to the trauma work (Pearlman & McCann, 1995). McCann and Pearlman (1990) describe that trauma counselors may experience symptoms similar to Post Traumatic Stress Disorder. These

symptoms can include intrusive thoughts as well as emotional reactions such as anxiety and anger. McCann and Pearlman suggested that these disturbances can affect all aspects of a counselor's life and that they may well be permanent. Pearlman and Mac Ian (1995) point out certain personal factors such as personal trauma history, psychological style, interpersonal style, professional development and stressors or supports in the therapist's life that may increase or protect against, the degree of vicarious traumatization experienced. They also discuss various workplace or organizational correlates which when combined with those personal vulnerabilities may contribute to vicarious trauma, including, client behavior and type of trauma experienced, the work setting and social-cultural context. However these organizational factors have not been measured specifically. The importance of so doing derives from the fact that organizational factors have a long history of being recognized as stressors, and are likely to act in ways that are independent of any stress associated with the therapeutic relationship.

Along similar lines, Charles Figley defines Secondary Traumatic Stress as "the natural consequent behaviors and emotions resulting from knowing about a traumatizing event experienced by a significant other-the stress resulting from helping or wanting to help a traumatized or suffering person" (Figley, 1993 as cited in Figley, 1995 p.7). Figley also uses the term compassion fatigue to describe the same phenomenon and explains that "*the terms compassion stress and compassion fatigue are favored by nurses, emergency workers and other professionals who experience STS, and STSD (Secondary Stress Disorder) in the line of duty. Therefore the terms can be used interchangeably by those who are uncomfortable with STS or STSD (p.15)*

The theory of Compassion Fatigue also portrays the impact of trauma therapy as comparable to Post Traumatic Stress Disorder. Therefore, Compassion Fatigue is described as

symptomatology of (1) intrusions (e.g. flashbacks, recollections, and dreams), (2) avoidance (e.g. avoiding thoughts/feeling, avoiding activities, detachment from others, and diminished affect) and (3) hyperarousal (e.g. difficulty staying/falling asleep, hypervigilance, and irritability) (Bicknell, 2004). Compassion Fatigue also includes burnout symptoms (Gentry, Baranowsky & Dunning, 2002). As the level of stress increases in the lives of caregivers, such as the hassles that occur in daily working life, their resilience to additional stressors diminishes and they are then more susceptible to Compassion Fatigue (Gentry, Baranowsky & Dunning, 2002). Regardless of different descriptions, Compassion Fatigue , Secondary Traumatic Stress and Vicarious Traumatization can be viewed as reactions to the emotional demands on therapists and social network members from exposure to trauma survivors' shocking images; fierce, chaotic affect; and disturbing traumatic memories (Figley, 1995; Pearlman, 1995; Sexton, 1999).

Posttraumatic Growth Following Trauma

Despite the historical focus on negative reactions to trauma and trauma work, this may not be the only emotional response that can follow direct or indirect exposure to a traumatic event. Although positive consequences of trauma have been documented in philosophical and religious writings throughout history (Tedeschi & Calhoun, 1995), it is only relatively recently that a branch of psychotraumatology research has shifted from the deficit-based models, which focus on the negative symptomatology presented by clients, to one where the positive aspects of the human experience in times of trauma, are being studied (Bicknell, 2004; Linley & Joseph, 2007).

"The survivor who has accomplished her recovery faces life with few illusions but often with gratitude. Her view of life may be tragic, but for that very reason she has learned to cherish

laughter. She has a clear sense of what is important and what is not. Having encountered evil, she knows how to cling to what is good. Having encountered the fear of death she knows how to cling to life" (Herman, 1992 p. 213). Tedeschi and Calhoun (1996) used the term posttraumatic growth to describe the positive outcomes of survivors in times of trauma. However, Raphael, Singh, Bradbury, and Lambert (1983-1984), conducted one of the earliest studies in this area, and they reported that in a sample of rescue workers who helped with the recovery of a train disaster while only 20 percent showed on-going symptoms of depression, anxiety and insomnia, 35 percent felt more positive about their own lives as a result of their involvement in the recovery. In fact, according to Linley and Joseph (2002), between 30 and 90 percent of survivors report a number of positive changes following trauma. For example, positive changes have been reported by husbands of women with breast cancer (Weiss, 2002), in parents of murdered children (Parappully, Rosenbaum, Van Den Daele, & Nzewi, 2002), in road trauma survivors (Harms & Talbot, 2007), in children following exposure to natural disaster (Cryder, Kilmer, Tedeschi, & Calhoun 2006), and in survivors of chronic illness, sexual assault, war, injury, drug addiction and in the parents of children with disabilities (Linley & Joseph, 2004).

A range of positive reactions has been reported in previous research literature by those who experience and survive trauma. For example, when investigating the experiences of parents of murdered children Parappully et al. (2002), found that many parents were able to talk about some positive outcomes resulting from their trauma, and reported examples of transformation occurring for them personally and also for their communities or society as a whole. The survivor parents reported that they were able to make a difference in their communities by working with other victims or offenders, helping to solve similar crimes and to avoid further loss of lives. In their personal lives many parents were also able to identify positive transformations, for example

they felt stronger, and more self confident after surviving the murder of their son or daughter and they also reported that the tragedy had brought out positive characteristics they did not know they possessed (Parappully et al. 2002). In a study by Weiss (2002), women who had survived breast cancer and their husbands were asked open-ended question about their experiences. Ninety eight percent reported significant positive changes in their lives following their illness, and 88 percent of their husbands reported positive long lasting changes in their lives after the experience. Participants in Weiss's study reported positive changes such as, improved tolerance, and greater appreciation for "*the little things in life*", greater compassion and understanding of people, and having stronger religious beliefs following the experience (Weiss, 2002). A recent example of survivors finding new strength following severe adversity has been written about by Osofsky (2008), following Hurricane Katrina in New Orleans. Osofsky described that although she and others had witnessed much trauma and suffering, she and her colleagues had found strength they didn't know they possessed, and as a result also found they had a new found respect for colleagues who had also lived and worked through the event.

These papers support the notion suggested by Folkman and Moskowitz (2000), who claimed that positive affect can occur at the same time as suffering. They maintain that positive affect performs a valuable adaptive function and that "meaning based coping processes" are important in encouraging and sustaining positive affect at the times of trauma. It is important to note here therefore, the fact that people can find positives from a traumatic experience, does not rule out the event being upsetting or traumatizing, but does recognize that the traumatic experience can be a mechanism for positive change (Moran & Shakespeare-Finch, 2003).

Many positive changes have been reported in extant literature, however, there are three outstanding themes which appear repetitively; (1) Survivors often report that they have a new

found appreciation for their relationship with others; they value their relationships more and feel an "increased altruism" toward friends and family. (2) They also report that they have a new perspective of themselves; they may feel stronger and more resilient for surviving the trauma, and (3) people report feeling a changed philosophy of life; finding a better appreciation of their lives and reevaluating what is important to them (Tedeschi & Calhoun, 1995, 1996; Linley & Joseph, 2002). According to Fredrickson (2003), a ground breaking researcher in the area of positive psychology, "positive emotions help people to survive and thrive" (p171). Further support for this notion comes from Fredrickson, Tugade, Waugh and Larkin's (2003) research conducted following the September 11, 2001 New York, terrorist attacks to investigate the effects of positive emotions which have been observed to exist alongside negative reactions to traumatic events. Fredrickson and colleagues concluded from their findings that positive emotions in the aftermath of crises safeguard resilient people against depression, stimulate recovery, and encourage post crisis growth. Fredrickson (2003) has also looked into the effects of positive emotions in organizational settings and discusses previous organizational field work by George (1991) which illustrated that salespeople who experienced more positive emotions at work were more helpful to their customers. Fredrickson then goes on to describe the contagious nature of positive emotions and the rewarding outcome this may have on the helper as well as the person being helped. Calhoun and Tedeschi (1998), describe a conceptual model for recognizing the mechanisms of posttraumatic growth and the contributing factors. The cognitive model proposes that after a "seismic" traumatic event, which shakes survivors' core beliefs and basic assumptions about their world, they experience severe distress as they come to the realization that their previous beliefs and goals are ill fitting since the trauma. By mentally revisiting the trauma they engage in "constructive rumination" and may rely on social support to help realign

their goals for the future and to formulate new perspectives, about themselves, their world, and those around them. This change to a positive perspective is more likely to occur in a supportive environment that is open to hearing about the life changing event, and overtly addresses and promotes posttraumatic growth (Tedeschi & Calhoun, 2004).

Tedeschi and Calhoun (2004) describe how a trauma therapist can play a crucial part in the process of change and how they can help facilitate posttraumatic growth; "the therapy relationship can be a vehicle to promoting growth and noticing and enhancing personal strength at a time of vulnerability" (p. 405). They stress the importance of listening to the language of crisis and psychological response that the client's use, and joining them in this form of communication. They also note that it is important for a clinician to respect and work within the existential framework that clients have developed. They stress the importance of listening without trying to solve, listening for and labeling posttraumatic growth at the appropriate time during therapy, as well as focusing on the struggle with the idea of growing after a tragic event. Tedeschi and Calhoun also recommend exposing the client to others who have grown from their experience with trauma, and discuss the need to gently push the client toward noticing aspects of growth from their struggles through narrative assignments, which allow the client to reflect and allow the clinician the opportunity to highlight emerging growth perspectives (p 415).

Posttraumatic growth is multidimensional (Tedeschi & Calhoun, 1996; Calhoun & Tedeschi, 1998), and a person may experience growth in one area of their lives but not in another (Calhoun & Tedeschi, 1998). For example a survivor may experience heightened spirituality since surviving a near death encounter, however, they may not feel that their perspectives of themselves or relationship with others has been altered by the experience. In order to quantify the areas of growth that a survivor may experience, The Posttraumatic Growth Inventory was

developed by Tedeschi and Calhoun (1996), and measures five factors (1) relating to others; (2) new possibilities; (3) personal strength; (4) spiritual change and; (5) appreciation of life. From the development of the scale the authors concluded that those who have experienced a traumatic event report more positive outcomes than those who have not, and that women report more benefits than men. They also found that the scale is useful "in determining how successful individuals, coping with the aftermath of trauma, are in reconstructing or strengthening their perceptions of self, others, and the meaning of events" (p. 455).

Vicarious Posttraumatic Growth

Just as it is possible for those who suffer trauma first-hand to experience adversarial growth, it is also thought that those who are affected vicariously may experience some form of growth or positive symptomatology. Linley, Joseph, Cooper, Harris and Meyer (2003), investigated this phenomenon in a sample of people living in Britain who, by watching television, had been vicariously exposed to the New York terrorist attacks of September 11, 2001. Using the Posttraumatic Growth Inventory, the Changes in Outlook Questionnaire (CiOQ), as well as Perceptions of September 11 Scale, and a Television Viewing Questionnaire, they reported that negative and positive symptoms may coexist in those vicariously affected by trauma. The researchers also concluded from this study that people, who have the same ideals, or worldviews as those who have been directly traumatized, are more likely to experience vicarious posttraumatic growth, than those who do not.

In an attempt to further the line of inquiry regarding the effects of vicarious exposure to trauma, particularly for caregivers, such as nurses, doctors, and therapists, Stamm (2002) incorporated a positive slant to his investigation into Compassion Fatigue, using the

ProQOL/Compassion Fatigue and Satisfaction Test. Stamm extended the original Compassion Fatigue assessment in order to investigate the potential benefits of looking after those who have been traumatized, and developed the Compassion Satisfaction scale. Yet, despite the development of this scale, to date, few studies have investigated specifically the positive repercussions for therapists working with trauma survivors. However, in early literature several authors (e.g., Herman, 1992; Pearlman & Saakvitne, 1995) wrote about the positive effects or transformation that a therapist might experience as part of the therapeutic process. For example in 1995, Pearlman wrote "Those who voluntarily engage empathically with survivors to help resolve aftermath of psychological trauma open themselves to a deep personal transformation. This transformation includes personal growth, a deeper connection with both individuals and the human experience, and a greater awareness of all aspects of life" (p. 51). In addition, extant studies have provided incidental or anecdotal results in support of this phenomenon (Schauben & Frazier, 1995; Tedeschi & Calhoun, 2004; McCann & Pearlman, 1990; Brady, Guy, Poelstra & Brokaw, 1999). For example, following is an excerpt from Schauben and Frazier's 1995 study, discussing the effects on counselors working with sexual assault victims; "the most enjoyable aspect of this work is the creativity, strength and resilience of survivors who thrive even in the face of enormous pain...counselors greatly enjoy seeing clients grow and change" (p.62).

