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Vicarious Posttraumatic Growth and Attachment Style in Mental Health Professionals

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VICARIOUS POSTTRAUMATIC GROWTH AND ATTACHMENT STYLE IN
MENTAL HEALTH PROFESSIONALS

A DISSERTATION

Submitted to the Faculty of
Montclair State University in partial fulfillment
of the requirements
for the degree of Doctor of Philosophy

by
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2014

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THE GRADUATE SCHOOL

DISSERTATION APPROVAL

We hereby approve the Dissertation

VICARIOUS POSTTRAUMATIC GROWTH AND ATTACHMENT STYLE IN MENTAL HEALTH PROFESSIONALS

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ABSTRACT

VICARIOUS POSTTRAUMATIC GROWTH AND ATTACHMENT STYLE IN MENTAL HEALTH PROFESSIONALS

by Claire J. Wooloff

Mental health professionals treating clients who are trauma survivors spend many hours listening to traumatic material. The impact of this material may affect the individual in different ways. Some of the negative effects are documented in the literature as vicarious traumatization (Pearlman & Saakvitne, 1995), compassion fatigue (Figley, 1995, 2002) and burnout (Baird & Jenkins, 2003). However, mental health professionals also attest to the positive side of their work including posttraumatic growth (Arnold, Calhoun, Tedeschi & Calhoun, 2005) and compassion satisfaction (Stamm, 2010). Little is known about why some individuals may be impacted negatively, but others experience psychological growth. Attachment theory provided a framework to understand individual differences in relational characteristics that may predict vicarious traumatization or vicarious growth.

This study explored the role of attachment style as a predictor of positive and negative psychological changes in mental health professionals. Positive psychological change was conceptualized as compassion satisfaction and posttraumatic growth. Negative psychological change was conceptualized as compassion fatigue/secondary traumatic stress and burnout. Secure attachment was not predictive of positive or negative changes in this sample. Sense of coherence levels proved to be the most significant predictor of both positive and negative changes in trauma therapists. Age and supervision
were also predictors of positive growth, and being a survivor of trauma was significantly related to compassion satisfaction. Implications for practice and for future research are discussed.
ACKNOWLEDGEMENTS

They say, “It takes a village to raise a child…..” And my village has enabled me to bring my work to fruition. I would like to use this opportunity to thank the following:

To my committee chair, Dr. Larry Burlew who has seen me through the ups and downs, and without whom I could not have completed the task. Larry, I am so very grateful for your patience, your insight and your consistently helpful comments. You have held me to a high standard and I hope I have reached it. I have learned so much from you as a professor, a colleague and a friend. I know this came at an incredibly busy and stressful time in your life, but you have been so responsive and accessible to me. I wish you a long and relaxing retirement, it is much deserved and I am only happy I made it before the beaches of Florida claimed you. Thank you for everything.

To Dr. Catherine Roland, without whom there would have been no doctoral program to graduate from. I am deeply appreciative of all the opportunities you have offered me since we first met in my Master’s program. You have been a wonderful mentor, an inspiring teacher and supportive clinical supervisor. For the many roles you have played in my life since I started this journey, I can only thank you, knowing that you have always been there for me.

To Dr. Les Kooymen, thank you for being on my committee, for your positive and encouraging feedback. I have enjoyed working with you and appreciate all you have done.
To Dr. Brian Carolan, you never said it would be easy and it wasn’t! But I thank you for challenging me to do more than I ever thought possible, for believing I could do it, and for staying with me through the process.

To the faculty and staff of the counseling department, it has been many years since I first started in my master’s and then doctoral program at MSU. Thank you for all the care I have been shown, the classes I have enjoyed and for making MSU the awesome place it is. I will miss you.

To my support group: Dr. Vanessa Alleyne, my good friend and colleague. Without your encouragement and shoulder to cry on I would have been lost. Thank you for all the hours you’ve listened to me, the good advice you’ve offered, for giving me a place to stay on my trips back to Montclair, and for being a truly caring friend.

Dean Margaree Coleman-Carter and Ms. Marsha Coleman-Young; you are both my dearest friends and mentors. I am blessed that you are in my life. I thank you both for being there when I needed you.

Ms. Julia Mazzarella: you are a wonderful and kind person. You truly kept me going in those first months after I moved and felt so lost and disconnected. Your steadfast belief in me helped me through those difficult moments and got me through. I hope I can provide you with as much support as you have offered me. We’ll be there together next May!

To my doctoral colleagues: I am delighted to see the successes of those who made it before me and I eagerly anticipate the success of those still to come. I have learnt so much from all of you.
To the Texas Counseling Association’s Educational Endowment Fund Committee for their generous award towards dissertation costs: I am most grateful.

I am also most appreciative of all the participant mental health professionals who took time out of their busy schedules to complete my survey.

Most of all I want to express my deepest love and appreciation for my family, my husband Uche and children, Theo and Jemima. Uche, your unstinting belief in me has carried me through the rough parts. Never did I expect to move thousands of miles from Montclair before I’d finished (actually not even then) but life with you is never dull. You have been my rock, you have supported me in so many ways and I will always be grateful. Thank you more than I can say.

Theo and Jemima, I am so proud of you both. I am sorry for all those hours when I said, “No, go away, I’m working!” Thank you for giving me the time to complete my task. Remember, if I can do it, so can you…
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Chapter One

Vicarious Posttraumatic Growth and Attachment Style in Mental Health Professionals

Introduction

Trauma affects the lives of many of our clients, whether through natural disasters such as hurricanes, fires, earthquakes, or via human hand, as in war and torture or through interpersonal violence. Counselors working with such clients are at an increased likelihood of experiencing a change in their own psychological functioning (Chrestman, 1999; Devilly, Wright & Varker, 2009; Herman, 1997). Changes may include avoidance of the trauma, feelings of horror, guilt, rage, grief, detachment, or dread, and may lead to burnout (Simpson & Starkey, 2006). These reactions may include symptoms similar to posttraumatic stress symptoms experienced by some trauma survivors (McCann & Pearlman, 1990) and may impact the counseling relationship. If counselors are unaware of this stress response, they may implicitly convey a message to clients that they are unwilling to hear the details of the client’s trauma, or be less likely to ask questions to facilitate dialogue related to the event (Simpson & Starkey, 2006). This can result in a re-victimization of individuals who often have limited environments in which telling their story is safe and acceptable (McCann & Pearlman, 1990).

Researchers have identified vicarious traumatization (VT) (McCann & Pearlman, 1990), secondary traumatic stress (STS), compassion fatigue (CF) (Figley, 2002), and burnout (Figley, 1998) to be some of the risks for mental health professionals providing services for trauma survivors. Along with the research on the negative effects of working with trauma survivors, a few positive effects have been noted. These have included gains
in relationship skills, increased appreciation for the resilience of the human spirit, the satisfaction of observing clients’ growth and being a part of the healing process, personal growth, and spiritual well-being (Linley & Joseph, 2004).

Tedeschi and Calhoun (1996) referred to the positive changes that an individual may experience as a result of the struggle with highly challenging life circumstances as posttraumatic growth. This phenomenon is distinct from similar concepts such as resilience, hardiness, or optimism, in that posttraumatic growth implies not just the ability to resist the damages of trauma, but also a transformation of established schemas that results in a change in functioning (Tedeschi & Calhoun, 2004). The posttraumatic growth process begins with a traumatic event that severely upsets an individual’s pre-trauma schemas, or the way in which the individual perceived the world before the trauma. The individual then engages in coping responses, including cognitive processing of the event, to mitigate distressing emotions (Tedeschi & Calhoun, 2004). The extent to which an individual cognitively processes the trauma is a major influence on the outcome of the posttraumatic growth process, and seems to be related to the development of wisdom about life and the individual’s life narrative (Tedeschi & Calhoun, 2004).

Just as trauma counselors may experience the negative effects of working with the primary victims of trauma described variously as VT, STS, CF and burnout, so it is possible for counselors to experience vicarious posttraumatic growth (Arnold et al., 2005) and compassion satisfaction (Stamm, 2005). Vicarious posttraumatic growth is defined as “psychological growth following vicarious brushes with trauma” (Arnold, Calhoun, Tedeschi & Cann, 2005, p.243). Although much of the research on
posttraumatic growth focused on direct survivors of traumatic events, there is some research looking at vicarious posttraumatic growth, for example, in disaster workers (Linley & Joseph, 2006); interpreters (Splevins, Cohen, Joseph, Murray & Bowley, 2010); ambulance workers (Shakespeare-Finch, Smith, Gow, Embelton, & Baird, 2003); funeral workers (Linley & Joseph, 2005); and counselors and psychotherapists (Arnold et al., 2005; Joseph & Linley, 2005).

The role of individual differences related to whether a counselor will experience vicarious growth when exposed to clients’ experiences is still largely unexplored. In particular, the role that attachment style may play has not been investigated. Attachment theory (Bowlby, 1973, 1980) has generated extensive research on caregiving and emotional regulation in stressful situations and provides a framework for understanding the inner resources that can sustain counselors as they deal with the emotional strains of caring for traumatized people (Mikulincer & Shaver, 2007; Pardess, Mikulincer, Dekel, & Shaver, 2013). Very few studies have examined attachment styles in relation to posttraumatic growth, but a secure attachment style was associated with growth among torture survivors (Salo, Qouta & Punamaki, 2005). Dekel (2007) found that the anxiety and avoidance dimensions of attachment were associated with posttraumatic growth among wives of prisoners of war, and posttraumatic growth was positively associated with attachment anxiety in Turkish university students experiencing traumatic events (Arikan & Karanci, 2012).

This study investigated predictors of vicarious posttraumatic growth and compassion satisfaction, and examined the role played by attachment styles. This
information may contribute to the theory of adult attachment and caregiving enabling therapists to care for both their clients and themselves more effectively and may contribute to a better understanding of compassion satisfaction and posttraumatic growth.

**Background Research**

Working with people who have experienced trauma is recognized as being emotionally demanding. Therapists are called upon to be empathic, understanding and giving, yet they must control their own emotional needs and responsiveness in dealing with their clients (Simpson & Starkey, 2006). Whilst engaging empathically with an adult who has been traumatized, counselors are at risk of experiencing a state of emotional, mental and physical exhaustion. Treatments for Posttraumatic Stress Disorder (PTSD) often involve elements of exposure work, such as prolonged exposure therapy (PET; Foa, Hembree, & Rothbaum, 2007) and cognitive processing therapy (CPT; Resick, Monson, & Chard, 2008). These therapies have been recognized as recommended treatments for PTSD (e.g., Ponniah & Hollon, 2009) and typically involve clients describing their traumatic experience(s) and counselors listening to the trauma narrative. This vicarious exposure to traumatic material may significantly affect counselors both personally and professionally. This work can be a profound experience; becoming skilled requires facing not only one’s own limitations as a clinician, but also as a human being (Simpson & Starkey, 2006).

Research on the well-being of trauma counselors has focused almost exclusively on the deleterious effects of caring. The negative effects of providing trauma therapy on counselors have been described in several different terms, including secondary traumatic
stress (STS) and compassion fatigue (CF) (Figley, 1995) and vicarious trauma (VT, Figley, 1995; McCann & Saakvitne, 1995). It has been suggested that both STS and VT arise from assimilating the traumatic material of clients, and can manifest in general distress with burnout (Jenkins & Baird, 2002). Counselors suffering from STS develop the symptoms of PTSD as a result of listening to trauma narratives, whereas counselors with VT experience changes in their schemas, views of the world, and their relationships, which are similar to the changes that occur in a traumatized individual (Pearlman & MacIan, 1995). Whereas some consider the terms STS and CF to be synonymous (e.g. Deighton, Gurris, & Traue, 2007), others consider CF to be a separate phenomenon, related to the psychological and emotional strain of empathic work (Sabin-Farrell & Turpin, 2003). The effects of vicarious traumatization, compassion fatigue, and secondary trauma refer to changes in one’s world view, inner experience, sense of safety, attitude toward work life, and possibly behavior. One conclusion that can be drawn is that, despite different terminology, there is consistent evidence for the negative effects on mental health professionals as a result of this work (Jenkins & Baird, 2002; Ortlepp & Friedman, 2002; Pearlman & MacIan, 1995).

However, this focus on the negative effects ignores the possibility of the personal growth and satisfaction that counselors themselves may experience as they seek to facilitate these developmental experiences in their clients following trauma (Linley & Joseph, 2007). There is a growing body of evidence with regard to people directly exposed to trauma, supporting the idea that it may lead to positive, as well as negative changes (e.g., Kashdan & Kane, 2011; Linley & Joseph, 2004; Saccinto, Prati,
Pietrantoni & Pérez-Testor, 2013; Shigemoto & Poyrazli, 2013). The positive change may not negate the distress felt, so the two may co-exist, a condition that can also be observed in those who have suffered a significant loss (Joseph & Butler, 2010). The positive effects on the mental health professionals working with trauma clients and why these occur still needs to be examined in more detail.

**Positive Effects of Counseling Trauma Clients**

**Compassion Satisfaction**

Compassion satisfaction is about the pleasure and gratification that trauma professionals may derive when they are able to do their work well (Stamm, 2010). Some counselors may experience enormous pleasure or contentment when the traumatized survivor or community they have worked with heals or is able to function better. Therapists may develop positive feelings toward their co-workers or feel optimistic about their ability to make a constructive difference in their work environment or the larger community. The concept of compassion satisfaction is supported by evidence indicating that while some counselors exposed to their clients' traumatic material become negatively affected, many others do not (Stamm, 2002). Recent research has found that specialized trauma training of therapists significantly increased compassion satisfaction and decreased compassion fatigue and burnout (Sprang Clark & Whit-Woosley, 2007).

Although there have been many studies of secondary stress and trauma work (Adams, Figley & Boscarino, 2008; Boscarino, Figley & Adams, 2004; Sabin-Farrell & Turpin, 2003) compassion satisfaction as a construct of interest has been excluded in these
studies. This study expanded the scope of inquiry by including compassion satisfaction and relating it to attachment orientation in trauma therapists.

**Posttraumatic Growth**

Within the last decade the topic of growth after adversity or trauma has become the subject of empirical research. Making meaning out of traumatic events was defined by Calhoun and Tedeschi (1998) as posttraumatic growth. They identified posttraumatic growth as both a process and an outcome. Posttraumatic growth is more than simply resilience, but refers to going beyond the previous levels of functioning (Linley & Joseph, 2005). Westphal and Bannanno (2007) identified posttraumatic growth as an idea that conveys “hope amid the increasing threat of global terrorism and man-made catastrophes” (p. 418).

There is now a substantial literature documenting positive changes following a wide range of stressful and traumatic events (for a review see Linley & Joseph, 2004). Vicarious experiences of posttraumatic growth have been shown in a variety of populations not directly suffering themselves, but exposed to the suffering of others, including counselors, funeral directors, disaster workers, spouses and parents of people with cancer, as well as people who observed the events of September 11th on television (Linley & Joseph, 2005, 2007; Linley, Joseph, & Loumidis, 2005). At least three categories of benefits have been identified after trauma: changes in self-perception; changes in personal relationships; and a changed philosophy of life (Tedeschi & Calhoun, 1996).
Personal and Professional Factors in the Literature

Factors that may help predict if the trauma therapist will experience posttraumatic growth in relation to their work have been examined in studies with mixed results. These studies suggested that these factors fall in three main areas – factors specific to the therapist, the therapeutic relationship, and the working environment. Identified predictors of growth are therapists’ sense of coherence, empathy, the therapeutic bond, and social support (Brockhouse, Msetfi, Cohen & Joseph, 2011; Linley et al., 2005; Linley & Joseph, 2007).

The concept of sense of coherence (SOC) is defined as a global orientation that expresses the extent to which one has a pervasive, enduring yet dynamic feeling of confidence, that one’s internal and external environment are predictable, and that there is a high probability that things will work out as well as can reasonably be expected (Antonovosky, 1987). For example, high SOC was a buffer against negative changes in the perceptions of psychotherapists and even contributed to positive changes in their perceptions (Linley, Joseph & Loumidis, 2005). Trauma counselors who reported high SOC experienced less compassion fatigue and burnout, and more compassion satisfaction (Ortlepp & Friedman, 2002).

Therapists receiving personal therapy, either current or past, reported more positive psychological changes, as did therapists receiving clinical supervision, and those who had a personal trauma history (Joseph & Linley, 2007). Specialized trauma training of therapists significantly increased compassion satisfaction (Sprang, Clark & Whitt-Woosley, 2007). Female therapists who were receiving personal therapy and supervision
for their clinical work reported more positive psychological findings (Joseph & Linley, 2007). A higher internal locus of control in the workplace resulted in higher levels of compassion satisfaction in clinicians working with trauma survivors (Killian, 2008). In addition, the higher the number of hours per week spent working with traumatized people, the lower the compassion satisfaction score (Killian, 2008). But Joseph & Linley (2007) found those who worked a greater number of trauma cases per workload reported more personal growth and positive change, and Brockhouse et al. (2011) concluded higher cumulative levels of vicarious exposure to trauma predicted higher levels of growth.

Both positive and negative psychological effects of trauma work are the result of a unique experience between the professional’s work and the self. As Saakvitne & Pearlman (1996) discussed, this represents a complex, multifaceted set of interactions between person, situation and environment. In order to control for those factors that have been identified to contribute to psychological changes in trauma therapists, information about personal factors such as age, gender, race, personal history of trauma, and personal therapy was collected. Also, information about the professional environment – specialist training, and supervision was collected.

One factor specific to the therapist that has not been examined is the role attachment style may play in predicting vicarious posttraumatic growth and compassion satisfaction. Attachment style may have a significant impact on how vicarious exposure to trauma and resultant levels of growth are experienced.
Attachment Theory

Attachment theory has become one of the primary frameworks for understanding emotion regulation and interpersonal functioning in stressful situations (Currier, Holland & Allen, 2012). It encompasses a developmental perspective focusing on the importance of interpersonal relationships throughout the lifespan. The theory purports that a child’s sense of security is rooted in relationships with familiar figures, and that security is the necessary foundation for confident and productive exploration of the world and for developing the cognitive and social skills that are necessary throughout life (Makariev & Shaver, 2010).

According to attachment theory, the long-term effects of early experiences with caregivers are due to the persistence of “internal working models” – cognitive/affective schemas or representations of the self in relation to close relationship partners (Bartholomew, 1990; Bartholomew & Shaver, 1998; Shaver, Collins & Clark, 1996). Although the theory does not assume or require that internal working models persist without change across the life span, researchers (e.g., Bartholomew, 1990; Main, Kaplan, & Cassidy, 1985; Shaver, Hazan, & Bradshaw, 1988) undertaking longitudinal studies suggested that the effects of childhood attachment relationships extend into adulthood, where they can be seen in the domains of parenting and close peer relationships, including romantic relationships.

The model for adult attachment styles that was used for this study is based on Bowlby’s (1973) concept of the internal working model and developed by Bartholomew
and Horowitz (1991). The four attachment styles seen in adults are: secure, dismissing, preoccupied and fearful.

Pines (2004) suggested that secure attachment provided people with an inner resource that helps them to positively appraise stressful experiences and to cope with these in a constructive way. On the other hand, insecure attachment styles implied poor coping strategies, which can eventually lead to career burnout (Pines, 2004). Other research supports this argument: attachment styles moderated stressful experiences and the processing of emotional stimuli (Mikulincer & Shaver, 2007; Zilber, Goldstein, & Mikulincer, 2007). Racanelli (2005) studied mental health counselors working with trauma victims and observed that the avoidant attachment style was related to burnout. However few studies have explored the relationship between secure attachment and positive psychological change, or if vicarious posttraumatic growth may be related to attachment styles.

**Statement of the Problem**

The positive consequences that have been noted in the research literature tend to be mentioned in passing, in the context of more comprehensive explorations of the negative sequelae of trauma work. From the perspective of the trauma clinician, underlying the ability to cope with difficult affect, or internalization of client suffering is maintaining boundaries between the pain experienced by victims, a general sense of self, and a world perspective (Pearlman & Saakvitne, 1995). A sense of self, a larger world view and a perspective of person, place and relationships within the world, although influenced by multiple variables, were suggested to be rooted in core attachment
structures, dependent upon attachment history, internal working models and self-other representations (Bowlby, 1988; Fonagy, Gergely, Jurist & Target, 2002).

Researchers in the fields of PTSD (Van der Kolk, 1994) and vicarious trauma (McCann & Pearlman, 1990) have suggested the importance of the individual’s attachment experience in coping with stressful life events. Individual differences in attachment-system functioning can play an important role in determining the extent to which PTSD ensues following exposure to trauma. Bowlby (1988) suggested that the attachment system would be most strongly activated during times of stress. Counselors who listen to others’ trauma related stories on a daily basis may react differently and attempt to cope differently to trauma, based on their attachment style. Optimal functioning of the attachment system can allow even a severely threatened person to feel relatively safe and secure, thereby decreasing the likelihood of long term PTSD. In addition, attachment security may also contribute to the reconstruction of comforting, health sustaining beliefs shattered by trauma, otherwise known as post-traumatic growth (Tedeschi & Calhoun, 2004). Counselors working with trauma victims have identified significant and often profound personal growth after their vicarious brushes with clients’ trauma (Arnold, Calhoun, Tedeschi, & Cann, 2005) similar to post-traumatic growth. However, for those with less secure attachment orientations, vicarious traumatization may be more of a risk. Exploration of the internal coping mechanisms of counselors in response to working with trauma victims has been virtually overlooked in existing research (Simpson & Starkey, 2006).
Therefore, the overall research question I investigated was how the attachment styles of mental health professionals related to psychological growth and negative psychological change as a result of their work with trauma survivors. In addition, I considered the personal and professional factors that may be relevant to both the positive and negative changes.

The study investigated the following hypotheses:

1. After controlling for statistically significant demographic variables towards positive psychological growth, there will be a significant relationship between secure attachment style and posttraumatic growth.
2. Secure attachment style will be positively related to compassion satisfaction.
3. Non-secure attachment styles will be positively related to compassion fatigue and burnout.
4. Non-secure attachment styles will be negatively related to posttraumatic growth

In addition, this study examined the extent to which personal and professional factors identified in the literature were predictive of positive growth or negative psychological changes in trauma counselors.

**Purpose of the Study**

The purpose of the study was to explore the relationship between compassion satisfaction, vicarious posttraumatic growth and attachment style in trauma mental health professionals and to identify factors that were predictive of the positive aspect of these professionals’ growth. Measures of positive sequelae for counselors working with
trauma survivors were examined with regard to the following constructs: vicarious posttraumatic growth and compassion satisfaction. Because the research shows that positive growth can occur alongside the negative aspects of caring, I also measured compassion fatigue/secondary stress and burnout, to gain an overall picture of the impact of working with trauma clients and determined if these constructs were present along with aspects of growth. The aim was to identify the relationship of attachment style for counselors in developing positive sequelae when working with trauma clients.

**Significance of Study**

The need for well-functioning and healthy mental health professionals to address the needs of people who have been traumatized is critical and increasingly in demand in today’s world. The numbers of traumatized clients seeking help is likely to rise as veterans from the conflicts in Iraq and Afghanistan return to their communities (Van Horrell, Holohan, Didion, & Vance, 2011) and there is no lack of other human and natural events that create trauma. There has long been an awareness of the negative costs of caring and the need for counselors’ self-care is a recurrent theme in the literature (Baker, 2003; Figley, 1995; Stamm, 1999; Pearlman & MacIlan, 1995; Pross, 2006). It is not yet understood why some counselors experience burnout but others growth, and this study investigated if secure attachment style is predictive of this process.