There is a growing awareness and interest into the potential positive outcomes a therapist may encounter due to vicarious exposure to trauma (Tedeschi & Calhoun, 2004; Bicknell, 2004; Stamm, Varra, Pearlman, & Giller, 2002), and Arnold, Calhoun, Tedeschi and Cann, (2005) devised the term "Vicarious Posttraumatic Growth" to describe this phenomenon, and conducted a study exploring the perceptions of 21 trauma therapists and the ways in which their work with trauma clients had affected them. The researchers aim was to use a "naturalistic interview style,"

with a specific concentration on potential changes in therapists' "memory systems and schemas about self and the world – the hallmarks of vicarious traumatization" (McCann & Pearlman 1990, Arnold et. al, 2005) and Calhoun and Tedeschi's (1998) "perceived psychological growth." Arnold and colleagues found that while 90 percent of clinicians reported some negative outcomes and symptoms such as; "intrusive thoughts and images of client's", they also reported many benefits of working with survivors of trauma and those positive outcomes were very similar to the aftereffects reported by those who experience trauma first-hand. For example, many therapists reported that they had become more spiritually aware and had increased religious faith from working with survivors, and more than half of the respondents said that they had "gained a heightened awareness of their own relatively good fortune" (p. 251), and some reported that their work with survivors had caused them to become more optimistic about the future. Above all, every one of the 21 therapists interviewed reported some kind of positive response from working with trauma-affected clients, and 90 percent of the sample reported "observing and encouraging clients' posttraumatic growth" as a positive consequence of the work (Arnold et al., 2005).

Linley, Joseph and Loumidis (2005) also investigated the positive vicarious effects of trauma therapy on the therapist, however in order to hone in on the potential personality differences between therapists who may or may not experience vicarious trauma and growth, they focused on the associations of the personality construct "sense of coherence" with both positive and negative changes. The researchers used the Sense of Coherence Scale, which is designed to assess "a person's perception of the world as comprehensible, manageable and meaningful", the Posttraumatic Growth Inventory, and The Changes in Outlook Questionnaire, a measure of positive and negative changes as a result of 'your work as a trauma therapist'. The

researchers found that a greater sense of coherence was associated with more positive changes and fewer negative changes.

More recent work in this area however, has been conducted by Linley and Joseph (2007), who devised a study to explore the positive aspects (personal growth, compassion satisfaction) and negative aspects (compassion fatigue, burnout) of therapists "well-being" in 156 therapists. They collected information using the Crisis Support Scale, which asks questions about practical and emotional support, the Jefferson Scale of Physician Empathy, a measure of therapists' empathy, the Working Alliance Inventory, which measures the positive personal attachments between client and therapist, and the Professional Quality of Life Scale, which assesses compassion satisfaction, compassion fatigue and burnout, The Sense of Coherence Scale, Posttraumatic Growth Inventory, and the Changes in Outlook Questionnaire. Linley and Joseph's findings showed that those therapists, who had engaged in their own therapy in regards to the trauma work, reported more positive changes and less burnout, than those who had not seen a therapist. They also reported that those therapists who had regular professional supervision and those with personal trauma histories also reported more positive changes than those who did not. This may imply that those with a personal experience of trauma (and how it was resolved) may be better equipped to deal with the impact of their client's stories, and perhaps the cumulative impact of personal plus vicarious trauma allows for greater change, and cognitive restructuring in a positive way?Linley and Joseph also found that therapist who had worked longer in the field reported more negative symptoms and more burnout, but those who worked more hours per week with trauma clients reported more personal growth and more positive changes. Perhaps this is due to the fact that those therapists who have worked longer in the field have worked for longer within an organization, and therefore have had longer to deal

with organizational hassles and negative system issues? The authors believed that therapists who are benefiting from their work are more likely to take on heavier caseloads, rather than the heavier caseload causing them positive changes and growth (Linley & Joseph, 2007).

The researchers also investigated four psychological factors drawn from previous literature and found that therapeutic bond (as measured by the Working Alliance Inventory) was the best predictor of positive psychological changes and compassion satisfaction. Sense of coherence (as measured by the Sense of Coherence Scale, SOC-13) was the best predictor of less negative psychological change and compassion fatigue, and sense of coherence and the therapeutic bond were the best predictors of less burnout.

Although previous literature has indicated that vicarious posttraumatic growth may be possible for the treating therapist, there is only a small pool of research to draw from in this area, and it would seem that little attention has been given to the environmental or personal differences that therapists may have to deal with, and which may have an effect on how they interpret their vicarious exposure to trauma. One of the most significant differences between the client who presents with symptoms of trauma, and their trauma therapist is the fact that for the therapist there may be many more extraneous factors for them to deal with whilst managing their vicarious exposure to trauma. For example they may have multiple trauma narratives to listen to in one day or one week, they may have additional personal issues to deal with such as personal experiences of trauma, or family caring responsibilities, and they may have organizational variables to contend with.

The factors identified in previous research which may contribute to the development of vicarious trauma and/or vicarious posttraumatic growth in the trauma therapist, can be divided into two categories; (1) organizational factors, for example, therapists workload and supervision

attitudes and practices, levels of bureaucracy and the hassles and uplifts experienced on a day-to-day basis, and (2) personal factors, such as personality, and personal trauma history (e.g., type, how resolved). Several studies (Bicknell, 2004; Harrison & Westwood, 2009; Linley & Joseph, 2007; Sexton, 1999; Schauben & Frazier, 1995; Steed & Bicknell, 2001) identified that supervision and other organizational factors such as workload management, are important workplace considerations if negative reactions to trauma work are to be avoided. To pursue this issue, it is necessary to identify organizational factors and their potential influence on well-being. These could range from caseload and workload to organizational culture.

Organizational Factors

The therapists' workload or amount of exposure to traumatic material is one organizational variable that has received attention in extant research literature, however results have been conflicting. For example, Brady et al. (1999) found that psychologists who were exposed to more sexual abuse material experienced more symptoms of trauma, and Schauben and Frazier (1995) found that counselors, who had a higher percentage of survivors in their caseload, reported more vicarious trauma, more disrupted beliefs, and symptoms of Post Traumatic Stress Disorder. Yet, Linley and Joseph (2007) found that therapist's who reported a greater number of hours per week spent with clients in therapy, reported more positive psychological changes, and more growth. It would be useful to know in these differing studies how the impact of the trauma was resolved. For example if a therapist was working with the traumatized client and consistently and specifically focused on facilitating posttraumatic growth they may have a different experience than the therapist who took a more deficit based approach to treatment. The therapists personality may also play a part in these results, as mentioned

earlier, these findings may be due to the fact that therapist who enjoy their work and experience more positive outcomes from their work, may be more inclined to take on more clients.

Supervision for the trauma therapist is another important factor which has been written about extensively (see Herman, 1992; Mc Cann & Pearlman, 1990; Pearlman & Saakvitne, 1995: Wilson & Lindy, 1994), and results from recent studies have shown that those therapists who engage in supervision report less negative symptoms and are more likely to benefit from their work (Harrison & Westwood, 2009; Linley & Joseph, 2007). In review of the literature on the organizational correlates of vicarious trauma, Bell, Kulkarni & Dalton (2003) suggest that in order to avoid vicarious trauma, organizations should focus on; (1) organizational culture; for example encouraging a culture that "normalizes the effect of working with trauma survivors", and encourages time out from the work. (2) Diversifying the workload; for example distributing clients in a manner that pays attention to the risk of vicarious trauma, they also suggest "linking clients with adjunctive services... will support not only clients but also decrease the workload for their staff". (3) Consider the work environment; for example, ensuring that staff feel safe when at work, and providing a comfortable space for therapists away from clients. (4) Provide education about vicarious trauma and keep staff up to date on trauma theory. (5) Encourage group support; for example, debriefing sessions, case discussions, or even social events such as staff birthday get-togethers. (6) Ensuring all staff engage in effective supervision, and (7) self Care; for example, encouraging peer support groups, resources for therapy, stress management and physical activities (p. 466). Much of the research into organizational factors affecting therapists has been conducted in regard to vicarious trauma; however when looking beyond the therapy field at other helping professions who may also be exposed to secondary trauma in the workplace, the area of disaster and emergency work, can provide some insight into posttraumatic

growth. Emergency response work, may differ from therapist work in many ways, however they share some commonalities in that both therapists and emergency response workers often deal with the effects of trauma. Research into posttraumatic reactions in disaster and emergency workers has recognized that the way an organization operates significantly impacts on employee's experience of traumatic events (Gist & Woodall, 2000; Paton, Smith, Violanti & Eranen, 2000, Paton 2006). In fact, Paton, Violanti and Smith (2003), stipulate that organizational variables have a significant impact on both traumatic stress symptoms and posttraumatic growth in disaster and emergency workers. In a study of 512 police officers, Paton et al. (2003), found that posttraumatic growth was more likely to occur if those officers reported experiencing positive organizational experiences, as measure by the Police Daily Hassles and Uplifts Scale (Hart, Wearing, & Heady, 1993). The researchers examined how organizational culture, hardiness etc could account for variance in posttraumatic symptoms. Therefore the experience of work (e.g., number of uplifts) facilitates the interpretation of challenging events in ways that increase the likelihood of increased growth. Paton et al. (2003) found that organizational hassles (e.g. lack of consultation, poor communication, red tape) affected traumatic stress symptoms, but had no effect on posttraumatic growth. However, posttraumatic growth was significantly affected by organizational uplifts (e.g., having responsibility, recognition of good work, empowerment).

More recently, along the same lines of emergency response work, Paton and Burke (2007) discussed the affects of critical incidents on police officers and argued that while exposure to these traumatic events can "challenge psychological equilibrium"; the event should be viewed as an opportunity for positive change rather than the certain antecedent for negative psychological outcomes. Paton and Burke go on to outline two main factors involved in shaping

a police officer's response to a critical incident. One factor relates to previous experience and training prior to the event even happening, and the second relates to how personal, team and organizational factors interact to render challenging experiences as comprehensible and meaningful and resulting in positive psychopathology. This line of enquiry is taken further by Paton, Violanti, Johnston, Burke, Clarke, and Keenan, (2008), in their development of the Stress Shield model. This model is built on "the view that the resilience (ability to adapt and grow from the experience) of a person or group reflects the extent to which they can call upon psychological and physiological resources and competencies in ways that allow them to render challenging events coherent, manageable, and meaningful"(p.95). The model goes on to propose that a police officer's ability to interpret traumatic events 'coherent, manageable and meaningful, reflects the interaction of person, team, and organizational factors (Paton et al., 2008). This model stipulates that critical incidences can result in resilient (adaptive and growth oriented) outcomes for police officers if the interaction of person, team and organization are effective and supportive, and therefore may provide agencies with a model they can use to guide the development and maintenance of resilience. Components of the model include organizational and dispositional influences such as hardiness, employee empowerment, access to resources, supervisor support, trust, and peer cohesion as impacting factors on job satisfaction and resilience.

In another branch of organizational research, which has investigated how mental health professionals are affected by their workplace, Rupert and Morgan (2005) replicated existing research literature (Ackerley, Burnell, Holder, & Kurdek, 1988; Hellman & Morrison, 1987; Pearlman & Mac Ian, 1995; Raquepaw & Miller, 1989), and demonstrate that burnout in particular, was more likely to be reported by clinicians working in hospitals and institutions, or agencies as opposed to those working in private practice. These findings are relevant because

although the previous research into vicarious trauma, compassion fatigue, and posttraumatic growth have identified many factors that may contribute to consequences of trauma work, to my knowledge no one thus far has investigated if there are any differences when comparing work settings. Rupert and Morgan conclude from their findings that therapists in clinic employment report more negative symptoms and assume that this is because they have less autonomy and have less control over their own caseloads, and that those working as independent practitioners report less negative symptoms because they may have greater control over their appointment scheduling; workload and case distribution, have less paperwork and other bureaucratic responsibilities. However further research is needed to confirm the role of organizational differences. It is also worth noting here, that along with many other possible influencing variables there may be a difference in client presentation in these two differing work environments, given that those working in clinic employment may be working with clients who have more problematic presentations and life circumstances, and therapy may be hampered by the short term nature of the treatment. Furthermore, those therapists in private practice who report less stress may be exposed to less disturbed clients (Pearlman & Saakvitne, 1995; Rupert & Morgan, 2005). However, it may not be enough to focus solely on these organizational characteristics.

As Paton et al. (2008) indicate in regard to emergency response workers, within the Stress Shield Model, personal considerations are also part of the equation leading to workplace fulfillment and increased ability to manage work stress. That is, it is important to adopt a person-environment fit approach and consider how personal characteristics interact with organizational characteristics to determine the nature and implications of the stress response. Paton and colleagues discuss the personality correlates of hardiness, and conscientiousness and how they

interact with factors such as organizational culture, workplace hassles and uplifts, supervisor support, coping style etc to predict stress outcomes. Comprehensive understanding of vicarious trauma and growth thus require a multidimensional approach that includes therapist characteristics.

Individual Differences

One of the factors in therapists' personal lives that may have an effect on how they react to their vicarious exposure to trauma is if they have themselves have experienced a significant trauma in their own lives. This factor has produced conflicting result in previous research. For example, Linley and Joseph (2007) found that therapist with a personal history of trauma reported more growth and less negative symptoms, however in earlier research (Pearlman & MacIan, 1995; Schauben & Frazier, 1995; Meyers & Cornille, 2002; Nelson-Gardell & Harris, 2003) it has been suggested that those therapists who have experienced a significant personal trauma in their lives are more likely to experience negative reactions to trauma work. In fact, Pearlman and Saakvitne (1995) theorized that "survivor therapists" may experience heightened feelings of empathy, for their client and old memories and personal pain may resurface due to their clients retelling of traumatic events.