Attachment theory provided a framework for understanding the inner resources that can sustain professionals as they deal with the emotional strains of caring for traumatized people (Pardess, Mikulincer, Dekel, & Shaver, 2013). Different attachment styles may predict more or less positive change in trauma counselors. Existing research
has examined attachment security and compassion fatigue and burnout (Pardess et al., 2013; Pines, 2004; Racanelli, 2005; Tosone, Minami, Bettman, & Jasperson, 2010). Tosone et al. (2010) examined the relationship between attachment, compassion fatigue and resiliency using a sample of social workers living in Manhattan following 9/11. Racanelli (2005) also considered compassion satisfaction along with compassion fatigue, with counselors working with victims of terrorism in New York and Israel. No published studies, to date, have examined attachment styles and vicarious posttraumatic growth in a general sample of trauma mental health professionals, yet it is important to have a better understanding of how working with trauma survivors may impact mental health professionals, in both positive and negative ways.

Currently there is a limited understanding of psychological growth and positive changes resulting from exposure to vicarious trauma among mental health professionals (Brockhouse et al., 2011). A majority of the research studies on posttraumatic growth have focused on direct trauma experience (e.g., Calhoun, Cann, Tedeschi & McMillan, 2000; Lawrence et al., 2007; McGrath & Linley, 2006; Tedeschi & Calhoun, 1996). Adult attachment and posttraumatic growth and negative emotions in political prisoners (Salo et al., 2005) found secure attachment played a protective role in enhancing posttraumatic growth, while men with insecure-avoidant attachment were vulnerable to negative emotional experience in the face of trauma.

Recently posttraumatic growth has been applied to vicarious trauma with inconsistent outcomes on the relationship of trauma exposure and growth (Linley, Joseph & Loumadis, 2005; Linley & Joseph, 2007). There is limited research on the
identification of predictors of posttraumatic growth (Putterman, 2006) and understanding of moderating effects (Brockhouse et al., 2011). The purpose of this study was to examine the relationship of attachment styles to vicarious posttraumatic growth and compassion satisfaction in mental health professionals who work with clients who have experienced trauma. This study looked at the overall impact of trauma on trauma counselors – not just vicarious trauma or vicarious growth, but both. This provided a more cohesive view of trauma work, rather than the traditional binary perception of either PTG or VT (Cohen & Collens, 2012). Because attachment theory may help us understand individual differences in mental health professionals’ responses to working with traumatized people and their ability to care effectively for them, it was important to examine the role secure attachment played in developing vicarious posttraumatic growth in trauma professionals.

In addition, personal and professional factors that have been identified as relevant to posttraumatic growth and compassion satisfaction were considered: gender, age, personal therapy, a personal history of trauma, specialist trauma training, clinical supervision and sense of coherence. Together with information about attachment style, this information contributed to the literature on the personal and professional variables that predicted vicarious posttraumatic growth and compassion satisfaction in trauma therapists.

**Definition of Terms**

*Attachment Style*—In this study, the four categories of attachment style were based on Bartholomew & Horowitz (1991) model used in the Relationship Questionnaire.
1. Secure: “it is easy for me to become emotionally close to others. I am comfortable depending on them and having them depend on me. I don’t worry about being alone or having others not accept me.”

2. Fearful: “I am uncomfortable getting close to others. I want emotionally close relationships, but I find it difficult to trust others completely, or to depend on them. I worry that I will be hurt if I allow myself to become too close to others.”

3. Preoccupied: “I want to be completely emotionally intimate with others, but I often find that others are reluctant to get as close as I would like. I am uncomfortable being without close relationships, but I sometimes worry that others don’t value me as much as I value them.”

4. Dismissing: “I am comfortable without close relationships. It is very important to me to feel independent and self-sufficient, and I prefer not to depend on others or have others depend on me (p. 244).”

Compassion Fatigue: A state experienced by those helping people in distress, characterized by an extreme state of tension, vicarious traumatization, and physiological and psychological symptoms. Compassion fatigue is conceptualized to include secondary traumatic stress. Compassion fatigue is often seen as one of the costs of caring for those in emotional distress (Figley, 2002; Stamm, 2010).

Compassion Satisfaction - The enjoyment and gratification that a professional trauma helper feels when they are able to perform their work well (Stamm, 2010).
Posttraumatic Growth - describes the “positive psychological change experienced as a result of the struggle with highly challenging circumstances” (Tedeschi & Calhoun, 2004, p. 1)

Secondary Traumatic Stress - refers to “the experience of tension and distress directly related to the demands of living with and caring for someone who displays the symptoms of post-traumatic stress disorder” (PTSD) (Figley, 1998, p. 7).

Sense of Coherence – describes the extent to which the world is seen as comprehensible, manageable, and meaningful (Antonovsky, 1987).

Trauma - Trauma is defined as the individual’s unique experience, associated with an event or enduring conditions in which a) the individual’s ability to integrate affective experiences is overwhelmed, b) the individual experiences a threat to life or bodily integrity, and c) disrupts the individual’s frame of reference and other psychological needs and related schemas (Pearlman & Saakvitne, 1995).

Vicarious Posttraumatic Growth – Increased recognition of personal strength; gains in self-confidence, sensitivity, and compassion; improved personal relationships; an enhanced appreciation for what is important in life; and spiritual growth, resulting from the provision of therapy to trauma survivors (Arnold, Calhoun, Tedeschi & Cann, 2005).

Vicarious Traumatization – A transformation in the therapist’s inner experience (such as disrupted cognitive schemas and intrusive trauma imagery) resulting in empathetic engagement with the client’s trauma material (Pearlman & Maclan, 1995).
Personal Factors

Age - For the purpose of this study, the chronological age of a participant at the time taking the survey.

Gender - For the purpose of this study gender was considered the therapist’s self-identified biological sex. Participants may identify as female, male or transgender.

Personal history of trauma - For the purpose of this study, participants self-identified as a trauma survivor.

Personal therapy - For the purpose of this study, participants self-identified as having received personal therapy at any time.

Professional Factors:

Specialist training - Participants had undertaken specialist training in trauma via continuing education, trauma certification, graduate courses, and/or specialist training.

Supervision – Participant had received clinical supervision with regard to trauma cases (i.e. not administrative supervision).

Organization of the Study

This dissertation includes five chapters. Chapter 1 provides an introduction to the literature on posttraumatic growth and attachment in trauma counselors, a statement of the problem, purpose of the study, and key terms. Chapter 2 is an in-depth literature review of the key concepts. Chapter 3 includes an overview of the methodology. Chapter 4 is a presentation of the results from the statistical analyses of the data. Finally, Chapter 5 is a discussion and interpretation of the results and the implications for practice, suggestions for areas of future research and limitation of the study.
Chapter Two

Literature Review

Increasingly counselors in all settings are dealing with clients who have experienced some sort of trauma (Trippany, White, Kress & Wilcoxon, 2004). Survivors of childhood sexual abuse, sexual assault, and intimate partner violence are reaching out for help, and then there are clients who have experienced natural disasters such as Hurricane Katrina or the 9/11 attacks. Not only are people traumatized by experiencing such events, but because of the news media constantly replaying traumatic images, such as people jumping from the World Trade Center towers, more people may be traumatized or re-traumatized by such events.

Mental health professionals, including counselors, psychotherapists, social workers and other licensed professionals provide an invaluable service to those in need. But working with a traumatized population, in particular, brings with it the need for highly-skilled, empathic clinicians who are not immune to the stories they hear.

Trauma Counseling

Psychological trauma is caused by experiencing a traumatic event that overwhelms a person’s ability to cope and/or the individual experiences an intense fear, helplessness, loss of control, or threat to life or bodily integrity (Pearlman & Saakvitne, 1995). The individual may feel emotionally, cognitively, and physically overwhelmed. The circumstances of the event commonly include abuse of power, betrayal of trust, entrapment, helplessness, pain, confusion, and/or loss (Giller, 2013). Unfortunately, traumatic events are frequent in our world and all people can be at risk for experiencing
traumatic events. This definition of trauma is broad, and encompasses responses to powerful one-time incidents such as accidents, natural disasters, crimes, surgeries, deaths, and other violent events. It also includes responses to chronic or repetitive experiences such as child abuse, neglect, combat, urban violence, concentration camps, battering relationships, and enduring deprivation. The individual's experience of these events or circumstances helps to determine whether it is a traumatic event. A particular event may be experienced as traumatic for one individual and not for another.

As a result of traumatic experiences one may develop posttraumatic stress disorder (PTSD) which consists of a range of emotional, behavioral, and cognitive symptoms that result from such events (Conrad & Perry, 2000). PTSD is “an adjustment disorder that may develop as a result of exposure to an extraordinary stressful event or series of events” (Figley, 1995, p.571). Common symptoms of PTSD include anxiety, startle responses, fatigue, sleep disturbances, intrusive thoughts, difficulty concentrating, and problems controlling anger (American Psychiatric Association, 2000). It is estimated that almost 70% of adults in this country have experienced a traumatic event at least once in their lives, and that up to 20% of these people go on to develop PTSD. An estimated 5% of Americans, more than 13 million people, have PTSD at any given time (PTSD: A Guide for the Front Line, n.d).

In therapy with the traumatized clients, the therapist becomes witness to, and through transference-counter transference enactments, sometimes part of, the past traumas of the client (Smith, Kleijn, Trijsburg & Hutschemaekers, 2007). This does not leave the therapist untouched, and there is a substantive literature chronicling the impact
of trauma therapy on the therapist in his/her empathic connection with the client (Smith et al., 2007). In a process called vicarious or secondary traumatization, a professional’s inner experience can be negatively transformed through empathic engagement with client’s trauma material (Cunningham, 1999; McCann & Pearlman, 1990; Pearlman & Maclan, 1995). In this process, trauma discussed in therapy sessions can be transferred from clients to the therapist, who can then become susceptible to psychological distress and PTSD symptomology (Figley, 2002; Sabin-Farrell & Turpin, 2003). In evidence-based treatment for PTSD clients, mental health professionals are providing services increasingly focused on traumatic memory and traumatic symptomology (Bober & Regehr, 2006). Studying the effects of working with trauma survivors is an important area of investigation because healthy, psychologically present and committed professionals are in a better position to offer assistance to trauma survivors than those providers who fall victim to compassion fatigue and burnout (Killian, 2008).

**Theoretical Framework—Attachment Theory**

The therapist brings their own personal characteristics and learned traits that will affect the therapeutic process (Beutler et al., 2004). Prolonged exposure to the client’s trauma narrative combined with the therapist characteristics may have negative effects (Marmaras, Lee, Siegel & Reich, 2003; Pearlman & Saakvitne, 1995) or positive effects (Tedeschi & Calhoun, 2004). Adult attachment style is a relational construct that can help us understand how an individual connects within human relationships (Wei, Russell, Malinckrodt & Vogel, 2008). John Bowlby proposed attachment theory as an account of how an individual bonds in a relationship (Bowlby, 1973). For trauma therapists their
adult attachment style is a relational characteristic that may either increase their likelihood of being negatively affected by client’s traumatic material, or enhance their chances of being positively affected, increasing compassion satisfaction and the potential for vicarious posttraumatic growth.

Attachment is an emotional bond to another person. John Bowlby was the first attachment theorist, describing attachment as a "lasting psychological connectedness between human beings" (Bowlby, 1969, p. 194). Bowlby believed that the earliest bonds formed by children with their caregivers have a tremendous impact that continues throughout life. During the attachment process, an infant begins to develop cognitive schemas regarding themselves and their attachment figures (Bowlby, 1973). The infant begins to build an inner working model of the world and themselves, based on their experiences with their attachment figures. If the infant believes the primary caregiver to be responsive to their needs, the infant will develop a positive working model of others – that is, I can depend on others to be there for me if I am hurt, or hungry. During this attachment process, the infant also develops a working model of self. If the care givers are reliable, then the infant develops a concept of self-worth (a positive model of self). If however, caregivers are not responsive, or unable to meet the infant’s needs, then the infant might develop a negative model of self. Infants with positive models of self and others are secure in their attachments (Bowlby, 1973). Attachment theory has been proposed as a way to explain the inner mechanisms of social bonding, the influences of past experiences in establishing relationships with others, and the role of attachment as a stress buffer (Bowlby, 1969; Mikulincer & Shaver, 2007).
Individuals vary in their early experiences and form different working models. The mental representations of the self and others contribute to attachment styles, and this early relationship would determine both the nature and quality of the individuals’ relationships in adulthood (Hazan & Shaver, 1987), how they cope with negative emotions, and how they develop constructive, adaptive strategies in times of stress in adulthood (Mikulincer & Shaver, 2005; Sroufe & Waters, 1997). Insecure individuals who were rejected as children may develop insecure attachment relationships with significant others later in life, whereas secure individuals who experienced positive relationships may continue to seek such relationships (Hazan & Shaver, 1994). For insecure individuals, those who are anxiously attached may show a preoccupation with intimacy and engage in proximity seeking behaviors, whereas avoidant attached individuals may require limited closeness with others (Mikulincer & Shaver, 2007). Thus, attachment theory may provide a way to understand emotional regulation following exposure to vicarious trauma and might help understand individual differences in reactions to trauma exposure.

**Attachment Styles**

Mary Ainsworth and colleagues used the strange situation paradigm to classify infant attachment into three different groups based on the observation of infant behavior when the child was separated and then reunited with her/his mother. During the experiment, infants were initially put into a room with their mother. After their mother left, a stranger entered and interacted with the infants. Then, the mother reappeared. Infants who cried when the mother left, but warmly greeted her when she reentered, were
classed as securely attached. Infants who appeared anxious, agitated and were not easily comforted were classed as anxious-ambivalently attached. These children showed conflicting feelings of seeking proximity and rejecting the mother. A separate group of insecurely attached infants showed little or no distress upon separation and avoided the mother on reunion, instead directing their attention towards their toys. These children were classed as avoidant. Later research by Main and Solomon, (1986) focused on those infants who were considered unclassifiable under Ainsworth’s original (1978) classification system. These infants showed contradictory behaviors on reunion, such as falling on the floor, or freezing in mid approach to the caregiver. This group was identified as the disorganized type, in which infants experience the loss of the primary caregiver or an abusive relationship with the primary caregiver and the infant’s perception of the parent is as abusive or frightening (Cassidy & Mohr, 2001).

These attachment relationship styles reflect the infants’ relationship types with their primary caregiver and are determined by their previous experiences with their parent or primary caregiver.

**Adult Attachment**

Bowlby (1969) proposed that attachment relationships and attachment styles might have a life-long impact on the individual’s life. These expectations form working models of self and other, which guide perceptions and behaviors in adult relationships.

Hazan & Shaver (1987) investigated attachment styles in adult romantic relationships. Referring to Ainsworth’s categories, they formulated three attachment styles for adult intimate relationships-secure, avoidant and anxious attachment. Building
on the work on adult attachment, Bartholomew and Horowitz (1991) proposed a two-dimensional model of attachment styles and attachment relationship in adulthood that represented the mental model of self (a person’s positive or negative view about him/herself) and the mental model of others (a person’s positive view of others as being available and caring, or a negative view of others as unreliable or rejecting). Compared to Hazan & Shaver’s model, this model added a new category; fearful attachment in which individuals have a negative model of both themselves and others. So, according to Bartholomew & Horowitz (1991) there are four attachment styles that depend on internal working models: secure, preoccupied, dismissing-avoidant, and fearful-avoidant. The secure individual has positive views of self and others, and is comfortable with intimacy and autonomy.

The preoccupied individual has a negative view of self, and a positive model of others, tends to be overly dependent on others and demonstrate high levels of anxiety and low levels of avoidance. They tend to be hyper vigilant to stress cues and preoccupation with their intimate relationships. Dismissing individuals have a positive view of self, a negative view of others and prefer to be independent in their relationships and expect others to be self-reliant as well. Finally, the fearful-avoidant individuals have negative models of self and others, which usually results in high levels of anxiety as well as the avoidance of intimate relationships and social avoidance.

Bartholomew and Horowitz (1991) developed the Relationship Questionnaire (RQ) to be a measure containing multi-sentence prototype descriptions of the four theoretical types. Participants completed the RQ, chose the description that best
characterized them, and they also rated how well each of the four descriptions fits them. The \( RQ \) was the measure used in this study to determine attachment style. Utilizing the self-report method, as in the \( RQ \), conceptualized adult attachment in the content and quality of the current romantic and friendship relationships, and personality characteristics. Self-report methods were used to capture the characteristic ways in which secure and insecure individuals feel about themselves and how they behave in their current important relationships (Collins, 1996; Feeney, Noller & Hanrahan, 1994; Shaver & Hazan, 1993).

**Attachment Theory and Counseling**

The relevance of adult attachment patterns to counseling and psychotherapy has been investigated in a growing number of studies that link insecure attachment patterns in clients with psychological problems and psychopathology. At a general level, the conclusion was that very few individuals with psychological disorders are classified as secure, but that there are a few clear cut connections between diagnostic categories and specific insecure attachment patterns (Crowell, Fraley & Shaver, 1999; Dozier, Stovall & Albus, 1999). However these were correlational studies, so no causal relationships can be inferred, and as most people with insecure attachment styles do not develop psychological disorders, insecure attachment is seen as more of a general risk factor (Daniel, 2011).

Attachment styles can also be predictive of a person’s ability to function as a secure base for another person who feels threatened or vulnerable. Therefore, the therapist’s own attachment style becomes an important variable in the therapeutic
relationship as attachment patterns are relevant to help-giving behavior (Daniel, 2011). Insecure therapists, relative to secure therapists, have greater difficulty maintaining a strong working alliance (Sauer, Lopez & Gormley, 2003) and tend to respond to clients less empathically (Rubino, Barker, Roth & Fearon, 2000). It appears likely that the therapist’s contributions to a good working alliance can be disrupted by his or her own attachment insecurities. In another study, Black, Hardy, Turpin and Parry (2005) found that securely attached therapists were more likely to report stronger alliances, whereas anxiously attached therapists reported weaker alliances and more therapy-related problems (e.g. “lacking the confidence that I have a beneficial effect on the client”). Interestingly these associations were found even after controlling for general personality traits (extraversion, neuroticism) and therapeutic orientation.

As well as examining the therapeutic alliance, other studies have looked at the direct link between therapist attachment styles and therapist behavior in session. Rubino et al. (2000) presented videotapes of actors presenting a therapeutic rupture episode as it might be experienced with each of the four Bartholomew attachment styles to 77 therapists-in-training and their suggested response was noted. The relationship between therapist attachment patterns and degree of empathy and depth of intervention was assessed. Scores were analyzed in terms of avoidance and anxiety, and degree of anxiety in the therapist was found to be negatively related to degree of empathy in responding to the rupture episodes. This makes sense, in that the more anxious therapists might feel threatened by the rupture and thus fail to empathize with the client.
Empirical studies on attachment have shown that secure therapists were more responsive to their clients, whereas insecure therapists exhibited greater dependency and intervened more intensively (Dozier, Cue & Barnett, 1994). Mental health professionals must connect empathically with their trauma clients in order to be effective, but this connection may come at the price of vicarious traumatization (Figley, 1995; Stamm, 2002) or the reward of positive growth (Tedeschi & Calhoun, 2004) or possibly both (Linley & Joseph, 2007).

Literature on the attachment style of the trauma therapist in relation to trauma therapist variables and psychological changes is limited. Marmaras, Lee, Siegel and Reich (2003) looked at the attachment style of female trauma therapists in relationship to vicarious trauma. A significant positive relationship was found between attachment style and disrupted cognitive schemas, intrusion symptoms, hyper-arousal and avoidance. Therapists with fearful or preoccupied attachment styles reported more disruptions in their cognitive schemas than did dismissive-avoidant or securely attached trauma therapists. The researchers suggested that securely attached trauma therapists may have felt more comfortable reporting a low level of distress, while the dismissive avoidant therapists may have denied feeling any emotional distress.

The role that attachment style may play in determining the outcomes for individual trauma therapists has yet to be determined in relation to working with survivors of trauma. This study investigated the role secure attachment style played in therapists’ positive and negative changes to vicarious trauma.
The Effects of Counseling Trauma Clients

The impact of trauma work on the mental health professionals involved has generally been described in terms of the potential negative emotional and schematic impact of trauma work. Initially, an interest emerged within the framework of secondary traumatic stress (STS, Figley, 1995; Sabin-Farrell & Turpin, 2003) and vicarious trauma (McCann & Pearlman, 1990). However, in recent years, along with the growth of the positive psychology paradigm, researchers have begun to examine the possibility of positive effects of trauma work for mental health professionals. Understanding how the therapist relates to the client from an attachment perspective may be a helpful way to make sense of why some individuals are affected in more positive ways than others.

Positive Effects

Despite the documented negative effects of trauma work, therapists have also described both rewards and benefits that come from doing this work. Posttraumatic growth is the most widely used label for describing such adaptations to traumatic stressors, but other terms are also used including compassion satisfaction (Stamm, 2002, 2005), adversarial growth (Joseph & Linley, 2008), stress-related growth (Park, Cohen & Murch, 1996), perceived benefits (McMillen & Fischer, 1998) and thriving (Abraido-Lanza, Guier & Colon, 1998). Vicarious resilience has also been used to describe a unique and positive effect that transforms therapists in response to client trauma survivors’ own resiliency (Hernández, Gangsei & Engstrom, 2007).

Cohen and Collens (2012) undertook a metasynthesis study on vicarious trauma and vicarious post traumatic growth examining the impact of trauma work on trauma
workers. They examined the findings from twenty published qualitative articles, looking specifically at the process of growth. In their discussion they summarized the themes and concepts found in the synthesis. Alongside the potential negative emotional and schematic impact of trauma work, usually presented within the framework of vicarious trauma, trauma workers also experienced growth as a consequence of their engagement in trauma work (Cohen & Collens, 2012). It appeared that the two processes of vicarious trauma and vicarious post traumatic growth stemmed from empathic engagement with traumatized clients and occurred as a result of challenges to cognitive schemas that lead to their adaptation. The challenge to the schemas is experienced due to the shocking revelations in relation to the clients’ traumatic experiences or the clients’ own post traumatic growth.

Cohen and Collens’ (2012) study concurred with the idea put forward by Joseph and Linley (2008) suggesting that the self is a multifaceted structure and that some facets can be accommodated positively, some negatively, and some assimilated. It also pointed to a gap in the literature whereby most studies have investigated VT and VPTG as independent processes leading to different outcomes for different schemas. Cohen and Collens (2012) suggested that this may have limited our understanding of both these phenomena. My study looked at the impact on schemas of both VT and VPTG as there may be separate and distinct pathways leading to positive and negative psychological change, as suggested by Linley & Joseph (2007).
Compassion Satisfaction

Compassion satisfaction is the term given to the pleasure derived from effectively helping others through the therapeutic process (Stamm, 2005). The relationship between compassion satisfaction and compassion fatigue is not yet clear, but Stamm (1995) proposed it is an important component that mediates the negative effects of burnout and compassion fatigue in healing professionals. It is a construct that was said to explain therapists’ continuation with stressful work (Carmel & Friedlander, 2009). Although similar in concept to the other terms used to describe positive outcomes, compassion satisfaction focuses specifically on helping professionals such as counselors and first responders.

The idea that compassion satisfaction was possibly a protective factor in mental health and was associated with lower levels of burnout and compassion fatigue was supported by the results of several studies (Van Hook & Rothenburg, 2009; Conrad & Kellar-Guenther, 2006; Collins & Long, 2003).