Pearlman and MacIan, (1995) conducted a study that examined vicarious traumatization in 188 self identified trauma therapists and found that therapists with a personal trauma history showed more negative effects from the work than those without a personal trauma history. Similarly, Schauben and Frazier (1995) assessed vicarious traumatization in 148 sexual violence counselors and found evidence that those professionals who have a personal history of trauma are more likely to develop vicarious trauma. Furthermore, Meyers and Cornille (2002)

investigated 205 Child Protection Workers and found that those participants who had experienced personal trauma reported being more depressed, anxious, somatic, withdrawn, isolated, and distressed than workers who had not experienced a personal trauma, and Nelson-Gardell and Harris (2003), found that professionals who have personally experienced trauma are more likely to develop secondary traumatic stress. In contrast however, Follette, Polusny, and Milbeck (1994), found that in a sample of 558 mental health and law enforcement professionals, having a personal trauma history was not linked to the development of vicarious trauma, and Van Deusen and Way (2006), studied vicarious trauma effects in clinicians who treat sexual abuse survivors and they found that although many of their sample reported experiencing childhood sexual abuse, there was no relationship between clinicians abuse and vicarious trauma. Furthermore, Creamer and Liddle (2005) found that in a sample of 81 disaster mental health workers who responded to the New York terrorist attacks of September 11, 2001, personal trauma history and secondary traumatic stress were not significantly related. These discrepancies in the research however, may be indicative of varying definitions of personal trauma experiences, if and how the therapists personal therapy had previously been resolved and different scales used to assess their reactions to their work.

Experience of the therapist is another variable with potential influence on a therapist's reaction to their work. One study (Benatar, 2000), investigated the effects of personal trauma history on vicarious trauma but also took into account the experience of the therapist, and found that the more experienced therapists with a personal trauma history did not appear to be more likely to suffer vicarious trauma than their colleagues without such a history. Throughout the extant literature it is often recorded that the therapist newest to the field of trauma work is the most vulnerable to negative consequences of their work (Adams & Riggs, 2008; Bicknell, 2004;

Creamer & Liddle, 2005; Neuman & Gamble, 1995; Pearlman & MacIan 1995; Steed & Bicknell 2001; Schauben & Frazier, 1995). Pearlman and MacIan's 1995 study reported that, those therapists newest to the field reported more somatic symptoms, anxiety, and depression than those who were more experienced. Creamer and Liddle (2005) found that higher secondary traumatic stress was related to less professional experience. However it is also worth noting that Meyers and Cornille (2002) showed that those therapists who had worked for longer in the field experienced more symptoms of secondary traumatic stress than those with fewer years' experience, and Linley and Joseph (2007) also found that those therapists who had worked longer in the field reported higher rates of negative psychological changes and burnout.

Another personal variable identified in the previous research is the value of personal therapy for therapists. Personal therapy has long been recognized as a useful tool for therapist to improve their practices (see Harrison & Westwood, 2009; Macran, Stiles & Smith, 1999, Pearlman & Saakvitne, 1995). Macran Stiles and Smith (1999), wrote that personal therapy will not only give a therapist experience of how it feels to be a client, and the opportunity to observe another therapist in action, but it may also increase the therapists confidence in the power of the therapeutic process. Most importantly, by helping to ease the pressure of their work, personal therapy can improve therapists' emotional stability and assist them in becoming more aware of their own problems and areas of conflict, thus reducing the impact of their personal problems on their professional lives. This school of thought was supported by Linley and Joseph (2007) who found that therapists who had undergone personal therapy in relation to their trauma work reported more positive symptoms and less burnout.

Finally, differences in the personality characteristics of those touched by trauma are another variable that has been the focus of previous research. It has been found that people who

show personality characteristics such as "extraversion", and "openness to experience" (Tedeschi & Calhoun, 1996) as well as internal locus of control, self efficacy, sense of coherence, and hardiness (Tedeschi & Calhoun, 1995) are more likely to experience posttraumatic growth. Perhaps then the same may be said about the therapists working with trauma survivors. This notion is supported in part by Linley and Joseph (2007) who found that therapists who score higher on the sense of coherence construct and empathy were more likely to show vicarious posttraumatic growth, they also found those with more social support and greater therapeutic bond to benefit more from their work. Similarly, in recent research by Harrison and Westwood (2009), in looking at potential protective factors for therapist against vicarious trauma, they found, that clinicians who engaged in "exquisite empathy (a discerning, highly present, sensitively attuned, well-boundaried, heartfelt form of empathic engagement)" reported being "invigorated" rather than "depleted" by their contact with traumatized clients (p. 213).

Conclusion

Taken together, the research suggests that those in the helping professions such as therapists, social workers, and psychologist who are continuously exposed to stories from their clients about traumatic experiences are at risk of developing similar negative symptoms. However, just as it is possible for the clients they treat to experience positive repercussions following trauma, the trauma therapist may also experience benefits in their personal and professional lives as a result of their work. Largely, it has been suggested that those professionals who work in an environment that is positive and aware of the potential negative effects of trauma work, are more likely to report positive consequences of their work than if they work in an environment that does not take into account the emotional and professional needs of their staff.

This notion is further supported by previous experimental studies that have shown that one person's expression of positive emotion can produce experiences of positive emotion in those with whom the person interacts (Hatfield, Caccioppo, & Rapson, 1993; Lundqvist & Dimburg 1995; as cited in Fredrickson 1993). It has also been indicated by previous authors (Ackerley et al., 1988; Hellman & Morrison, 1987; Pearlman & Mac Ian, 1995; Raquepaw & Miller, 1989; Rupert & Morgan, 2005) that professionals who work in clinic or agency employment are more likely to experience stress as a result of their work in comparison to those therapists who work in private practice.

From previous research it could be implied that therapists with more experience may encounter more personal growth and positive symptoms as a result of their work, and so would the therapist who engages in supervision, and personal therapy, and the therapist who works in private practice with more autonomy over organizational influences. However, further research is needed to solidify the evidence regarding the existence of vicarious posttraumatic growth in the trauma therapist and due to the conflicting findings of much of the previous research into vicarious trauma and compassion fatigue, it is necessary to investigate the impact of the therapists workplace, and other personal variables such as personal trauma history, and level of experience, on the therapists positive or negative reactions to trauma work.

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Empirical Study

Vicarious Posttraumatic Growth in the Trauma Therapist:

Do organizational factors impact differently on therapists working in private practice compared to therapists employed in clinic/institutional workplaces?

Abstract

An extensive literature illustrates the possible negative effects that providing trauma therapy can have on the therapist. Yet little is known about the potential positive outcomes experienced by therapists as a result of this work. An influencing factor on a therapists well being and mental health may be the climate of their work environment and the hassles or uplifts they experience in their workplace, and personal differences such as their own experience of trauma, and personal therapy. This questionnaire based study aimed to investigate firstly, the existence of positive outcomes or vicarious posttraumatic growth for therapists as a result of working with trauma clients, but also examines organizational differences in therapists who work in private practice and those who work in clinic/institutional employment, and sought to determine if those differences impede or facilitate vicarious posttraumatic growth. Sixty four therapists completed the Posttraumatic Growth Inventory, demographic questionnaire and the Work Hassles and Uplifts scales. Data were divided into two groups based on type of work place (private practice vs. clinic/institution). Results show that most therapists reported positive outcomes as a result of their work. No difference was found between the employment groups and levels of posttraumatic growth. However, therapists who reported more work uplifts also reported higher levels of posttraumatic growth. No difference was found between the two workplace groups on the uplifts scale, however, clinic/institutional therapists scored significantly higher on the work hassles questionnaire. Implications for the workplace are discussed and suggested directions for further research is outlined.

Research has shown that due to repeated exposure to client accounts of traumatic experiences, the therapist risks developing negative symptoms similar to those presented by their clients (Kassam-Adams, 1995; McCann & Pearlman, 1990; Pearlman & MacIan, 1995; Schauben & Frazier, 1995). The therapist may develop symptoms that are similar to Posttraumatic Stress Disorder, as if they too have experienced the event. The expressions Vicarious Traumatization (Pearlman & McCann, 1990) and Secondary Traumatic Stress or Compassion Fatigue (Charles Figley, 1995) have been developed to describe this phenomenon. The terms although slightly different in definition can be summarized as reactions to the emotional demands on therapists and social network members from exposure to trauma survivors' terrifying, horrifying, and shocking images; strong, chaotic affect; and intrusive traumatic memories (Figley, 1995; Pearlman, 1995; Sexton, 1999; Stamm, 1995). However new lines of empirical enquiry also indicate the possibility for positive cognitive changes following trauma (Linley, Joseph & Goodfellow, 2008). In fact Tedeschi and Calhoun (1996) used the term posttraumatic growth to describe the positive outcomes of survivors in times of trauma, and it has been well documented that along with, and often following negative reactions to a traumatic event many people report at least some positive outcomes or experience a helpful change in the way they think about their place in the world, the way they relate to others, their perception of their community or their family and friends, in their own self confidence, or in their perception of their own ability to cope (Parappully et al. 2002), and some report greater compassion and understanding of people, and having stronger religious beliefs (Weiss, 2002).

The link between positive changes and posttraumatic stress recently researched by Linley et al. (2008) has indicated that the experience of positive changes may also reduce the occurrence of symptoms of Post Traumatic Stress Disorder, depression and anxiety.

Vicarious Posttraumatic Growth

Arnold, Calhoun Tedeschi and Cann (2005), coined the term vicarious posttraumatic growth, to describe the process of "psychological growth following vicarious brushes with trauma" (p. 243). In 2005 Arnold at al. conducted a study exploring the experience of therapists working with trauma clients and the ways in which their work had influenced them. Arnold and colleagues found that while most of the sample reported some negative outcomes and symptoms, they also reported many benefits of working with survivors of trauma and those positive outcomes were very similar to the aftereffects reported by those who experience trauma first-hand. In fact, every one of the 21 therapists interviewed reported some kind of positive response from working with trauma-affected clients, and 90 percent of the sample reported witnessing and supporting their clients' post trauma growth as a positive consequence of the work (Arnold et al., 2005).

More recently, Linley and Joseph (2007) devised a study to explore the positive (personal growth, compassion satisfaction) and negative aspects (compassion fatigue, burnout) in a group of therapists working with trauma clients. They also looked in more detail at the potential influencing factors of vicarious posttraumatic growth, taken from existing research in vicarious trauma and secondary traumatic stress. Their findings showed that those therapists, who had engaged in their own therapy in regards to the trauma work, and those who had regular professional supervision reported more positive changes and less burnout, than those who had not seen a therapist. They also reported that those therapists with personal trauma histories reported more positive changes than those who did not. They also found that therapist who had worked longer in the field reported more negative symptoms and more burnout, but those who worked more hours per week with trauma clients reported more personal growth and more

positive changes, implying that client workload and years of experience are factors that require more research.

Although research to date has identified some organizational influences such as therapists work load (Bicknell 2004; Linley & Joseph 2007; Sexton 1999; Schauben & Frazier, 1995; Steed & Bicknell, 2001) and supervision practices (see Herman, 1992; Mc Cann & Pearlman, 1990; Pearlman & Saakvitne, 1995; Wilson & Lindy, 1994) as contributing factors to the facilitation of vicarious posttraumatic growth, little empirical research has been concerned with investigating how specific workplace practices influence post trauma outcomes in trauma therapist. However, in order to examine organizational differences and reactions to trauma work, we can turn to research on disaster and emergency workers to provide some insights.

Previous research into posttraumatic reactions in disaster and emergency workers (Gist & Woodall, 2000; Paton, Smith, Violanti & Eranen, 2000, Paton 2006) has recognized that organizational culture and the procedures, practices and attitudes that flow from it significantly impacts on employee's experience of traumatic events. In fact, Paton, Violanti and Smith (2003), point out that organizational variables have a significant impact on both traumatic stress symptoms and posttraumatic growth in disaster and emergency workers, and may be more important than the event itself. For example, emergency workers expect to be involved in traumatic events. What may be challenging are the reactions (e.g., personnel being blamed for less than satisfactory outcomes (due to factors outside their control), performance based more on compliance with bureaucratic procedures than operational performance). Paton et al. (2003) found that posttraumatic growth was more likely to occur if police officers reported experiencing positive organizational experiences, as measure by the Police Daily Hassles and Uplifts Scale (Hart, Wearing, & Heady, 1993). Paton et al. (2003) found that organizational hassles (e.g. lack

of consultation, poor communication, red tape) affected traumatic stress symptoms, but had no effect on posttraumatic growth. However, posttraumatic growth was significantly affected by organizational uplifts (e.g., having responsibility, recognition of good work, empowerment).

In another branch of organizational research, which has investigated how mental health professionals are affected by their workplace, Rupert and Morgan (2005) replicated existing research findings (Ackerley, Burnell, Holder, & Kurdek, 1988; Hellman & Morrison, 1987; Pearlman & Mac Ian, 1994; Raquepaw & Miller, 1989), and demonstrated that burnout, which has been identified as a critical contributing component of Compassion Fatigue (Gentry, Baranowsky & Dunning, 2002) in particular, was more likely to be reported by clinicians working in hospitals, institutions, or agencies as opposed to those working in private practice. These findings are pertinent because although the previous research into vicarious trauma, compassion fatigue, and posttraumatic growth have identified many factors that may contribute to consequences of trauma work, to my knowledge little empirical research has investigated if there are any differences when comparing the two different types of work settings that most mental health therapists, or counselors would work (i.e. private practice or clinic/institution), and Tedeschi and Calhoun (2004), have identified that in order for posttraumatic growth to be possible a supportive environment is an important contributing factor. However, these studies have not identified the specific characteristics of each type of workplace that influence this differential outcome.

Rupert and Morgan (2005) conclude from their findings that therapists in clinic employment report more negative symptoms and make the assumption, that this is due to less autonomy and less control over their caseloads, and that those working as independent practitioners report less negative symptoms because they may have greater control over their

appointment scheduling; workload and case distribution, have less paperwork and other bureaucratic responsibilities, however this needs further research and clarification.

In addition to the organizational variables potentially impacting on a therapist's experience of work as well as how they interpret that experience, are the personal variables which have been measured in previous research. One personal variable identified in the research is the value of personal therapy for therapists. Personal therapy has long been renowned as a useful tool for therapist to improve their practices (see Macran, Stiles & Smith, 1999, Pearlman & Saakvitne, 1995). This notion was supported by Linley and Joseph (2007) who found that therapists who had undergone personal therapy in relation to their trauma work reported more positive symptoms and less burnout. Another individual difference discussed is the impact of personal experiences of trauma on the therapist. Previous literature (Linley & Joseph, 2007; Pearlman & MacIan, 1995; Schauben & Frazier, 1995; Meyers & Cornille, 2002; Nelson-Gardell & Harris, 2003) has identified personal experiences of trauma as a potential impacting factor on therapists' reactions to their work. Though, research into the impact of these experiences on the trauma therapist is problematic.. This factor is problematic as it is extremely difficult to measure for two reasons. Firstly, an issue that complicates the assessment or implications of the effects of personal experiences of trauma on the trauma therapist is the issue of how the experience was resolved at the time of the event. Did the therapist engage in personal therapy, and what was the style of the therapy, or did they not resolve it at all? Secondly, previous experiences of trauma may not be interpreted as significant at the time of the event, however may become significant when a new personal or vicarious experience creates a trigger linking the old and new events and increasing the impact or significance of the events. Therefore personal experiences of trauma and how they impact on a therapist working with trauma clients would need to be measured over the

life time of the therapist in longitudinal style research. Also, the cumulative impact of personal trauma experiences and vicarious trauma would be difficult to measure as there is no existing method of assessing content of mental model or the challenge required to prompt change in schema in the direction of growth. Furthermore, the organizational environment has been identified as an influence on how professionals at high risk of experiencing traumatic events impose meaning on their traumatic experience (Paton, Violanti, Burke and Gherke, 2009).

Rationale for the present study

Research to date has been limited in regard to the vicarious positive effects of trauma therapy on the therapist, and in the small pool of existing research, results have been unclear regarding organizational influences on the potential for vicarious posttraumatic growth in the treating clinician. Recent research into both the deleterious and salutary effects of exposure to trauma on emergency response workers, such as police critical response officers, has indicated that organizational influences (uplifts and hassles such as red tape and supervisor support) can have a significant impact on those professionals (Paton et al., 2003). In order for Psychologists, therapists and counselors to sustain this type of work, and to assist in avoiding negative reactions to their work, further research is imperative in this area. A recent study by Linley, Joseph and Goodfellow (2008) indicates that those who experience growth following trauma are less likely to develop symptoms of Post Traumatic Stress Disorder, depression and anxiety. Therefore, as there are clear similarities between those directly exposed to trauma and those vicariously exposed (Arnold et al., 2005), clearer understanding of the protective factors within organizations for therapists who are often exposed to stories of trauma will assist in developing strategies to ensure growth is possible and vicarious trauma less likely.

Aims and Hypothesis

This study has three main aims, the first is concerned with establishing the presence of vicarious posttraumatic growth in the trauma therapist, and the second aim is to examine the amount of vicarious posttraumatic growth in the therapist who works in private practice compared with those who work in clinic or institutional employment. The third aim of this study is to look into to some of the differences noted in earlier research that may affect levels of vicarious posttraumatic growth in those therapists.

Hypothesis 1: Using an amended version of the Posttraumatic Growth Inventory scale evidence will be found of vicarious posttraumatic growth in the sample of trauma therapists.

Hypothesis 2: Using an amended version of the Police Hassles and Uplifts scale, therapists who work in private practice will report more workplace uplifts and fewer hassles than those who work in clinic or institutional employment.

Hypothesis 3: Therapists working in private practice will report higher levels of vicarious posttraumatic growth than those who work in clinic or institutional employment.

Hypothesis 4: Trauma therapists who have worked longer in the field of trauma will report higher levels of vicarious posttraumatic growth.

Hypothesis 5: Therapists who have a higher case load of trauma clients will report higher levels of vicarious posttraumatic growth, and finally;

Hypothesis 6: Therapists who have visited a psychologist or counselor in relation to their work will report higher levels of vicarious posttraumatic growth.

Method

Participants

One hundred and fifty psychologists, social workers or therapists working in private practice, hospitals, or clinics were selected from the online Yellow Pages Australia wide. Participants were selected following an online search for "therapists" in "all states" of Australia, and the first 150 listings in alphabetical order were selected Another 25 social workers, psychologists or therapists were recruited through a 'Working with Survivors of Sexual Assault' workshop in Hobart, Tasmania. The criterion for inclusion was that they were therapists who had experience working with traumatized clients. The total number of participants who returned questionnaires was 68, giving a rate of return of 39 percent, and four cases were excluded as they reported no experience working with trauma leaving a total of 34 participants. In order to protect participant confidentiality, no information was collected about the participants who completed the questionnaire and those who did not. Participants' ages ranged from 20 years to 60+ years with the majority of participants in the age range of 50-60 years (see Table 1). Regarding experience working as a therapist 36 percent of the total sample had worked for less than 5 years as therapist, 56 percent had worked for between 5 and 15 years as therapist and 26% had worked for more than 15 years as therapist (See Table 2).

Table 1

Age Group Range of Participants

Age group	No of participants	Percent of total
20-30 years	16	25.0
30-40 years	14	21.9
40-50 years	8	12.5
50-60 years	24	37.5
60+ years	2	3.1

Fifteen participants or 23% of the total group indicated that they had spent half of their career working with trauma clients and the remaining 77% had spent less than 50% of their career working with trauma clients. Participants data was divided into two groups based on their type of work place (1) clinic/institutional employment (n = 45) or (2) private practice (n = 19).

Table 2

Years Working As a Therapist

No. of Years	Total no of participants	Percent of total
5 years or less	23	36
5-15 years	48	56
15 – 30 years	17	26

Materials

All participants were asked to complete four questionnaires (see Appendix C) relating to workplace hassles and uplifts, posttraumatic growth, demographic and workplace information.

Demographic and workplace information

Participants were asked to indicate if they worked in private practice, or clinic/institutional employment (if they worked in both settings they were directed to select the workplace in which they spent the majority of their time). They were also asked to select from a drop down menu, the type of training they had undergone (Postgraduate psychology degree, 4 years undergraduate plus supervision, 4 years undergraduate, social worker or other), if they were a psychologist registered with their state registration board, and which age group they were in. Participants were also asked to indicate from a drop down menu the percentage of their careers they had spent working with trauma clients and the percentage of their working weeks spent with trauma clients (selection options ranged from 0 percent to 100 percent). Finally, they were asked to indicate if they had ever visited a Psychologist (or any other mental health provider) for work related stress.

Workplace hassles and uplifts

An amended version of the Police Daily Hassles (PDHS) and Police Daily Uplifts (PDUS) Scales (Hart, Wearing, & Heady, 1993) was used to measure the positive (beneficial to well-being) and negative (harmful to well-being) work experiences encountered by therapists on a day to day basis. The PDHS measures 19 dimensions of negative work experiences (Cronbach Alpha for this scale .966), while the PDUS measures 12 dimensions of positive work experiences (Cronbach Alpha for this scale .966), The scales were amended so that questions were appropriate for psychologists, therapists or social workers, and questions specific to police work were removed.

Posttraumatic growth

The posttraumatic growth inventory (Posttraumatic Growth Inventory) (Tedeschi & Calhoun, 1996) is a 21-item self-report measure of positive outcomes following traumatic experience. The scale was amended slightly to measure the perspectives of therapist treating victims of trauma as opposed to first hand victims (Cronbach Alpha for this scale .945). Participants were asked to indicate for each of the 21 statements, the degree to which the positive change occurred in their lives as a result of hearing about other people's crises. It is scored using a 6-point Likert format scale (0 = I did not experience this change; 5 = I experienced this change to a very great degree). All 21 items are positively scored, yielding a potential range of 0-105, where higher scores are indicative of a greater experience of posttraumatic growth.

Procedure

The majority of participants were Psychologist randomly selected via the Australian Yellow Pages, and their workplace was contacted via phone. However, a small number (approx

25) of participants were recruited during a sexual assault workshop, in Hobart Tasmania. Once permission was obtained, from workplace administrative staff, or directly from the participants, further contact was made via an email (see appendix A), which provided a link to an online information sheet (see appendix B). Participants were then directed to the online questionnaires (see appendix F), and were informed that completion of the questionnaires was considered to be an indication of their consent to take part in the study and that they had read and understood the Information Sheet. Participants were informed that the study would take no longer than 30-40 minutes to complete. Once the questionnaires were completed, they were directed to press a '*submit*' button at the bottom of the online page. Participants were also informed that raw data obtained from the study would be stored at the University of Tasmania, School of Psychology, in a secure web server for a period of at least 5 years, at which time the data would be destroyed/deleted from the computer.

Results

Results of the amended Post Traumatic Growth Inventory (PTGI) show that ninety five percent of participants reported to at least a small degree some positive outcomes measured by the PTGI. Percentage of participants agreeing with individual statements from the PTGI can be seen in Figure 1. These results support the first hypothesis that evidence of PTG would be found in the sample of therapist. Descriptive results of PTGI can be seen in Table 3.

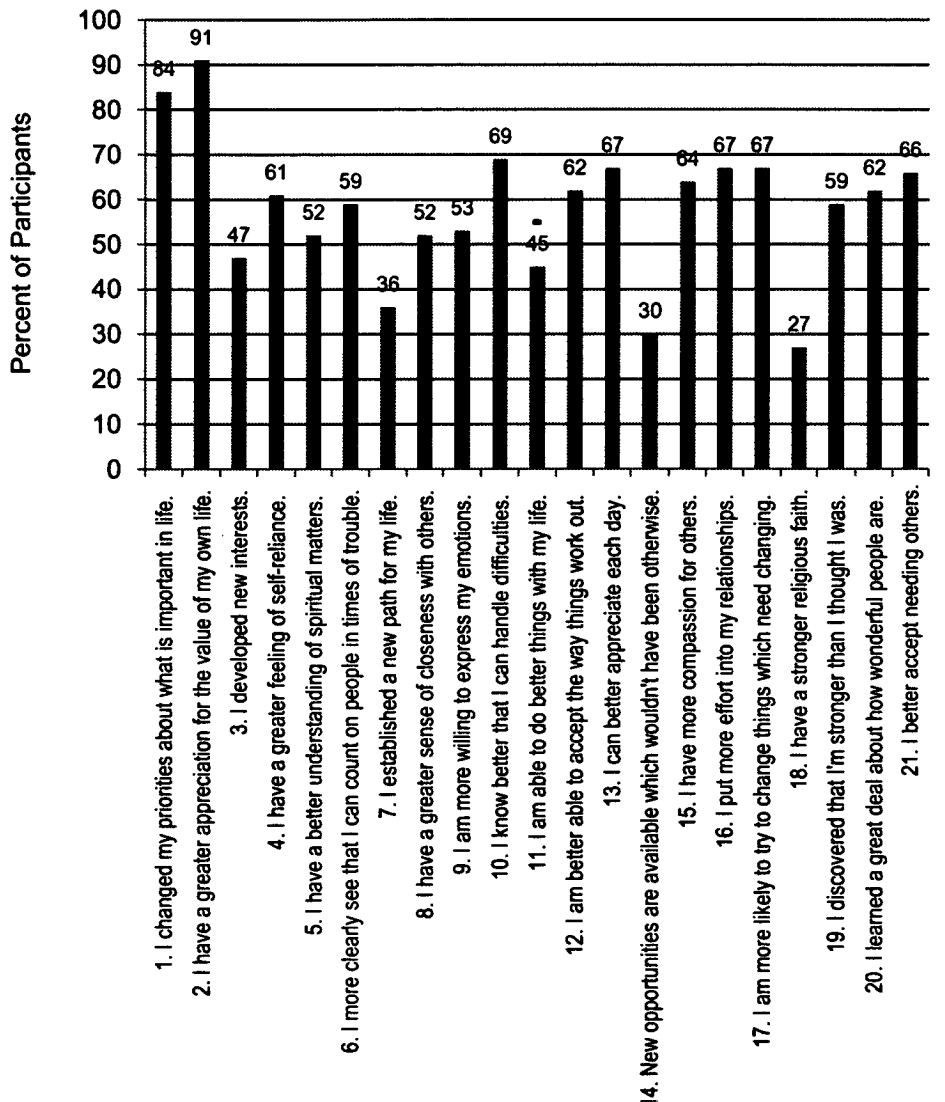

Figure 1. Percent of participants who reported Vicarious Post Traumatic Growth (VPTG) to at least a small degree on each question

Table 3

PTGI Descriptive Results

Group	N	Mean	Std. Dev	Range
Institutional	45	35.28	24.32	0-92
Private	19	43.05	28.19	0-91
Total	64	37.59	25.55	0-92

A one-way ANOVA was conducted to assess the second hypothesis, that therapists who work in private practice will report more workplace uplifts and fewer hassles than those who work in clinic or institutional employment. The first ANOVA looked at whether the private practice psychologists differed from the clinic/institution psychologists on work uplifts, and although no significant difference was found between the two groups overall $F(1,66)=0.53$, $p=.469$ (see Appendix D), it should be noted that there were trends in the data indicating that those working in private practice recorded higher scores for the following items; *Flexible work hours* $F(1,62)=15.5$, $p>.001$; *Support for my work from my family* $F(1,62)=5.32$, $p=.024$; *Sufficient time with my family* $F(1,62)=7.55$, $p=.008$; *Receiving feedback on how I am doing my job* $F(1,62)=5.5$, $p=.022$ and *A comfortable work environment* $F(1,62)=5.24$, $Pp=.025$. However, the statement, Getting *along with other staff* also produced significant results with private practicing Psychologist being lower than institutional Psychologists $F(1,62)=6.26$, $p=.015$.