Compassion satisfaction amongst trauma therapists was shown to increase with specialist trauma training (Sprang et al, 2007), and utilization of evidence based practices (EMDR; cognitive behavioral therapy and behavioral therapy) were also found to increase compassion satisfaction in therapists (Craig & Sprang, 2010). The researchers suggested that this may be because the provider feels more equipped to deal with the complexities and horrors of trauma work. Incorporating a strengths based perspective into the research, prevention and treatment of compassion fatigue may be a valuable approach toward mitigating the negative impact of secondary trauma (Bell, 2003).
Compassion fatigue and compassion satisfaction may be experienced at the same time (Bride & Figley, 2007). Interestingly, LaFauci Schutt and Marotta (2011) studied 269 emergency management professionals and found relatively more compassion satisfaction than burnout in their sample. The findings also suggested that emergency management professionals can exhibit coexisting compassion satisfaction and PTSD symptomology.

They concluded that the more professionals engage in their work involving emergency events, the more likely they are to experience compassion satisfaction but at an increased risk for PTSD symptoms.

The majority of studies on compassion fatigue and compassion satisfaction have used Stamm’s Professional Quality of Life scale, as in my study, but have been interested in compassion fatigue as the primary construct. There are far fewer studies that are interested in the role of compassion satisfaction in trauma work. My study helped to redress this balance.

**Posttraumatic Growth**

Calhoun and Tedeschi (2006) pioneered the concept of Posttraumatic Growth (PTG) – a construct of positive psychological change that occurs as the result of one’s struggle with a highly challenging, stressful and traumatic event.

The events for which posttraumatic growth outcomes have been reported included transportation accidents (shipping disasters, plane crashes, car accidents), natural disasters (hurricanes, earthquakes), interpersonal experiences (combat, rape, sexual assault, child abuse), medical problems (cancer, heart attack, brain injury, spinal cord
injury, HIV/AIDS, leukemia, rheumatoid arthritis, multiple sclerosis, illness) and other life experiences (relationship breakdown, parental divorce, bereavement, immigration) (Gibbons, Murphy & Josep

h, 2011). Interestingly, at least 30-90% of survivors reported some positive changes following trauma (Calhoun & Tedeschi, 1995).

Two theories of posttraumatic growth that are well supported are the functional descriptive model of posttraumatic growth (Tedeschi & Calhoun, 1995, 2004) and the organismic valuing theory of growth (OVP) (Joseph & Linley, 2005). Both theories suggest that trauma can challenge an individual’s assumptions and beliefs about the world. Because of these adverse events, the validity of the individual’s beliefs can be threatened and cause individuals to question their understanding of the world as well as their place in it. This was usually a process accompanied by high levels of psychological distress. These stressful life events can shatter an individual’s prior assumptive beliefs about the world. According to theory, posttraumatic growth occurs when individuals attempt to come to terms with the event and rebuild their assumptive world. During this process individuals have an opportunity to think carefully about how they want to rebuild their lives, and can often develop adaptive beliefs that will lead them to have increased resilience in the face of future challenges. They may also identify new characteristics and strengths (Calhoun, Cann, & Tedeschi, 2010; Janoff-Bulman, 1992, 2006; Splevins et al., 2010).

Posttraumatic growth refers to a process by which trauma survivors are positively transformed by their experience of trauma. It refers specifically to positive changes that go beyond adjustment in spite of adversity. These positive changes do not however mean
that trauma survivors will not experience distress and struggle in the aftermath at the same time (Tedeschi & Calhoun, 1995, 2004). Positive changes included improved relationships, the recognition of new possibilities for one’s life, a greater appreciation of life and personal strength, and spiritual development. Posttraumatic growth does not necessarily lessen the trauma survivor’s emotional distress, but it may include or trigger a reconsideration of assumptions about life, the world, and others and a search for meaning (Calhoun, Tedeschi, Cann & McMillan, 2000).

The majority of research on posttraumatic growth has been focused on growth in direct survivors of traumatic events, but a growing body of literature has begun to examine the positive changes that workers in the caring professions can experience following their engagement with traumatized individuals such as disaster response workers (Linley & Joseph, 2006), funeral workers (Linley & Joseph, 2005), British social workers (Gibbons, Murphy & Joseph, 2010), Israeli social workers (Shamai & Ron, 2009), interpreters working with asylum seekers and refugees (Splevins, 2010) and clinical, administrative and managerial staff working with refugee survivors of torture and trauma (Barrington & Shakespeare-Finch, 2013). These studies showed that individuals who work closely with others who have gone through trauma and who were exposed to the suffering of others can find this to be personally growthful.

Trauma clinicians have reported benefits of working with their clients, including gains in relationship skills, increased appreciation for the resilience of people, satisfaction from observing growth, and being part of the healing process (Herman, 1995; Pearlman & Saakvitne, 1995; Schauben & Frazier, 1995; Shakespeare-Finch et al., 2003).
However, these gains have generally been mentioned in a tangential way as part of a larger discussion of the negative effects of working with trauma. The process of psychological growth that can follow vicarious exposure to trauma was first labeled “vicarious posttraumatic growth” by Arnold, Calhoun, Tedeschi, and Cann (2005).

Arnold et al. (2005) conducted an in depth exploration of the positive consequences of work with trauma survivors. They examined a sample of 21 psychotherapists who participated in a naturalistic interview, focusing on two areas 1) changes in memory systems and schemas about self and the world, and 2) perceived psychological growth. In addition to reporting several negative consequences, all the clinicians in the sample described positive outcomes. Many of the therapists reported that their lives had been changed in profound and positive ways and were remarkably similar to those described by individuals who have experienced trauma directly. All three major categories of posttraumatic growth outcomes – positive changes in self-perception, interpersonal relationships, and philosophy of life (Tedeschi & Calhoun, 1995; Tedeschi, Park & Calhoun, 1998) were reported by the clinicians in the study. The benefits of trauma work appeared to involve the same type of schemas about self and the world that have been identified as the hallmarks of vicarious traumatization (Arnold et al., 2005). Some of the positive outcomes reported in the study included gains in empathy, compassion, sensitivity and tolerance; improved interpersonal relationships; deepened appreciation for human resilience, greater appreciation of life; a desire to live more meaningfully; and positive spiritual change.
The current study focused on compassion satisfaction and posttraumatic growth as therapist outcomes because little research has been done on the positive outcomes of therapists’ trauma work.

**Attachment and Posttraumatic Growth**

Little is known about the contribution of attachment style to posttraumatic growth. The few studies that have been conducted are reviewed here.

Fraley, Fazzari, Bonanno, and Dekel (2006) examined the relationships between individual differences in adult attachment and psychological adaptation in a sample of high-exposure survivors of the terrorist attacks on the World Trade Center (WTC) on September 11, 2001. Their aim was to examine the role that individual differences in attachment play in adaptation to the WTC attack. Participants were asked to complete measures of adult attachment style, depression and PTSD symptoms, 7 and 18 months following the attack. Their findings were that highly secure adults tended to be the best adjusted following the tragedy. They also found that highly dismissing people may not have adjusted particularly well. In addition to the highly secure people being well adjusted seven months following the attacks, according to the reports of friends and relatives, they were better adjusted than they were normally. Fraley et al. (2006) claimed that these highly secure people may have exhibited a form of psychological growth—that is they were able to use the experience as a means for exhibiting not just better adjustment than others in the tragedy, but other forms of personal growth or strength. As Fraley and colleagues noted, this is similar to the incidence of posttraumatic growth, defined by Tedeschi & Calhoun. Highly secure individuals in Fraley et al.’s (2006) study
might have been able to draw on their previous interpersonal experiences and their sense of security as a means to exhibit the kinds of non-self-serving acts that would be viewed by others as signs of social strength and adjustment. The researchers also noted that psychological strength is not just the relative absence of problematic symptoms and research that assessed both the positive and negative consequences of traumatic experiences should be able to help illuminate the unique ways in which people adapt to trauma.

Another study examined the question why some victims of severe trauma such as imprisonment and torture have a predominantly negative time, when others managed to adapt, and even gained posttraumatic growth. Salo, Qouta and Punamaki (2005) investigated this question with Palestinian ex-detainees and concentrated on one possible explanation for the great individual differences following trauma – adult attachment. They hypothesized that survivors’ personal ways of responding to trauma, based on their earlier experiences, may have been crucial in determining whether trauma was associated with posttraumatic growth or negative emotions. Posttraumatic growth was measured using the *Posttraumatic Growth Inventory (PTGI*: Tedeschi & Calhoun, 1996); attachment was measured using the *Adult Attachment Questionnaire (AAQ)*; and other measures were used to report exposure to traumatic events. The authors found that secure attachment played a protective role in enhancing posttraumatic growth, while men with insecure-avoidant attachment were vulnerable to negative emotions in the face of trauma.

Another study investigated the relationship of coping styles, social support and attachment style with posttraumatic growth in cancer survivors (Schmidt, Blank, Bellizi
& Park, 2012). These researchers agreed with Salo et al. (2005) that secure attachment was found to be positively associated with PTG. Dekel (2007) also found that the anxiety and avoidance dimensions of attachment were associated with PTG among wives of prisoners of war.

**Negative Effects**

**Vicarious Trauma**

Vicarious trauma is defined as the personal transformation experienced by trauma workers resulting from a cumulative and empathic engagement with another’s traumatic experiences, rather than as a result of any pathology in the therapist (McCann & Pearlman, 1990; Pearlman & Maclan, 1995). Vicarious trauma in therapists and trauma counselors may manifest as posttraumatic stress symptoms and significant shifts in identity, worldview, spirituality, cognitive distortions about self and others, and changes in interpersonal relationships (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995). The aversive vicarious impact of trauma has been recorded in various groups: for example, therapists (Iliffe & Steed, 2000; Pearlman & Maclan, 1995); firefighters (Brown, Mulhern, & Joseph, 2002), and ambulance workers (Clohessy & Ehlers, 1999).

The theoretical framework for vicarious trauma is found in constructivist self-development theory (CSDT) (McCann & Pearlman, 1990). This theory suggested that individuals construct their realities through the development of cognitive structures or schemas. These schemas included a person’s beliefs, assumptions, and expectations about self, others and the world, and these were then used to interpret events and make sense of experiences (Janoff-Bulman, 1992). In CSDT theory, individual differences in adaptation
are emphasized with traumatized individuals viewed as complex persons trying to cope with their experiences rather than pathologizing such adaptations as symptomatic relationships (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995; Rasmussen, 2005). When possible, new information was assimilated into the existing schemas (McCann & Pearlman, 1990); however, if new information is incompatible with existing schemas and cannot be assimilated, the original schemas were challenged. According to CSDT, when an individual experiences vicarious traumatization, schemas are modified in a negative way, and this causes distress and heightened awareness to information that supports the newly negatively modified schema (McCann & Pearlman, 1990).

**Secondary Traumatic Stress**

Secondary traumatic stress referred to the experiencing in the trauma worker of symptoms similar to those seen in people with posttraumatic stress disorder (PTSD) such as intrusions, avoidance, and physiological symptoms of hyper arousal (Chrestman, 1999; Courtois, 1988; Kassam-Adams, 1999). The specific effects of vicarious exposure to traumatic events have been distinguished from the more general concepts of vicarious exposure, such as counter transference and burnout, through the recognition that secondary traumatic stress was a response to traumatic events disclosed by the client, but which the client has not experienced directly (Danieli, 1985). Secondary Traumatic Stress Disorder (STSD) and PTSD have identical symptoms (American Psychiatric Association, 2000). The difference lies in the type of exposure to the traumatic event; PTSD was a result of direct exposure, whereas the exposure resulting in STSD was an indirect effect of the empathic care provided to traumatized persons (Shamai & Ron, 2009).
Compassion Fatigue and Burnout

The terms compassion fatigue (CF) and burnout are related terms that have been used interchangeably with STS and VT (Jenkins & Baird, 2002). Some researchers have considered the terms STS and CF to be synonymous (Deighton, Gurris, & Traue, 2007), whilst others have said CF is a separate phenomenon, related to the psychological and emotional strain of empathic work (Sabin-Farrell & Turpin, 2003). Burnout more generally referred to an occupational stress response and chronic tediousness in the workplace (Jenkins & Baird, 2002). Only STS and VT were unique to working with trauma populations (Sabin-Farrell & Turpin, 2003).