Table 4.

Work place Hassles and Uplifts Descriptive Statistics

Test	Group	N	Mean	SD	Range
Hassles	Private	19	42.31	36.38	4 -133
	Institution	45	94.15	52.05	15 - 195
	Total	64	78.76	53.29	4 - 195
Uplifts	Private	19	159.52	63.45	14 - 230
	Institution	45	148.26	53.38	0 - 260
	Total	64	151.60	56.28	0 - 260

A one-way ANOVA was also conducted to determine whether the private practice and clinic/institution psychologists differed on total work hassles and a significant difference was found, $F(1,63)=15.56$, $p<.001$, with clinic/institution psychologists scoring significantly higher on the scale ($M=94.16$, $SD=52.05$) than private practice psychologists ($M=42.32$, $SD=36.38$). A significant correlation was also found between total scores of Vicarious Posttraumatic Growth and total Work Uplifts reported by all participants *($r=0.413$, $p<.01$)*.

A one-way ANOVA was conducted to assess the third hypothesis; that therapists working in private practice will report higher levels of vicarious posttraumatic growth than those who work in clinic or institutional employment, no significant difference was found between the two groups, $F(1,63)=1.24$, $p=.27$ (see Appendix D).

A Pearson's correlation was used to test hypothesis 4 and 5; that trauma therapists who have worked longer in the field of trauma will report higher levels of vicarious posttraumatic growth, and therapists who have a higher case load of trauma clients will report higher levels of

VPTG. No significant correlation was found between percentage of weekly trauma caseload and VPTG, however there was a small but significant correlation between total levels of VPTG and percentage of career working with trauma clients (r=0.265, p<.05) (see Appendix D).

Discussion

The trauma therapist has an opportunity to assist a client in dealing with shocking, intrusive, and life altering experiences, and it is possible that beyond simply coping with this disturbing event the client could find that as a result of ruminating about the event and trying to make sense of the event, may discover some positive revelations about themselves, life itself or about others. The trauma therapist is in a unique and sensitive position to witness and possibly assist in this transformation, consequently they may also benefit from this interaction. Positive symptoms as a result of working with trauma victims have been reported in samples of therapists in past research (Arnold, Calhoun, Tedeschi & Cann, 2005; Linley, Joseph & Loumidis 2005; Linley & Joseph 2007), and one of the goals of this study was to investigate whether psychologist working with victims of trauma report positive symptoms associated with their work. Therefore, regarding the hypothesis motivating this study, the first predicted that results would show vicarious posttraumatic growth in the sample of trauma therapists, and the results indicate that out of the total group of therapists, of which seventy two percent were psychologists, and thirteen percent were social workers, ninety five percent reported at least one positive outcome from the work.

When individual statements from the Posttraumatic Growth Inventory were examined further, it was noted that eighty four percent of therapists indicated that as a result of hearing about other people's crisis, they had "*changed their priorities about what is important in life*"

and had experienced that change at least to a small degree. Ninety one percent of therapists had experienced to at least a small degree "*a greater appreciation for the value of my own life*" as a result of hearing about other people's crisis, and sixty seven percent indicated that they "*can better appreciate each day*" to at least a small degree as a result of hearing about other people's crisis. Other statements on the questionnaire that scored high amongst the total group were *"I have more compassion for others"*, *"I learnt a great deal about how wonderful people are"*, and *"I know better that I can handle difficulties"* as a result of hearing about other people's crisis.

The second hypothesis proposed that therapists who work in private practice will report more workplace uplifts and less hassles than those working in clinic or institutional employment. Although no significant difference was found between the two groups on the uplifts scale, with regard to scores on the work hassles questionnaire, clinic/institutional psychologists scored significantly higher than private practicing therapists. This may imply that those who work in clinic/institutional workplaces experience more negative workplace experiences such as red tape, and lack of control or autonomy, than those who work privately. These are commensurate findings to Rupert and Morgan's (2005) study, who found that employees in clinic/institutional employment reported more negative symptoms such as burnout. Our findings support Rupert and Morgan's assumption that their participants suffered more burnout due to work hassles such as bureaucratic responsibilities, and less autonomy.

When looking closer at the results it seems that the most common work hassle experienced by clinic/institutional therapists were things like *"a lack of encouragement from superiors"*, *"inadequate guidance and back up from superiors"*, *"lack of opportunity for staff participation in policy and decision-making"*, and *"having far too much work to do"*. These statements may be clear indications of influence of greater bureaucracy.

Results of the hassles and uplifts questionnaire provides important links to previous research conducted in the area of emergency response work, and in particular in regard to the model proposed by Paton and colleagues (2008), the Stress Shield model. The Stress shield model is written in reference to emergency response workers, which obviously differ significantly from therapists work, however share some commonalities in that both therapists and emergency response workers often deal with the effects of trauma in the workplace. The Stress Shield model proposes that the resilience of a person or group reflects the extent to which they can call upon their psychological and physical resources and competencies in ways that allows them to render challenging events coherent, manageable, and meaningful. The model posits that a police officer's capacity to render challenging experiences meaningful, coherent, and manageable, reflects the interaction of person, team and organizational factors. Although this model has been developed in regard to police officers who may directly witness a traumatic event happening, or may attend the event directly after it has occurred and have to deal with the aftermath, many similarities have been seen in previous research in regard to vicarious trauma and posttraumatic growth in these professionals (See Paton Violanti & Smith, and Paton, 2006).

Within the model Paton and colleagues draw out certain elements of an organization, and of an individual which may impact the development of resilience (adaptive and growth oriented) and job satisfaction for an individual or organization, and to do so also used the Hassles and Uplifts questionnaires. The authors discuss psychological and physical resources such as feelings of empowerment, support from superiors and your team or colleagues, and they also talk about access to information and adequate resources as critical components of the model. The model suggests that with these critical components a person, who is exposed to incidents such as a police officer, will be able to translate the event as meaningful and manageable, will develop

resilience for future experiences and have greater job satisfaction. Although the work of a trauma therapist is quite different to that of a police officer, they are both dealing with or hearing about traumatic material that challenges significant personal and /or professional beliefs and that fall outside of the realms of average daily experiences. Therefore when looking at the results, the finding that those working in clinic/institutions experienced more work place hassles such as *"inability to change the system"* and *"lack of opportunity for staff participation in policy and decision-making"*, *"inadequate back up and guidance from superiors"*, may indicate that those therapists are less likely to develop resilience and will have less job satisfaction than those in private practice who indicate more workplace uplifts. However this could also be a result of participants externalizing their negative experiences and blaming organizational factors in order to protect their own self esteem. The Stress Shield model also looked into personality factors such as conscientiousness, however we did not measure this factor in our study, and this may be an area for further investigation in the future.

The third hypothesis projected that therapists working in private practice would report higher levels of vicarious posttraumatic growth than those who work in clinic or institutional employment. When looking at the results it is clear that, although the majority of the sample indicated that they had experienced vicarious posttraumatic growth as a result of their work, there was not a significant difference between the two employment groups on the post traumatic growth measure. This suggests that vicarious growth is feasible in both private practice or clinic/institution therapists. However, considering the sample size of this study and in particular the size of the two groups measured this may not be a true reflection of therapists experience and requires further investigation.

The fourth hypothesis is drawn from earlier findings that have indicated a relationship between years of experience of the trauma therapist and the potential impact the work may have on the individual. Previous findings have been inconsistent. For example much research has found that the therapist newest to the field of trauma work is more vulnerable to negative consequences of the work (Adams & Riggs, 2008; Bicknell, 2004; Creamer & Liddle; Neumann & Gamble, 1995; Pearlman & MacIan, 1995; Steed & Bicknell, 200; Shauben & Frazier, 1995), and other results have show the opposite, for example Linley and Joseph (2007) found that those therapists who had worked longer in the field reported higher rates of negative psychological changes and burnout, and interestingly that those with a heavier caseload reported more growth. Therefore the fourth hypothesis, stated that trauma therapists who have worked longer in the field of trauma will report higher levels of vicarious posttraumatic growth, and the results indicated a small but significant relationship between Vicarious Posttraumatic Growth and percentage of career working with trauma.

Related to this is the fifth hypothesis, which proposed that those therapists with a greater case load of trauma clients will report increased levels of vicarious posttraumatic growth. Consequently, analysis revealed that those who reported working a higher percentage of their week with trauma clients scored higher on the growth scale, the results relating to hypotheses four and five indicate that those who had worked longer in the field, and with higher trauma caseloads, were more likely to experience positive reactions to the work. These findings can be related to part of Linley and Joseph's study who found that those therapists with a heavier caseload reported more personal growth and positive changes, and imply that therapists who are repeatedly exposed to trauma clients are more likely to experience posttraumatic growth than those with lighter trauma caseloads. This may be because those therapists who spend more time

with trauma clients develop more practiced and refined skills in dealing with the potentially deleterious effects of this work, and have the opportunity to work with and observe many clients transforming and growing from their experiences. Or it could be that as a result of observing many clients suffer through trauma and the effects, they appreciate their own life and circumstances more than they would otherwise. However, these results may also indicate that therapists who are more likely to experience positive transformations and growth due to differing personality traits, personal experience or other extraneous factors, tend to take on higher caseloads than their peers or remain in the trauma field for longer. Clearly this is an area that requires further investigation and clarification.

The final hypothesis is drawn from previous research which has identified differing personal factors which may have affected the development of posttraumatic growth in therapists, such as seeking personal therapy to assist in dealing with this type of work. Linley and Joseph (2007) found those therapists who had engaged in their own therapy reported more positive changes than those who had not seen a therapist. Therefore the sixth Hypothesis anticipated that those therapists who have visited a psychologist or counselor in relation to their work will report higher levels of vicarious posttraumatic growth. The findings of our study found that half of the sample indicated that they had visited a Psychologist (or other mental health provider) for work related stress, and there was not a significant relationship found between personal therapy and workplace type (i.e. private or clinic/institution), or level of PTG.

Examination of the Post Traumatic Growth Inventory results indicated that overall, therapist who scored higher on the Work Uplifts scale also reported higher levels of posttraumatic growth. This implies that a workplace that allows for and facilitates more "uplifts" such as "receiving recognition of good work", and "working with people I like", and working

with "superiors who listen", harbors employees who are more likely to experience positive outcomes as a result of their work. This finding has crucial implications for employers and supervisors of therapists, especially considering that other research (Linley et al., 2008) has indicated that those who experience more posttraumatic growth following exposure to trauma, experience less long term negative implications such as depression, anxiety and symptoms of Post Traumatic Stress Disorder. This in the trauma therapist would equal less absenteeism from the workplace, and other potential costs for them or their employer, such as compensation claims for vicarious trauma and reduced productivity. An organizational culture and structure that is designed to ensure that employees are adequately supported and thus experiencing workplace uplifts, must reap the benefits of happier staff, good workplace relationships, overall morale and general workplace wellbeing.

As was already mentioned, those in the study who report more uplifts reported more growth. Therefore, although not directly asserted by our results, perhaps it could be assumed that those who experience more hassles report less growth and are therefore more susceptible to long term negative effects of working with trauma clients such as depression and anxiety, and are consequently potentially more costly to their employer. This may not be directly shown by the data; however it is an important consideration for future research, and for employees of those exposed to trauma.

Limitations and future research

The interpretation of the findings of this study need to be viewed as tentative in light of the small size of sample, particularly with regard to the numbers represented in each of the groups. Ideally, the study should be repeated using a larger national sample in order to assess,

with more accuracy the implications of the findings for training and practice, which will be elaborated on in the next section. The systematic and comprehensive analysis of this issue would also benefit from prospective, longitudinal research. Huddleston, Paton & Stephens (2006), in a prospective study of police officers found that the impact of uplifts on workplace experience was a function of the number of events experienced over time. The cross-sectional design used here would not have captured this relationship. Another potential limitation of this study may be in the style of distribution. This study was distributed as an online questionnaire; some participants may have not completed it due to concerns about security. Furthermore, due to the nature of the questions, specifically in regard to workplace hassles, some participants may have been unlikely to answer honestly about their workplace for fear of information being leaked to their employer. In addition, due to the nature of the questionnaire style study, the questionnaires may be considered transparent and it is possible that some participants may have answered with a preconceived agenda; therefore other methods of data collection such as naturalistic interview style may need to be considered. Other potential limitations exist in the necessary alterations to two of the questionnaires, the Post Traumatic Growth Inventory was amended to be answered by therapists instead of primary victims and the uplifts and hassles questionnaire was also amended for use by therapists instead of police officers, and these changes may have affected validity of scales. Therefore it may be worthwhile developing scales specific to the therapy field for future use. Finally, a measure may need to be included to look at traumatic stress symptoms, as well as measuring the positive symptoms.

For the purpose of this study we did not include a measure of traumatic stress because we wanted to focus on more positive outcomes of this work, and as this was an online questionnaire, we did not want to put off participants by extending the number of questionnaires

and subsequently the time it may take to complete. However for future research a measure for both the positive and negative symptoms associated with trauma work could be included to provide a more balanced depiction of the impact of this work on therapists.

Another area that may require further clarification in future research is the issue of the availability of peer support and supervision for the trauma therapist. It may be that due to the nature of clinic/institution employment, employees have more access to these supports than a therapist working in private practice. This was not measured in the current study and as peer support and supervision have been identified as protective factors for the trauma therapist, this may require further clarification in future research. It would also be useful to include a measure in future research that would tap into participant's potential for self serving bias. That is because previous research (Weiner 1985) has indicated that people tend to externalize negative experiences or feedback in order to protect their self esteem, confidence and self worth and this may interfere with the validity of results when measuring workplace hassles.

Implications for the trauma therapist, and the organizational context

Based on the findings of this study, and similar guidelines written about the prevention of vicarious trauma by Bell, Kulkarni and Dalton (2003), recommendations for organizations and individual therapists are offered; In order to increase workplace uplifts and increase the likelihood that posttraumatic growth can occur in trauma therapists, organizations should focus on; (1) Education; ensuring that therapist have regular opportunities to learn about the findings of current trauma theory, and have a full understanding of the potential deleterious and salutary effects of this work on therapists. Therapist should also be given access to professional development in regard to posttraumatic growth, and assisting the facilitation of growth in their

trauma affected clients. Organizations should also focus on (2) developing an accommodating and understanding organizational climate; for example promoting an ethos that normalizes the potential effects of trauma work and encourages self care, such as managing workloads and work hours depending on personal and professional needs. (3) Organization should also encourage peer and supervisor support; employees should be encouraged to confidentially discuss cases with co-workers and other professionals on a regular basis and ideas and support shared amongst the group. All therapists (despite age or experience) should have access to a supervisor who they trust and can confide in, in order to obtain professional and personal support when necessary, as well as opportunities for more casual discussions about their work with their peers, and opportunities for social gatherings such as staff morning tea gatherings, and special occasion celebrations.

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Appendices

Appendix A: Email to Participants

To whom it may concern,

My name is Lydia Black and I am currently studying my Masters in Psychology at the University of Tasmania, and I am in the process of conducting a research thesis as a requirement of my degree.

On the __/__/__ I spoke with (previous contact by phone), who gave me permission to send this email to you/your organization.

For my thesis I am investigating both the positive and negative consequences for Psychologist/Therapists who work with trauma clients. I am also interested in whether organizational factors such as supervision, workplace climate and resources can influence the impact of working with trauma clients, as this has not been directly studied before.

In order for me to conduct this research adequately it is important that I obtain as many reponses as possible, therefore, it would be appreciated if this email could be forwarded on to all staff in your workplace who work as Psychologists or Therapists.

I have attached a comprehensive information sheet to explain the study in more detail, and within the information sheet there is a link to the online questionnaires. Should you choose to take part in the study, participation is entirely voluntary and confidential, no identifying information is required. Agreeing to, completing and submitting the questionnaire is considered to be an indication that you freely consent to participating in this study.

If you have any concerns or questions regarding the study please feel free to contact me (lydiab@utas.edu.au) or Associate Professor Douglas Paton (Douglas.Paton@utas.edu.au).

Thank you for your time

Lydia Black

Appendix B: Online Information Sheet

INFORMATION SHEET

How do organisational factors affect the Psychologist/Therapist in Private Practice compared to those in Clinic/Institutional Employment?

Douglas Paton (Associate Professor) Lydia Blundell (Mpsych Student)

We would like to invite your participation in the following research

In order to investigate possible organisational differences that may impede or relieve the effects of working with trauma clients, the present study will investigate the differences between psychologists' levels of secondary stress or compassion fatigue, described as the impact of empathic therapeutic engagement on therapists in clinic or institutional environments and the level of secondary stress/compassion fatigue in psychologists who work in private practice. This study is being conducted as part of the requirements for Masters in Psychology at the University of Tasmania.

There are a number of potential benefits of this research for yourself and for your place of work. Considerable research effort has been directed towards the professional and personal factors that may facilitate or impede Secondary Traumatic Stress in those who care for the traumatised. However, little research has been aimed at defining organisational factors that impact on the level of secondary trauma experienced by therapists in particular. In addition, to date, the literature has focused on the negative outcomes associated with secondary trauma exposure, with the possible positive consequence receiving little attention. In order to better understand Secondary Traumatic Stress the difference between those psychologists who are negatively affected by secondary trauma, and those who may grow from the experience, is important to ascertain in order to implement effective proactive prevention and treatment of secondary trauma. Individual therapists who choose to take part in this study will be able to access information on identifying compassion fatigue, and information on self care in the workplace, this information will be available to view on the secure questionnaire web page. Participants will also be able to access results of the study via the University of Tasmania website.

You have been selected to take part in his study because you are currently working as a psychologist, therapist, or councillor, and in order to protect your identity you have been contacted via your place of work. We, the researchers, will not know who was given the Information Sheets and Consent Forms or who will have filled out the questionnaires. No identifying information will be collected during the study and your employers will not be informed if you do or do not choose to participate. No private information has been accessed during recruitment and research data gathered for the study may be published but no participant will be identifiable in any research output.

If you choose to take part in this study, you will be required to complete five short questionnaires in your own time. The questionnaire will be completed by accessing a secure web page and completing the questionnaire on line. These on line forms will comprise of questions regarding job satisfaction, an inventory of traumatic experiences, an organisational and

professional factors questionnaire and a demographic information questionnaire regarding trauma survivor caseload. Completion of the questionnaire should take no longer than 30 - 40 minutes.

It is not envisioned that there will be any risk to you associated with this study. Participation in this study is voluntary and all information gathered is completely anonymous. Raw data will be stored at the University of Tasmania School of Psychology, in a secure web server for a period of at least 5 years, at which time the data will be destroyed/deleted from the computer. Your participation is voluntary. You may complete the questionnaire at your discretion, but are under no obligation to return it if you do not wish to do so.

This project has received ethical approval from the Human Research Ethics Committee (Tasmania) Network. If you have any concerns of an ethical nature or complaints about the manner in which the project is conducted, please contact the Executive Officer of the Human Research Ethics Committee (Tasmania) Network. The Executive Officer will direct you to the relevant Chair of the committee that reviewed the research. Executive Officer: Amanda McAully (03) 6226 2763

Each organisation involved will be provided with a copy of the results – at the request of management and administration. The results will also be posted on the school of Psychology homepage on the University website. Completing and submitting the attached questionnaires is considered to be an indication that you have read and understood the 'Information Sheet'.

If you have any questions or would like any additional information regarding this study please contact Assoc. Prof. Douglas Paton (03 6324 3168; Douglas.Paton@postoffice.utas.edu.au) or Lydia Blundell (0408 540 888; lydiab@postoffice.utas.edu.au)

Please press **submit** if you have read and understand the information sheet and consent to take part in this study

If you do not consent to take part in this study or would like to complete the questionnaires at a more convenient time, please press your "Back" button on your browser window and return later

Thank you

Appendix C: Data Set Used for Analysis

Pl ac e_ of _ w or k	A ge	Qu ati fic ati on s	Re gi st er ed	me _ w or kin g_ as _t he	_o f_ ca re er _ w or kin	_o f_ we ek _s pe nt _ wi	ug ht _h el p_ fo r_ w or	ac ko fe nc ou ra ge me ntf	bs en ce of em oti on ats up	bs en ce of st ab ilit yo rd	ab se nc eo fa ny po te nti	in gh el da cc ou nt ab lef	in gh el da cc ou nt ab lef	in gt ol d wh att od ob yo	Bu dg et co ns tra int s	on fi ct th co lle ag ue	ma nd st ha tw or km ak es	Ex ce ssi ve pa pe rw or k	eli ng so fh avi ng ch to co nf	vin gf ant oo mu ch w or kt	vin gt oa do pt an eg ati ve	vin gt o w or kv er yt on	me lf ew lth ap ant ne rw ho	bli ity to ch an ge th es ys	de qu at ef ee db ac ka bo	de qu at eg ui da nc ea nd	pp ro pri at er ude sa nd re	uff ici en tfi na nc eo ur ce s	lns uff ici en tre so to co m pl s	uff ici en tti me s	Inr eg ula rm eal ti me	Jo bi ns ec uri ty	ck of da ft yin op er ati on dc	ck of co ns ult ati on an nin g	ck of fo rw ar dp lan up po rtf	ck of pr ac tic ats up po rtf	ck of su pp or tfr o m my	Lo w m or ale	M ee tin gd ea dli ne s
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Mi ssi ng me als	ys po us ei sa tti tu de to	ot be in ga bl et oê sw itc	he rst aff no tp ulli ng th eir	er so nal ity lcl as he sw ith	Po or ad mi nis tra tio n	or co m mu nic ati on be tw	ob le ms wi th co w or ke	Ru sh ed ea tin g	ck of op po rtu nit yf or st	Ta kin g my w or kh o me	re at ofi m pe nd in gr ed	o mu ch ex pe ct ed of me	o mu ch re dt ap et og et	To o mu ch su pe rvi si on	ce rta int ya bo ut my fut ur	de rp ro m oti on dw or kin	Un ne ce ss ar yf or ms	or kin g wi th pe op le wh	or kin g wi th pe op le wh	or kin g wi th pe op le wh	or kin g wi th pe op te wh	or kin g wi th pe op le wh	ma nd sm yw or km ak es on	ob le ms wi thf oll o wi ng	Tot alW ork Has sels	or kin g wi th pe op le wh	or kin g wi th pe op le wh	or kin g wi th pe op le wh	or kin g wi th pe op left ike	or kin g wi th co m pe te	W or kin gh ar d	or kfi tti ng in wi th ot he	or kfi tti ng in wi thf am ily	Ti dy w or ka re a	pp or tf or my w or kfr o	ffi cie ntt im ew ith fa mil y	Su pe rio rs wh oli st en	pe rio rs wh ol ca nt ur nt	Su pe rio rs wh oa re op en
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pe rio rs wh oa re ho ne st	Su pe rio rst ru sti ng me	pe rio rs de te ga tin g w	So lvi ng ap ro bl em	fe w or ke rvi ro nm en t	sul ts of my pl an st aki ng	cei vin gr ec og nit io nf or	cei vin gf ee db ac ko nh o	ov idi ng qu ali ty se rvi ce	rs on alr ea cti on fr o m	he rst aff do in gt he rig ht	M ee tin gd ea dli ne s_ A	aki ng po pu lar de cis io ns	M aki ng de cis io ns	He lpi ng cli en ts	tpf uls up eri or se. g. ma na	vin gv ari et yin my w or k	vin gs uff ici en tre so ur ce	Ha vin gr es po nsi bil ity	Ha vin ga sa yin de cis io ns	G oo d w or kh ou rs	G oo df aci liti es	Ge tti ng thi ng sd on e	tti ng al on g wi th ot he	Fl exi bl ew or kh ou rs	Eq ui p me nt w or kin g	ui p me nt be in ga vai la	oi ng w or th wh ile w or	oi ng int er es tin g w or	oi ng ch all en gi ng w or	Da ys of f	o mf or ta bl ew or ke nvi	ari ty of op er ati on pr ot	in gi nv ol ve di nd eci si	in ga bl et o ma ke ad idi	in ga bl et oa ct on my o	lan ce be tw ee nw or ka nd	pp lic ati on of rul es an dp	hie vin ga he av yw or kl oa	Tot alW ork Upl ifts
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ge	ag	el	ag	ab	ect	bli	ag	m	w	bl	be	ett	op	m	m	m	as	ov	ne	er		ou	his	W	ny	his	nd	yo	his	nd	my	his	nd	cl	his	nd	ou	his	he
d	re	op	re	ett	ea	sh	re	or	be	et	tte	er	po	or	or	or	tr	er	da	ac		ev	ha	he	on	ha	idt	ue	ha	idt	on	ha	idt	os	ha	idt	ev	ha	nd
my	at	ed	at	er	rly	ed	at	ew	tte	od	ra	ap	nu	ec	ee	eli	on	ed	gr	ce		er	pp	nd	ee	pp	his	ve	pp	his	ee	pp	his	efr	pp	his	er	pp	idt
pri	er	ne	erf	un	se	an	er	ill	rth	ob	bl	pr	mi	o	fl	kel	ge	th	ea	pl	To	se	en	idt	ve	en	ha	rb	en	ha	ve	en	ha	ien	en	ha	su	en	his
ori	ap	wi	eel	de	et	ew	se	ng	ati	ett	et	eci	ies	m	or	yt	me	ati	td	ne	tal	iv	on	his	na	on	pp	ee	on	pp	rn	on	pp	do	on	pp	fle	on	ha
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0	3	2	3	0	3	0	3	3	3	0	3	0	0	3	2	3	0	2	0	2	35	1	-	-	2	2	4	2	2	3	2	1	4	1	-	-	1	-	-
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1	-	-	1	-	-	2	2	4	2	1	3	1
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1	-	-	1	-	-	1	-	-	1	-	-	0
1	-	-	2	1	3	1	-	-	1	-	-	1