Compassion fatigue is the negative effect of working with traumatized individuals, which included symptoms of secondary traumatic stress, such as avoidant behavior and hyper vigilance (Figley, 2002). It is a natural result of trauma work and can result from hearing about clients’ traumatic experiences through counseling. Compassion fatigue can contribute to burnout, in addition to negatively affecting client outcomes (Jacobson, 2012, Bride, 2007, Figley, 2002, Stamm, 2002).

Burnout is a condition of feeling emotionally exhausted or worn out commonly experienced as a consequence of increased workload and institutional stress. Rather than being a one-time event, burnout is a form of compassion fatigue that develops as a result of gradual processes that build over time.
Attachment and Trauma

This section outlines the role attachment organization plays in the face of vicarious trauma. According to attachment theory, secure and insecure individuals have learned unique ways of responding to danger and distress (Bowlby, 1973, 1980; Bretherton, 1990; Main, 1996). These experiences were incorporated in the early working models of oneself, benevolence of others and security of environment (Salo, Qouta & Punamaki, 2005). These models guided individuals’ emotional, cognitive and social development (Goldberg, 2000) and were especially activated when facing danger to one’s safety and integrity (Bowlby, 1980; Mikulincer, 1998) as happens in traumatic encounter.

Several studies have shown that attachment style contributed to people’s threat appraisals and ability to cope (Berant, Mikulincer & Florian, 2001; Birnbaum, Reis, Mikulincer & Florian, 1997; Cozzarelli, Sumer & Major, 1998; Moller, Fouladi, McCarthy & Hatch, 2003). Findings were consistent regarding secure and anxious individuals. Secure people had learned that other people were available, responsive, and supportive when needed. They therefore were more likely to seek social support and benefit from it in stressful times (Fraley & Shaver, 1998). In addition, the mental representations that secure people held are believed to have provided a direct source of comfort to them during challenging times (Mikulincer, Shaver & Horesh, 2006).

Studies of attachment orientation and real-life stressors have found a robust relationship between security and resiliency to trauma in military settings (Dieperink, Leskela, Thuras & Engdahl, 2001; Zakin, Solomon & Neria, 2003), in sexual abuse situations (Alexander et al., 1998; Feerick, Haugaard & Hien, 2002), during painful
medical procedures (Edelstein et al., 2004) and following the transition to parenthood (e.g. Rhodes, Simpson, Campbell & Grich, 2001). Therefore, highly secure people have a process (seeking support; models of self being cared for by attachment figures) that provided a buffer during times of stress (Fraley et al., 2006). In contrast, anxious attachment individuals appraised threats as extreme and coping resources as deficient.

For avoidant individuals the findings were less consistent. With regard to the appraisal of one’s own coping abilities, most studies have found that avoidant people’s appraisals were similar to those of secure people (appraising coping resources as adequate). With regard to threat appraisals, however, most studies have found that avoidant attachment, like attachment anxiety, was associated with appraising stressful events as highly threatening (see Mikulincer & Shaver, 2007). Also, attachment style variations may have influenced how a person reacted to trauma in terms of symptoms. Mikulincer et al. (1993) found that individuals who engage in hyper activating strategies are likely to ruminate and therefore may experience intrusion and avoidance symptoms. But avoidant individuals who used deactivating strategies may suppress trauma adversity and experience more avoidance symptoms. Thus, both anxious and avoidant participants suffered from trauma-related psychological problems, but in different ways.

The impact of attachment styles on emotional regulation could therefore be either a risk factor for vicarious traumatization or a protective factor, and possibly a predictor of post traumatic growth and compassion satisfaction in trauma therapists.
Personal and Professional Factors Impacting Positive Change in Trauma Therapists

Although factors affecting negative psychological change in trauma therapists have been discussed in the literature, much less attention has been paid to the factors associated with positive outcomes such as compassion satisfaction and posttraumatic growth. Indeed, few studies have even looked at both the positive and negative impact of working with trauma survivors. My study addressed this by investigating the possibility of vicarious traumatization and vicarious posttraumatic growth occurring concurrently in the sample of trauma therapists under investigation. Considering those factors in the literature that were predictive of vicarious traumatization and posttraumatic growth informed the information collected from participants in the current study.

Gender

Women report higher level of symptoms and more PTSD than males. Sixty-one per cent of men and 51% of women had experienced at least one traumatic event during their lives (Kessler, Sonnega, Bromet, Hughes & Nelson, 1995) but women and girls were more likely to meet the criteria for PTSD and more likely to experience sexual assault and child sexual abuse. One study found women were also more vulnerable to PTSD after disasters and accidents but in violence and chronic disease categories, gender differences were smaller (Ditlevsen & Eklit, 2012). Olff, Langeland, Draijer and Gersons (2007) concluded that women were more likely than men to perceive a situation as threatening, to rate events as significantly more stressful, and endorse more loss of personal control. Also, women were more likely than men to experience acute psychological and biological responses to trauma including intense fear, avoidance,
intrusive thoughts, horror, helplessness and panic. Given these differences it is possible that similar differences exist in vicarious posttraumatic growth also. Tedeschi and Calhoun (1996) found gender differences with respect to perceptions of growth in a sample of college undergraduates but little is known about gender differences in trauma therapists.

In one such sample, a higher percentage of women participants expressed concern about how traumatic case material might impinge on personal relationships with partners and children (Killian, 2008). The author suggested this may be a function of women’s socialization and cultural expectations that they be caregivers and emotionally attentive to their family members, and also indicative of the role overload experienced by so many women trying to meet unrealistic expectations of them in both the personal and professional areas of their lives (Killian, 2008).

Being female was also associated with more positive psychological growth responses (Linley & Joseph, 2007) amongst general therapists. A gender difference in adversarial growth (Helgeson, Reynold & Tomich, 2006) was also consistent with a meta-analytic review of the literature on coping that showed women engage in more positive reappraisal and more positive self-talk than do men (Tamres, Janicki, & Helgeson, 2002).

Current research is not very clear whether female gender is a vulnerability or a resilience factor with relation to vicarious trauma and so gender was included in this study as a variable.
Age

Weiss (2013) has argued that there may be an overlap of posttraumatic growth – a model of positive changes following traumatic events, and gerotranscendence, a theory of positive changes related to ageing. She implied that PTG may be viewed as part of normative adult development and as an accelerator of gerotranscendence. She suggested that PTG and gerotranscendence may be viewed as two facets of the universal human striving toward self-transcendence or emancipatory knowledge.

However, there is no theoretical connection between age and PTG, and growth from adversity is possible at any point in the life span. Empirical findings for PTG and older age are inconsistent. For example, Stanton, Bower and Low (2006) found that most studies reported non-significant relationships between age and PTG, with several having an inverse relationship. But one study with a very broad age range of 22-92 years (Kurtz, Wyatt & Kurtz, 1995) did find a positive connection between age and PTG in the participants aged 50-79 years reporting the highest level of positive change.

Being younger in age has also been found to be a factor for more negative effects of vicarious trauma (Ackerley, Burnell, Holder, & Kurdek, 1988; Pearlman & MacIlan, 1995). However, age may be confounded by attrition, with younger people who experience more negative effects, such as burnout, leaving the profession. Younger people also appear to engage in the most growth, maybe because they experience more stress (Helgeson, Reynold & Tomich, 2006) and allowing for the fact that positive and negative effects may occur from vicarious trauma experience.
Survivor

The distress that trauma therapists experience can be exacerbated by the fact that some 30% of psychotherapists have experienced trauma during their own childhood (e.g. Brady, Guy, Poelstra & Brokaw, 1999; Figley, 1995; Pearlman & MacIan, 1995). Helpers who have a personal trauma history may be most vulnerable to developing VT but the empirical findings have shown mixed results (Pearlman & MacIan, 1995; Schauben & Frazier, 1995). Consequently, more research is needed to clarify the contribution of having a personal trauma history to the positive and negative effects of trauma work, and in those with different attachment styles.

Personal Therapy

A few recent studies have indicated that therapists who have undertaken their own personal therapy reported greater growth and change (Linley & Joseph, 2007; Brockhouse et al., 2011). An earlier study by Joseph and Linley (2005) had also shown that therapists own personal therapy was a powerful predictive variable of more positive changes and fewer negative changes.

Specialist Training

Pearlman and Saakvitne (1995) argued that without formal trauma-specific training, the trauma therapist is vulnerable to confusion and is potentially harmed by the work. Adams and Rigg’s (2008) study backed up this statement as they found deficits in trauma-specific training were highly associated with a pattern of vicarious trauma symptoms in therapist trainees. Unfortunately, they also found 25% of the sample working with trauma clients with no prior formal training related to trauma. They concluded that one-time
lectures or class discussions are not sufficient, rather students need substantial trauma-specific training in the context of a full semester of coursework or multiple intensive workshops in order to protect themselves against the potential negative impact of trauma counseling (Adams & Riggs, 2008). Specialist trauma training has also been shown to increase compassion satisfaction (Sprang et al., 2007).

**Supervision**

McCann & Pearlman (1990) proposed that there is a need to engage in a process of integrating and transforming the traumatic experience in the same way that a client does during therapy. Those who have had little or no past or ongoing supervision, and who experienced high related job stress may be most vulnerable to developing VT, whereas one factor shown to increase compassion satisfaction was ongoing supervision (Linley & Joseph, 2007). However, the role of supervision although known to contribute to therapists well-being (Schauben & Frazier, 1995) has only been examined in one study with regard to vicarious posttraumatic growth in therapists and was not found to be significant (Brockhouse et al., 2011). However, in other professions, e.g. police officers, supervision has been found to be relevant to VPTG (Huddlestone, Paton & Stephens, 2006) and further research into the role of supervision with respect to change and growth in trauma therapists is needed.

**Sense of Coherence**

Sense of coherence (Antonovsky, 1979, 1987) is a construct that may help determine one’s ability to recover from traumatic events and return to normal life after experiencing distress (Kimhi, Eshel, Zysburg, Hantman & Enosh, 2010).
Antonovsky’s main question was: why do some people, despite stressful situations in their lives, manage to stay healthy and others do not? (Lindstrom & Eriksson, 2007). The Sense of Coherence (SOC) concept was developed as an answer to this salutogenic question (Lindstrom & Eriksson 2007) and was defined as a way of helping people to view the world as “making sense cognitively, instrumentally and emotionally” (Antonovsky 1996, p.15). The SOC construct has an enduring orientation with three components. Comprehensibility refers to one’s ability to make sense of one’s environment. Manageability refers to one having the resources required to deal with the challenges of the environment and meaningfulness is the extent to which the individual considers these challenges worth the investment and engagement (Antonovsky, 1987). While conventional coping measures assess preferences for particular coping strategies, the sense of coherence scale measures the individual’s capacity to respond to stressors (Antonovsky, 1993). Individuals with high sense of coherence scores are likely to perceive stressors as predictable and explicable, have confidence in their ability to overcome stressors, and judge it meaningful to rise to the challenges they face. Low sense of coherence scores indicate the relative absence of these perceptions.

Therapists who scored higher on the Sense of Coherence scale (SOC) (Antonovsky, 1987) indicated fewer negative changes and more positive changes. Based on these findings, Linley, Joseph and Loumidis (2005) suggested that the SOC personality construct may be a useful way of conceptualizing personality factors that influenced positive and negative adaptation to dealing with traumatic experiences.
Brockhouse et al. (2011) also found that sense of coherence to be predictive of growth in trauma therapists.

It is suggested that early environmental experiences around attachment needs influence attachment behavior and that these same experiences may also influence SOC. Antonovsky (1987) proposed that early childhood experiences, especially those experienced within the family, influence the development and strength of an individual’s SOC. According to attachment theory (Ainsworth, Blehar, & Waters, 1978; Bowlby, 1969, 1973) infants develop mental models of themselves and the relationship between the infant and caregiver. These working models account for the persistence of the types of strategies infants employ around attachment needs. Some of these strategies develop as a way of coping with the caregiving they receive.

According to Antonovsky (1979), an individual’s SOC is built up over time through experience using General Resistance Resources (GRR) in dealing with a source of tension. GRRs are the things that are available to the individual that can be used to help deal with those tensions. They include financial, material, social, and psychological resources. Thus, SOC is a personality trait that reflects the flexibility of an individual in being able to select the most appropriate coping resource to deal with a particular stressor (Antonovsky, 1998). An infant’s first social experiences revolve around the attachment relationship and these experiences could well contribute to both the infant’s availability of coping resources, conceptualized by Antonovsky (1979) as generalized resistance resources, and to the infant’s SOC. Once formed, these strategies of coping tend to persist and are applied to other attachment relationships. Thus, attachment history should help to
determine the type of GRRs available to the individual and therefore contribute to SOC. Both SOC and attachment classification appear to be based on an individual’s need to make sense of the world.

A higher SOC is therefore expected to contribute to positive growth and to relate to a secure attachment style in trauma therapists.

**Summary**

Positive and negative changes following exposure to vicarious trauma are undisputed. Posttraumatic growth theory does not suggest that there was an absence of suffering as wisdom builds, but rather that appreciable growth occurred within the context of pain and loss (Moore, 2012). Indeed, some measure of significant distress may be necessary for growth to occur, although too much may impair trauma therapists’ work, and render them unable to engage in the growth process. Empirical studies on attachment have shown that secure therapists were more responsive to their clients, whereas insecure therapists exhibited greater dependency and intervened more intensively (Dozier, Cue & Barnett, 1994). Mental health professionals must connect empathically with their trauma clients in order to be effective, but this connection may come at the price of vicarious traumatization (Figley, 1995; Stamm, 2002) or the reward of positive growth (Tedeschi & Calhoun, 2004) or possibly both (Linley & Joseph, 2007). The role that attachment style may play in determining the outcomes for individual therapists has yet to be determined in relation to working with survivors of trauma.

In this chapter I reviewed the literature on attachment style and indicated some of the important factors that may impact growth and change in trauma therapists. The
purpose of my study was to determine the relationship between adult attachment style and positive and negative changes in trauma therapists’ while taking into account the personal and professional factors of age, gender, race, personal trauma history, personal therapy, specialist training, supervision, and sense of coherence.
Chapter Three
Methodology

The purpose of my study was to investigate the role of different attachment styles (secure and not secure) on positive and negative psychological change in mental health professionals who work with survivors of trauma. In addition to the deleterious effects of working with trauma populations, there can be significant positive effects for therapists as well. Vicarious posttraumatic growth is described as psychological growth that occurs in therapists after vicarious exposure to trauma (Arnold, Calhoun, Tedeschi, & Cann, 2005), and some examples have been noted in the literature (e.g. Arnold et al., 2005; Linley & Joseph 2007; Ben-Porat & Itzhaky, 2009). A few studies have also examined the risk factors associated with therapists developing vicarious trauma, including their attachment style. Racanelli (2005) found that low attachment anxiety was the strongest predictor of satisfaction among American and Israeli clinicians working with victims of terrorism. Tosone, Minami, Bettman & Jaspers (2010) found that secure attachment was predictive of resilience and the ability to cope with secondary traumatic stress in New York social workers following 9/11.

Pines (2004) suggested that secure attachment provided people with an inner resource that helps them to positively appraise stressful experiences and to cope with these in a constructive way. However, insecure attachment styles implied poor coping strategies, which can eventually lead to career burnout (Pines, 2004). Surprisingly, the role adult attachment style may play in the development of positive or negative psychological changes in therapists providing trauma therapy has not often been
explored, nor the moderating effect that attachment can have in the relationship between psychological change and other personal and professional variables.

Therefore my study focused on mental health professionals counseling trauma clients. I was particularly interested in the relationship between secure attachment style and positive and negative psychological changes in counselors who work with survivors of trauma.

**Research Design**

My study was an observational study utilizing previously established groups—trauma counselors/therapists. It was a correlational design utilizing a one-time, cross-sectional survey methodology and included a number of survey instruments and demographic data. Its purpose was to assess the relationship of attachment style to positive and negative change in trauma counselors, as well as to predict the factors related to change. The study is non-experimental because the independent variable (attachment style) is not manipulated (Johnson & Christensen, 2012).

**Research Questions**

The first research question was to examine how a secure attachment style of mental health professionals predicted psychological growth and negative psychological change as a result of their work with trauma survivors. Psychological growth was measured in terms of posttraumatic growth and compassion satisfaction. Negative psychological change was measured by compassion fatigue/secondary traumatic stress and burnout. The following hypotheses were tested to address this question:
Hypothesis 1. There will be a significant relationship between secure attachment style and posttraumatic growth.

Hypothesis 2. Secure attachment style will be positively related to compassion satisfaction.

Hypothesis 3. Non-secure (i.e. fearful, preoccupied and dismissing) attachment styles will be positively related to compassion fatigue and burnout.

Hypothesis 4. Non-secure (i.e. fearful, preoccupied and dismissing) attachment styles will be negatively related to posttraumatic growth.

The positive changes resulting from working with trauma survivors is a relatively recent area of study. Several personal and professional factors have been suggested to contribute to negative changes, and far fewer to positive growth as a result of this work. Results from existing studies have also been inconsistent. Therefore, a secondary research question was to what extent are personal and professional factors identified in the literature predictive of positive growth or negative changes in this sample of trauma therapists. The factors identified from the research literature are gender, age, being a survivor of trauma, having received personal therapy, undertaken specialist training to work with trauma survivors, attended weekly supervision, and an individual’s sense of coherence.

Procedures

This section of Chapter 3 outlines the procedures followed to recruit participants and collect the data. I used the term trauma therapist interchangeably with trauma counselor and mental health professional.
Participants

The target population were licensed mental health professionals, working with survivors of trauma. The invitation email and the informed consent page of the survey asked participants to self-select on the basis of seeing at least 5 adult clients per week who were survivors of trauma, and for at least 6 months. Each participant had at least a master’s degree and was licensed in a professional mental health field, as recognized by his/her state. Participants were identified through current clinical membership of the American Mental Health Counselors Association (AMHCA); the Eye Movement Desensitization and Reprocessing (EMDR) International Association (EMDRIA) and 150 professionals at a recent training for clinicians who worked with survivors of torture.

Members of AMHCA were professional counselors employed in mental health services and worked within a variety of settings, including private practices, agencies, and institutions. There are over 7,000 members of AMHCA (AMHCA, 2013). The email invitation was sent to a subset (3,420) of these members who are registered as clinical members. Clinical membership of the AMHCA required a master’s degree in counseling or a closely related field, completion of a minimum of 2 years post-masters experience, and primary work in the direct delivery of services.

EMDRIA is a membership organization made up of mental health professionals, dedicated to the highest standards of excellence and integrity in EMDR, with over 4,000 members internationally. EMDR is an integrative psychotherapy approach that has been extensively researched and proven effective for the treatment of trauma (EMDRIA, n.d). An invitation to participate in the research was included in the spring newsletter sent to
2,331 of their members in the United States. Altogether a total of 5,901 invitations to participate were sent out including the e-newsletter and direct email to individuals. It is not known how many of the invitees met the criteria for participation, but 436 responses were begun (i.e., the web link opened) and 395 responses were completed. This yielded a response rate of 6.7%. An average return rate for online surveys is 10-15% (Granello, 2007) so this was slightly below that. Because of the anonymity of responses, it was not possible to say where participants’ responses came from.

Out of the 395 completed surveys collected via the SurveyMonkey website 81.3% were female (n=314) and 18.7% were male (n=72). The majority of the sample were White/European American (93.6%), with Black and African/American (1.3%), Hispanic/Latino (2.1%), Asian American (1%), Native American (.3%), and Multiracial (1.8%). From those who responded, 301 (76.6%) held Master’s level degrees, with 60 (15.3%) having a PhD, 21 (5.3%) PsyD, 8 (2%) EdD, 3 (.8%) an EdS. Professional counselors were the most commonly held license (59.9%) while 12% were licensed as marriage and family therapists, with 8.7% being licensed psychologists, and licensed clinical social workers comprised 18.9%.

The age range of the participants was as follows: 30-39yrs (11.7%), 40-49yrs (19.8%), 50-59yrs (32.5%) and 60 years and over (36%). The number of years practicing as a licensed mental health professional ranged from one year or less (.5%), 2-5yrs (8.6%), 6-10yrs (18.7%), 11-15yrs (16.6%), 16-20yrs (16.6%) and 20 plus years (39%). Table 1 describes additional descriptive data about the sample.
### Table 1

*Descriptive Statistics for Sample of Trauma Therapists (N=381)*

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<tr>
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Demographics

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Theoretical Orientation

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Note: Where numbers do not add up to 100% indicates missing data for that variable

Instrumentation

This study focused on the relationship of secure attachment style in trauma therapists and positive or negative changes resulting from their experiences of working with trauma clients. In total, the survey instrument (Appendix A) involved 70 questions, including the demographic questionnaire and the four measures described below.

Attachment style is derived from attachment theory and was measured using the Relationship Questionnaire (RQ; Bartholomew & Horowitz, 1991). To measure positive change the Post Traumatic Growth Inventory (PTGI; Tedeschi & Calhoun, 1996) and the Compassion Satisfaction subscale of the ProQOL (Stamm, 2009) were used, and to measure negative change, the Compassion Fatigue/Secondary Traumatic Stress and Burnout subscales of the ProQOL. A Sense of Coherence scale (Antonovsky, 1987) was also administered as this personality construct was associated with positive growth (Brockhouse et al., 2011).
The Relationship Questionnaire

The *Relationship Questionnaire (RQ)* is an adult attachment self-report measure developed by Bartholomew and Horowitz (1991) from an earlier attachment measure developed by Hazan and Shaver (1987). The *RQ* measures four attachment styles based on the four combinations resulting from the positive or negative view of one’s self and others. Each attachment style is described in one of four brief statements. Secure attachment is characterized by the following description: “It is easy for me to become emotionally close to others. I am comfortable depending on others and having others depend on me. I don’t worry about being alone or having others not accept me.” Preoccupation is characterized by the following description: “I want to be completely emotionally intimate with others, but I often find that others are reluctant to get as close as I would like. I am uncomfortable being without close relationships, but I sometimes worry that others don’t value me as much as I value them.” Dismissing-avoidance is characterized by the following description: “I am comfortable without close personal relationships. It is very important to me to feel independent and self-sufficient, and I prefer not to depend on others or have others depend on me.” Fearful-avoidance is characterized by the following description: “I am uncomfortable getting close to others. I want emotionally close relationships, but I find it difficult to trust others completely, or to depend on them. I worry that I will be hurt if I allow myself to become too close to others.” The *RQ* asks respondents to choose the attachment style that they perceive as most appropriate to their relational style. Respondents are then asked to rate how each
description corresponds to their general relational style on a 7 point Likert scale from 1 (Not at all like me) to 7 (Very much like me).

According to Bartholomew (1990), these attachment patterns are to be considered prototypes, where members of a particular attachment category may resemble two or more attachment prototypes to varying degrees, with one particular prototype being more prevalent than the others that existed within the individual.

Bartholomew and Horowitz (1991) developed and validated the *Relationship Questionnaire* in two multi-dimensional studies. The independence of the four attachment ratings is demonstrated with the secure and fearful ratings being negatively correlated with one another (-.65 and -.69, respectively). The preoccupied and dismissing ratings are also negatively correlated (-.37 and -.41, respectively). The *RQ* demonstrates test-retest reliability over 8 month and four year periods (Kirkpatrick & Hazen, 1994; Scharfe & Bartholomew, 1994). Griffen and Bartholomew (1994) found evidence for the construct, discriminate and convergent validity of the *RQ* in three separate studies. The four attachment styles correlate appropriately with instruments measuring positive or negative views of self and others. The *RQ* can be used to categorize individuals into the most appropriate attachment style according to the first item, using the second item as a consistency check (Kemp & Neimeyer, 1999). In addition, the *Relationship Questionnaire* demonstrates independence from self-deceptive biases (Leak & Parsons, 2001).