Appendix D: Data Outputs – Anova Correlations, and Scale Reliability Statistics

Descriptives

TotalVPTGI

	N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Minimum	Maximum
					Lower Bound	Upper Bound		
Private Practice	19	43.0526	28.19865	6.46921	29.4613	56.6439	.00	91.00
Clinic/institution	45	35.2889	24.32603	3.62631	27.9805	42.5972	.00	92.00
Total	64	37.5938	25.55897	3.19487	31.2093	43.9782	.00	92.00

ANOVA

TotalVPTGI

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	805.246	1	805.246	1.237	.270
Within Groups	40350.192	62	650.810		
Total	41155.438	63			

Oneway

Descriptives

TotalWorkHassels

	N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Minimum	Maximum
					Lower Bound	Upper Bound		
Private Practice	19	42.3158	36.38078	8.34632	24.7808	59.8508	4.00	133.00
Clinic/institution	45	94.1556	52.05153	7.75938	78.5175	109.7936	15.00	195.00
Total	64	78.7656	53.29425	6.66178	65.4531	92.0781	4.00	195.00

ANOVA

TotalWorkHassels

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	35901.468	1	35901.468	15.562	.000
Within Groups	143036.016	62	2307.033		
Total	178937.484	63			

Descriptives

TotalWorkUplifts

	N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Minimum	Maximum
					Lower Bound	Upper Bound		
Private Practice	19	159.5263	63.45897	14.55849	128.9401	190.1126	14.00	230.00
Clinic/institution	45	148.2667	53.38003	7.95742	132.2295	164.3038	.00	260.00
Total	64	151.6094	56.28093	7.03512	137.5508	165.6679	.00	260.00

ANOVA

TotalWorkUplifts

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	1693.698	1	1693.698	.531	.469
Within Groups	197861.537	62	3191.315		
Total	199555.234	63			

Correlations

		Place of work	%_of_career_working_with_trauma	%_of_week_spent_with_trauma_clients	Amount of time working as a therapist	TotalWorkHassels	TotalWorkUplifts	TotalVPTGI
Place of work	Pearson Correlation	1.000	-.031	.025	-.004	.448**	-.092	-.140
	Sig. (2-tailed)		.809	.845	.974	.000	.469	.270
	N	64	64	64	64	64	64	64
%_of_career_working_with_trauma	Pearson Correlation	-.031	1.000	.576**	-.019	.080	.196	.265*
	Sig. (2-tailed)	.809		.000	.879	.527	.121	.035
	N	64	64	64	64	64	64	64
%_of_week_spent_with_trauma_clients	Pearson Correlation	.025	.576**	1.000	-.176	.068	.198	.298*
	Sig. (2-tailed)	.845	.000		.163	.592	.116	.017
	N	64	64	64	64	64	64	64
Amount of time working as a therapist	Pearson Correlation	-.004	-.019	-.176	1.000	.078	-.019	-.061
	Sig. (2-tailed)	.974	.879	.163		.541	.879	.631
	N	64	64	64	64	64	64	64
TotalWorkHassels	Pearson Correlation	.448**	.080	.068	.078	1.000	.025	.069
	Sig. (2-tailed)	.000	.527	.592	.541		.847	.588
	N	64	64	64	64	64	64	64

TotalWorkUplifts	Pearson Correlation	-.092	.196	.198	-.019	.025	1.000	.413**
	Sig. (2-tailed)	.469	.121	.116	.879	.847		.001
	N	64	64	64	64	64	64	64
TotalVPTGI	Pearson Correlation	-.140	.265*	.298*	-.061	.069	.413**	1.000
	Sig. (2-tailed)	.270	.035	.017	.631	.588	.001	

Correlations

Variables=TotalVPTGI,Statistics=Pearson Correlation

Place of work	-.140
Working with people who listen	.285*
Working with people who know what they are doing	.352**
Working with people who are considerate	.259*
Working with people I like	.259*
Working with competent people	.244
Working hard	.240
Work fitting in with other activities	.164
Work fitting in with family obligations	.130
Tidy work area	.042
Support for my work from my family	.247*
Sufficient time with family	.123
Superiors who listen	.131
Superiors who I can turn to for help or advice	.117
Superiors who are open	.196
Superiors who are honest about my work	.177
Superiors trusting me	.133
Superiors delegating work	.269*
Solving a problem	.226
Safe work environment	.238
Results of my plans taking effect	.237
Receiving recognition for good work	.334**
Receiving feedback on how I am doing my job	.324**
Providing quality service	.285*
Personal reaction from other staff	.322**
Other staff doing the right thing	.346**
Meeting deadlines	.341**

Making popular decisions	.124
Making decisions	.354**
Helping clients	.346**
Helpful superiors (e.g. manager/supervisor/head psychologist)	.075
Having variety in my work	.367**
Having sufficient resources	.309*
Having responsibility	.206
Having a say in decisions	.396**
Good work hours	.158
Good facilities	.227
Getting things done	.197
Getting along with other staff	.085
Flexible work hours	.312*
Equipment working	.329**
Equipment being available	.308*
Doing worthwhile work	.307*
Doing interesting work	.320*
Doing challenging work	.331**
Days off	.268*
Comfortable work environment	.259*
Clarity of operation protocol	.274*
Being involved in decision making	.402**
Being able to make a difference	.347**
Being able to act on my own	.243
Balance between work and home life	.260*
Application of rules and policy	.276*
Achieving a heavy workload	.208
TotalVPTGI	1.000

Between-Subjects Factors

		Value Label	N
Place of work	1	Private Practice	19
	2	Clinic/institution	45

Reliability Statistics PDHS

Cronbach's Alpha	N of Items
.966	57

Reliability Statistics PDUS

Cronbach's Alpha	N of Items
.966	53

Reliability Statistics PTGI

Cronbach's Alpha	N of Items
.945	21

Descriptive Statistics

Dependent Variable=A lack of encouragement from superiors

Place of work	Mean	Std. Deviation	N
Private Practice	.16	.688	19
Clinic/institution	1.82	1.571	45
Total	1.33	1.564	64

Multivariate Tests[b]

Effect		Value	F	Hypothesis df	Error df	Sig.
Intercept	Pillai's Trace	.961	2.598[a]	57.000	6.000	.114
	Wilks' Lambda	.039	2.598[a]	57.000	6.000	.114
	Hotelling's Trace	24.683	2.598[a]	57.000	6.000	.114
	Roy's Largest Root	24.683	2.598[a]	57.000	6.000	.114
Place_of_work	Pillai's Trace	.919	1.197[a]	57.000	6.000	.452
	Wilks' Lambda	.081	1.197[a]	57.000	6.000	.452
	Hotelling's Trace	11.370	1.197[a]	57.000	6.000	.452
	Roy's Largest Root	11.370	1.197[a]	57.000	6.000	.452

a. Exact statistic

b. Design: Intercept + Place_of_work

Dependent Variable=Problems with following Australian Psychological Societyís Ethical Guidelines due to conflicting expectations in the workplace

Source	Type III Sum of Squares	df	Mean Square	F	Sig.
Corrected Model	6.254[be]	1	6.254	3.075	.084
Intercept	23.129	1	23.129	11.371	.001
Place_of_work	6.254	1	6.254	3.075	.084
Error	126.105	62	2.034		
Total	173.000	64			
Corrected Total	132.359	63			

be. R Squared = .047 (Adjusted R Squared = .032)

Multivariate Tests[b]

Effect		Value	F	Hypothesis df	Error df	Sig.
Intercept	Pillai's Trace	.975	7.215[a]	53.000	10.000	.001
	Wilks' Lambda	.025	7.215[a]	53.000	10.000	.001
	Hotelling's Trace	38.239	7.215[a]	53.000	10.000	.001
	Roy's Largest Root	38.239	7.215[a]	53.000	10.000	.001

Place_of_work	Pillai's Trace	.933	2.641[a]	53.000	10.000	.049
	Wilks' Lambda	.067	2.641[a]	53.000	10.000	.049
	Hotelling's Trace	13.995	2.641[a]	53.000	10.000	.049
	Roy's Largest Root	13.995	2.641[a]	53.000	10.000	.049

a. Exact statistic

b. Design: Intercept + Place_of_work

Source	Type III Sum of Squares	df	Mean Square	F	Sig.
Corrected Model	12.499[at]	1	12.499	5.245	.025
Intercept	583.999	1	583.999	245.086	.000
Place_of_work	12.499	1	12.499	5.245	.025
Error	147.736	62	2.383		
Total	779.000	64			
Corrected Total	160.234	63			

at. R Squared = .078 (Adjusted R Squared = .063)

Appendix E: Data Output - Frequencies

Place of work

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Private Practice	19	29.7	29.7	29.7
	Clinic/institution	45	70.3	70.3	100.0
	Total	64	100.0	100.0	

Age

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	20-30 years	16	25.0	25.0	25.0
	30-40 years	14	21.9	21.9	46.9
	40-50 years	8	12.5	12.5	59.4
	50-60 years	24	37.5	37.5	96.9
	60+ years	2	3.1	3.1	100.0
	Total	64	100.0	100.0	

Qualifications

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Postgrad Psych Degree	34	53.1	53.1	53.1
	4 years undergraduate + supervision	15	23.4	23.4	76.6
	4 years undergraduate	1	1.6	1.6	78.1
	Social Worker	9	14.1	14.1	92.2
	Other	5	7.8	7.8	100.0
	Total	64	100.0	100.0	

Registered with state registration board

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Registered	50	78.1	78.1	78.1
	Not registered	14	21.9	21.9	100.0
	Total	64	100.0	100.0	

Amount of time working as a therapist

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1-6 months	4	6.3	6.3	6.3
	6-12 months	2	3.1	3.1	9.4
	1-2 years	5	7.8	7.8	17.2
	2-5 years	12	18.8	18.8	35.9
	5-10 years	11	17.2	17.2	53.1
	10-15 years	13	20.3	20.3	73.4
	15-20 years	8	12.5	12.5	85.9
	20-25 years	5	7.8	7.8	93.8
	25-30 years	4	6.3	6.3	100.0
	Total	64	100.0	100.0	

%_of_career_working_with_trauma

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	0%	2	3.1	3.1	3.1
	10%	22	34.4	34.4	37.5
	20%	13	20.3	20.3	57.8
	30%	8	12.5	12.5	70.3
	40%	4	6.3	6.3	76.6
	50%	6	9.4	9.4	85.9
	60%	3	4.7	4.7	90.6
	70%	3	4.7	4.7	95.3
	80%	2	3.1	3.1	98.4
	90%	1	1.6	1.6	100.0

%_of_career_working_with_trauma

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	0%	2	3.1	3.1	3.1
	10%	22	34.4	34.4	37.5
	20%	13	20.3	20.3	57.8
	30%	8	12.5	12.5	70.3
	40%	4	6.3	6.3	76.6
	50%	6	9.4	9.4	85.9
	60%	3	4.7	4.7	90.6
	70%	3	4.7	4.7	95.3
	80%	2	3.1	3.1	98.4
	90%	1	1.6	1.6	100.0
	Total	64	100.0	100.0	

%_of_week_spent_with_trauma_clients

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	0%	1	1.6	1.6	1.6
	10%	31	48.4	48.4	50.0
	20%	9	14.1	14.1	64.1
	30%	5	7.8	7.8	71.9
	40%	3	4.7	4.7	76.6
	50%	8	12.5	12.5	89.1
	60%	1	1.6	1.6	90.6
	70%	4	6.3	6.3	96.9
	80%	1	1.6	1.6	98.4
	90%	1	1.6	1.6	100.0
	Total	64	100.0	100.0	

Sought help for work stress

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes i have sought help from a psychologist	32	50.0	50.0	50.0
	No i have not sought help from a psychologist	32	50.0	50.0	100.0
	Total	64	100.0	100.0	

Appendix F: Online Questionnaires

Compassion Satisfaction and Fatigue

How do organisational factors affect the Psychologist/Therapist in Private Practice compared to those in Clinic/Institutional Employment?

Please Specify your age group 20-30 years	**Please indicate if you work in:** Private Practise **(If you work in both categories, please choose the place you spend most of your working week)**
Please indicate your psychology/therapy training/qualifications: Postgraduate psychology degree **If other please specify below:**	**Please indicate if you are currently a registered psychologist with your state Registration Board:** Yes I am registered
Please indicate amount of time (months/years) working as a therapist: 1-6 months	**Please indicate the percentage of your CAREER spent working specifically with trauma victims:** 0%
Please indicate the percentage of your WORKING WEEK spent working specifically with trauma victims: 0%	**Please indicate if you have ever visited a Psychologist (or any other mental health provider) for work related stress:** Yes, I have

Listed below are 58 ways in which a person can feel **PRESSURED, HASSLED OR BOTHERED** as a result of their work.

Read each statement carefully, and indicate if it describes something that has made you feel pressured, hassled or bothered as a result of your work **during the past month**. If a statement **does not** apply to you (the situation did not happen to you, or did not make you feel hassled, bothered or pressured), please select'**0**'; if a statement applies strongly to you select'**5**'; and if it applies to some extent select'**1**' '**2**' '**3**' or '**4**' as appropriate.

Please remember, only circle 1 to 5 as appropriate if the experience actually happened and made you feel hassled, pressured or bothered during the past month.

1. A lack of encouragement from superiors 0 - Does not apply to me
2. Absence of emotional support from others outside work 0 - Does not apply to me
3. Absence of stability or dependability in home life 0 - Does not apply to me
4. An absence of any potential career advancement 0 - Does not apply to me
5. Being held accountable for things, I didn't do. 0 - Does not apply to me
6. Being held accountable for things I'm not responsible for. 0 - Does not apply to me

7. Being told what to do by others 0 - Does not apply to me
8. Budget constraints 0 - Does not apply to me
9. Conflict with colleagues over work practices 0 - Does not apply to me
10. Demands that work makes on my private or social life 0 - Does not apply to me
11. Excessive paperwork 0 - Does not apply to me
12. Feelings of having to conform to 'pressure'. 0 - Does not apply to me
13. Having far too much work to do. 0 - Does not apply to me
14. Having to adopt a negative role toward others. 0 - Does not apply to me
15. Having to work very long hours. 0 - Does not apply to me
16. Home life with a partner who is also pursuing a career 0 - Does not apply to me
17. Inability to change the system 0 - Does not apply to me
18. Inadequate feedback about my own performance. 0 - Does not apply to me
19. Inadequate guidance and back up from superiors. 0 - Does not apply to me
20. Inappropriate rules and regulations. 0 - Does not apply to me
21. Insufficient finance or resources to work with. 0 - Does not apply to me
22. Insufficient resources 0 - Does not apply to me
23. Insufficient time to complete a job 0 - Does not apply to me
24. Irregular meal times 0 - Does not apply to me
25. Job insecurity. 0 - Does not apply to me
26. Lack of clarity in operational protocol 0 - Does not apply to me
27. Lack of consultation and communication 0 - Does not apply to me
28. Lack of forward planning 0 - Does not apply to me
29. Lack of practical support from others outside work 0 - Does not apply to me
30. Lack of support from my superiors 0 - Does not apply to me

31. Low morale 0 - Does not apply to me
32. Meeting deadlines 0 - Does not apply to me
33. Missing meals 0 - Does not apply to me
34. My spouse's attitude towards my job and career 0 - Does not apply to me
35. Not being able to 'switch off' at home 0 - Does not apply to me
36. Other staff not pulling their weight 0 - Does not apply to me
37. 'Personality' clashes with others 0 - Does not apply to me
38. Poor administration 0 - Does not apply to me
39. Poor communication between staff and management 0 - Does not apply to me
40. Problems with co-workers 0 - Does not apply to me
41. Rushed eating 0 - Does not apply to me
42. Lack of opportunity for staff participation in policy and decision-making 0 - Does not apply to me
43. Taking my work home 0 - Does not apply to me
44. Threat of impending redundancy 0 - Does not apply to me
45. Too much expected of me 0 - Does not apply to me
46. Too much red tape to get something done 0 - Does not apply to me
47. Too much supervision 0 - Does not apply to me
48. Uncertainty about my future career prospects 0 - Does not apply to me
49. Under promotion – working at a level below my level of ability 0 - Does not apply to me
50. Unnecessary forms 0 - Does not apply to me
51. Working with people who are incompetent 0 - Does not apply to me
52. Working with people who are inconsiderate 0 - Does not apply to me
53. Working with people who are not suited to the job 0 - Does not apply to me

54. Working with people who do not listen [0 - Does not apply to me]

55. Working with people who lack professionalism [0 - Does not apply to me]

56. Demands my work makes on my relationship with my spouse, partner or children [0 - Does not apply to me]

57. Problems with following Australian Psychological Society's Ethical Guidelines due to conflicting expectations in the workplace [0 - Does not apply to me]

58. Other (please list any negative aspects of your work that we have missed)

Listed below are a number of situations at work, which may make you **FEEL GOOD**.

They can be a source of enthusiasm, peace, satisfactory or joy. Read each statement carefully, and indicate if it describes something that has made you feel good as a result of your work during the past month. If a statement does not apply to you (the situation did not happen to you, or did not make you feel good), please circle '**0**'; if a statement applies strongly to you circle '**5**'; and if it applies to some extent circle '**1**' '**2**' '**3**' or '**4**' as appropriate.

Please remember, only circle 1 to 5 as appropriate if the experience actually happened and made you feel good during the past month.

1. Working with people who listen [0 - Does not apply to me]
2. Working with people who know what they are doing [0 - Does not apply to me]
3. Working with people who are considerate [0 - Does not apply to me]
4. Working with people I like [0 - Does not apply to me]
5. Working with competent people [0 - Does not apply to me]
6. Working hard [0 - Does not apply to me]
7. Work fitting in with other activities [0 - Does not apply to me]
8. Work fitting in with family obligations [0 - Does not apply to me]
9. Tidy work area [0 - Does not apply to me]
10. Support for my work from my family [0 - Does not apply to me]
11. Sufficient time with family [0 - Does not apply to me]
12. Superiors who listen [0 - Does not apply to me]
13. Superiors who I can turn to for help or advice [0 - Does not apply to me]
14. Superiors who are open [0 - Does not apply to me]

15. Superiors who are honest about my work 0 - Does not apply to me
16. Superiors trusting me 0 - Does not apply to me
17. Superiors delegating work 0 - Does not apply to me
18. Solving a problem 0 - Does not apply to me
19. Safe work environment 0 - Does not apply to me
20. Results of my plans taking effect 0 - Does not apply to me
21. Receiving recognition for good work 0 - Does not apply to me
22. Receiving feedback on how I am doing my job 0 - Does not apply to me
23. Providing quality service 0 - Does not apply to me
24. Personal reaction from other staff 0 - Does not apply to me
25. Other staff doing the right thing 0 - Does not apply to me
26. Meeting deadlines 0 - Does not apply to me
27. Making popular decisions 0 - Does not apply to me
28. Making decisions 0 - Does not apply to me
29. Helping clients 0 - Does not apply to me
30. Helpful superiors (e.g. manager/supervisor/head psychologist) 0 - Does not apply to me
31. Having variety in my work 0 - Does not apply to me
32. Having sufficient resources 0 - Does not apply to me
33. Having responsibility 0 - Does not apply to me
34. Having a say in decisions 0 - Does not apply to me
35. Good work hours 0 - Does not apply to me
36. Good facilities 0 - Does not apply to me
37. Getting things done 0 - Does not apply to me

38. Getting along with other staff [0 - Does not apply to me]

39. Flexible work hours [0 - Does not apply to me]

40. Equipment working [0 - Does not apply to me]

41. Equipment being available [0 - Does not apply to me]

42. Doing worthwhile work [0 - Does not apply to me]

43. Doing interesting work [0 - Does not apply to me]

44. Doing challenging work [0 - Does not apply to me]

45. Days off [0 - Does not apply to me]

46. Comfortable work environment [0 - Does not apply to me]

47. Clarity of operation protocol [0 - Does not apply to me]

48. Being involved in decision making [0 - Does not apply to me]

49. Being able to make a difference [0 - Does not apply to me]

50. Being able to act on my own [0 - Does not apply to me]

51. Balance between work and home life [0 - Does not apply to me]

52. Application of rules and policy [0 - Does not apply to me]

53. Achieving a heavy workload [0 - Does not apply to me]

54. Other (please list any positive aspects of your work that we have missed).

Post Traumatic Growth Inventory

ndicate for each of the 21 statements below, the degree to which this **POSITIVE** change occurred in your life as result of **HEARING ABOUT OTHER PEOPLES CRISIS**, using the following scale.

= I did not experience this change
= I experienced this change to a very small degree
= I experienced this change to a small degree
= I experienced this change to a moderate degree
= I experienced this change to a great degree
= I experienced this change to a very great degree

1. I changed my priorities about what is important in life. 0 = I did not experience this change
2. I have a greater appreciation for the value of my own life. 0 = I did not experience this change
3. I developed new interests. 0 = I did not experience this change
4. I have a greater feeling of self-reliance. 0 = I did not experience this change
5. I have a better understanding of spiritual matters. 0 = I did not experience this change
6. I more clearly see that I can count on people in times of trouble. 0 = I did not experience this change
7. I established a new path for my life. 0 = I did not experience this change
8. I have a greater sense of closeness with others. 0 = I did not experience this change
9. I am more willing to express my emotions. 0 = I did not experience this change
10. I know better that I can handle difficulties. 0 = I did not experience this change
11. I am able to do better things with my life. 0 = I did not experience this change
12. I am better able to accept the way things work out. 0 = I did not experience this change
13. I can better appreciate each day. 0 = I did not experience this change
14. New opportunities are available which wouldn't have been otherwise. 0 = I did not experience this change
15. I have more compassion for others. 0 = I did not experience this change
16. I put more effort into my relationships. 0 = I did not experience this change
17. I am more likely to try to change things which need changing. 0 = I did not experience this change
18. I have a stronger religious faith. 0 = I did not experience this change
19. I discovered that I'm stronger than I thought I was. 0 = I did not experience this change
20. I learned a great deal about how wonderful people are. 0 = I did not experience this change
21. I better accept needing others. 0 = I did not experience this change

Traumatic Stress Schedule

he following questions ask you about any possible traumatic events you may have experienced. **A traumatic vent is any event, which is outside your normal range of experiences**.

ome people only ever have one or two traumatic experiences in a lifetime while some have many more. Listed elow are a few traumatic experiences, which may have happened to you. **You are not required to answer any f the following questions if you find them upsetting**.

) Did you ever serve in military combat, or in peacekeeping duties? NO (Please go to question 2)

id this happen -

/hen did this happen? (if it happened more than once, please give the last time) -

) Did anyone ever take something from you by force or threat of force such as in robbery, mugging or hold-up?
NO (Please go to question 3)

id this happen -

/hen did this happen? (if it happened more than once, please give the last time) -

) Have you ever been assaulted, injured or had your life placed under threat by another person?
NO (Please go to question 4)

id this happen -

/hen did this happen? (if it happened more than once, please give the last time) -

) Did anyone ever make you have sex by using force or threatening to harm you? This includes any type of nwanted sexual activity.

NO (Please go to question 5)

id this happen -

/hen did this happen? (if it happened more than once, please give the last time) -

) Has a close friend or family member ever died because of an accident, homicide, or suicide?

NO (Please go to question 6)

id this happen -

/hen did this happen? (if it happened more than once, please give the last time) -

) Did you ever suffer injury or property damage because of fire? NO (Please go to question 7)

id this happen -

/hen did this happen? (if it happened more than once, please give the last time) -

) Did you ever suffer injury, evacuation, or property damage because of severe weather or either a natural or a an-made disaster?

NO (Please go to question 8)

id this happen -

/hen did this happen? (if it happened more than once, please give the last time) -

) Were you ever in a motor vehicle accident serious enough to cause injury to one or more passengers?

NO (Please go to question 9)

id this happen -

/hen did this happen? (if it happened more than once, please give the last time) -

) Did you ever have some other shocking or distressing experience, something that has not been mentioned yet?

NO (Please go to question 10)

id this happen -

/hen did this happen? (if it happened more than once, please give the last time) -

) Since becoming a therapist, has a client died because of accident, homicide, or suicide?

O (Please go to question 11)

id this happen -

hen did this happen? (if it happened more than once, please give the last time) -

1) What is the worst thing that has ever happened to you?

Thank you for taking the time to fill in this questionnaire!

If you have any questions or would like any additional information regarding this study please contact Assoc. Prof. Douglas Paton (03 6324 3168; Douglas.Paton@utas.edu.au) or Lydia Blundell (0408 540 888; lydiab@postoffice.utas.edu.au)

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