Other researchers have used the *Relationship Questionnaire* to examine various client or personal issues; for example, Schwartz, Waldo and Higgins (2004) found that
college aged men with secure attachment styles had significantly less gender role conflict when compared with college aged men with preoccupied or dismissing or fearful attachment styles. Boatwright, Lopez, Sauer, VanDerWege and Huber (2010) found workers with preoccupied adult attachment styles expressed stronger preference for relational leadership behaviors than workers with either dismissing or fearful adult attachment styles. Kratz et al. (2010) concluded that dimensions of adult attachment – anxious and avoidant styles predict differing aspects of daily pain and pain coping in women experiencing chronic pain. Riggs & Bretz (2006) found perceived supervisor attachment style was significantly associated with supervision task and bond with supervisee. As is evident, the Relationship Questionnaire is one of the most common instruments used in research to measure attachment style, thus making it appropriate to use in my study.

Posttraumatic Growth Inventory

The Posttraumatic Growth Inventory (PTGI; Tedeschi & Calhoun, 1996) is the most commonly used instrument to measure psychological growth after a traumatic event. It is a 21-item self-report measure of positive outcomes following traumatic experience, scored using a 6-point Likert format scale (0= I did not experience this change as a result of my experiences as a trauma therapist; 5= I experienced this change to a very great degree as a result of my experiences as a trauma therapist). All 21 items are positively scored, yielding a potential range of 0-125, where higher scores indicate greater levels of growth. The items are generated from literature with three broad domains of perceived changes of self, a changed sense of relationship with others, and a
changed view of the world (Schaefer & Moos, 1992; Tedeschi & Calhoun, 1995). Sample items include “I changed my priorities about what is important in life” and “appreciating each day”.

The PTGI consists of five sub-scales; Relating to others (“more acceptance of needing others”), New possibilities (“more likely to try to change things that need changing”), Personal Strength (“greater faith in handling difficulties”), Spiritual Change (“increased understanding of spiritual matters”) and Appreciation of Life (“More appreciation for each day”). Tedeschi and Calhoun (1996) report that the internal consistency coefficient of the PTGI to be .90. Test-retest reliability over two months are reported at r=.71 (Tedeschi & Calhoun, 1996), and at r=.53 over six months (Linley & Joseph, 2006). Each of the five subscales also demonstrates adequate internal consistency: Relating to others .85, New Possibilities .84, Personal Strength .72, Spiritual Change .85 and Appreciation of Life .67.

In 2010, Cann et al. published a short form of the PTGI, and it is the short form that will be used in this study. This comprises 10-items including two items drawn from each of the five subscales of the original PTGI. The researchers claim that the short form PTGI represents an efficient and comparable substitute for the PTGI in research needing a single global indicator of posttraumatic growth. The short form appears to retain the same breadth of information as the full scale. The five factors (2 items in each) are: relating to others, new possibilities, personal strength, spiritual change and appreciation of life. The items are rated on a 6-point Likert scale from 0 (no change) to 5 (very great deal of change), with domain scores ranging from 0-10 and where higher scores indicate
a greater positive change. Authors of the PTGI-SF encourage the computation of a total score rather than scoring the five 2-item subscales separately to represent a more global sense of participants’ posttraumatic growth and to ensure greater reliability (Cann et al., 2010). The 10-item PTGI-SF has internal reliability only very slightly lower than the full form PTGI, and the reliability of the total score is generally in the .90 range, across a variety of samples (Cann et al., 2010). Currier, Holland, Rozalski, Thompson and Rojas-Flores (2013) used the PTGI-SF to examine the role of meaning among a sample of teachers from El Salvador who had experienced a variety of possible trauma and life events. The PTGI-SF, translated into Spanish, has an internal consistency of .93 in this sample. Teodorescu et al. (2012) measured posttraumatic growth, in multi-traumatized psychiatric outpatients with a refugee background in Norway using the PTGI-SF. In their study, a Cronbach alpha coefficient for the scale was calculated at .89. In my study the Cronbach alpha coefficient was .92.

Given that several measures were used in this study, using a shortened version of the PTGI was helpful, because the respondent’s time was likely to be limited in both time and energy and may have helped to promote participation.

The body of work investigating posttraumatic growth with the PTGI has largely been focused on direct experiences of trauma (e.g. Butler et al., 2005; Cobb, Tedeschi, Calhoun & Cann, 2006; Frazier et al., 2009; Kaler, Erbes, Tedeschi, Arbisi, & Polusny, 2011; Morris, Shakespeare-Finch, Rieck, & Newbery, 2005; Shakespeare-Finch & Barrington, 2010; Shakespeare-Finch & Enders, 2008; Taku, Cann, Calhoun, & Tedeschi 2008; Teodorescu et al., 2012). Use of the PTGI has broadened to assess psychological
growth in professionals who are exposed to potentially traumatic situations or to trauma survivors (Ben-Porat & Itzhaky, 2009; Gibbons et al., 2011; Lambert & Lawson, 2013; Lev-Wiesel, Goldblatt, Eisikovits, & Admi, 2009; Linley & Joseph, 2007). These professionals have included Israeli social workers in family violence settings; British social workers; professional counselors following hurricanes Katrina and Rita; social workers and nurses in Israel; British disaster response workers. A few studies used the PTGI to look specifically at trauma therapists (Brockhouse et al., 2011; Lambert & Lawson, 2013; Linley, Joseph & Loumidis, 2005) but the research in this area is still limited.

**The Professional Quality of Life Measure (ProQOL, Stamm, 2009)**

The ProQOL Version 5 (Stamm, 2009) is one of the most commonly used measures of the negative and positive effects of helping others who experience suffering and trauma. The ProQOL has sub-scales for compassion satisfaction, burnout and compassion fatigue/secondary stress. It is derived from multiple versions of the Compassion Fatigue Test (also known as Compassion Satisfaction and Fatigue Scales and Compassion Fatigue Self-Test) and consists of 30 items that were shortened from an original version of 66. The thirty items are scored on a Likert scale of 0-5, with 0=never; 5 = very often (Figley & Stamm, 1996; Jenkins & Baird, 2002). The ProQOL-V5’s subscales each consist of 10 items related to the research literature and theory on compassion satisfaction, compassion fatigue/secondary trauma, and burnout. Coefficient alphas for the three scales given in the scoring manual are compassion satisfaction .88, compassion fatigue/secondary trauma .81, and burnout .75 (Stamm, 2010). In my study
the Cronbach alpha coefficients were compassion satisfaction .87, compassion fatigue/secondary traumatic stress .79 and burnout .75. Craig and Sprang’s (2010) study of trauma treatment therapists found similar alphas for compassion satisfaction, compassion fatigue and burnout as .86, .77, .71 respectively.

The three scales measure separate constructs. The compassion fatigue scale is distinct and showed 2% shared variance with secondary stress scale and 5% shared variance with burnout. While there is shared variance between burnout and secondary stress the two scales measure different constructs with the shared variance reflecting the distress that is common in both conditions. The scales both measure negative affect but are clearly different- the burnout scale does not address fear while the STS scale does (Stamm, 2010).

Sprang, Clark and Whit-Woosley (2007) used the ProQOL to measure the emotional impact of stressful work on therapists across various impacts of professional life and different mental health professions. They found that female gender was associated with higher levels of compassion fatigue, and that trauma professionals with specialist training reported higher levels of compassion satisfaction than non-specialists. Craig and Sprang (2010) investigated the impact of using evidence-based practices on compassion fatigue, burnout and compassion satisfaction measured by the ProQOL in a national sample of self-identified trauma specialists. Age and years of experience proved to be powerful predictors of burnout and compassion satisfaction, with younger professionals reporting higher levels of burnout and more experienced providers endorsing higher levels of compassion satisfaction.
**Sense of Coherence (Antonovsky, 1987)**

Sense of coherence was measured with Antonovsky’s (1987) 13-item short version of the *SOC* questionnaire. The sense of coherence construct is a global and enduring orientation with three components. Comprehensibility refers to one’s ability to make sense of one’s environment; manageability refers to one having the resources required to deal with the challenges of the environment; and meaningfulness is the extent to which the individual considers these challenges worth the investment and engagement (Antonovsky, 1987). The short form of the *Sense of Coherence* scale (Antonovsky, 1987) has been used with therapist samples (Brockhouse et al., 2011; Linley & Joseph, 2007) and contains 13 items scored using 7 point Likert scales. Higher scores represent a greater sense of coherence. Examples of items are “do you have the feeling you don’t really care about what goes on around you?” (designed to measure meaningfulness) and “How often do you have feelings that you’re not sure you can keep under control?” (designed to measure manageability). Internal consistency testing of the 13-item *SOC* scale produced Cronbach’s alphas ranging from .74 to .95 (Antonovsky, 1993, 1996a; Gallagher et al., 1994; Lundman & Norberg, 1993, Post-White et al., 1996). In my study the Cronbach’s alpha was .84. Higher scores on the *SOC* scale indicate a greater SOC (i.e. the world is perceived as comprehensible, manageable and meaningful).

The *SOC* has also been tested and found to be reliable and valid across cultures, social classes, ethnic groups, ages and both genders (Antonovsky, 1996). Nyamathi (1991) provided criterion-related validity data for the *SOC* scale by correlating SOC with
self-esteem ($r = .63$). Flannery et al. (1994) demonstrated the construct validity of the scale via principal component analysis; three factors emerged as hypothesized by Antonovsky.

**Demographic Data Questionnaire**

Participants were asked to provide demographic information including age, gender, race/ethnicity, education, license as a clinician, work setting, theoretical orientation, length of time working as a clinician (years), hours per week with clients who have experienced trauma, specialist trauma training, use of personal therapy, personal history of trauma (yes/no) supervision (frequency and type) and to identify if their clients fall into a particular category of traumatic event (physical/sexual/emotional abuse, domestic violence, serious illness, violent crime, natural disaster, political oppression, combat exposure, or other trauma).

**Data Collection**

Dawis (1987) recommended the use of a small pilot study before the primary data collection procedures to determine how easily directions are followed, how long the instrument takes to complete and how appropriate the items are for the target population. Initially the survey instrument developed for this study was sent to a panel of five licensed and practicing mental health professionals to receive feedback about the instrument. The panel was comprised of a licensed psychologist, a licensed clinical social worker, a licensed professional counselor and two licensed professional counselor-interns. The panel was asked to complete the survey instrument, and then to complete a short questionnaire about their experience taking the survey (Appendix B). They were
asked to focus on such questions as “How long did it take you to complete the survey?” and “Were you comfortable answering all the questions? If not, were there specific questions that gave you trouble?” and “Did you find it easy to navigate and answer the questions in the format given?” Pilot participants were particularly asked to identify if there was anything that they would find difficult or uncomfortable because of the nature of asking about trauma experiences.

All five participants completed the survey and provided generally positive feedback about the length and ease of the survey. One participant noted the absence of a particular category in the question on types of trauma cases seen by mental health professionals, with the omission of a category for survivors of sexual abuse. This was in fact, an omission by me, and this category was added to the final survey.

The final survey instrument contained a total of 70 questions; 14 demographic items that I created, followed by four published self-report instruments: the Relationship Questionnaire, the Posttraumatic growth Inventory-Short Form, the Professional Quality of Life Scale and the Sense of Coherence (13 item) Scale.

The sample was a convenience sample comprising mental health professionals willing to participate in an online survey (Remler & Van Ryzin, 2011). An invitation to participate in the research was sent via email to 3,420 clinical members of the American Mental Health Counselors’ Association. In addition, the invitation to participate in the research and a link to the electronic survey were published in the spring 2014 newsletter of the EMDR International Association sent to 2331 members in the United States. These organizations have been identified as ones where their members have a major interest in
clinical mental health and trauma-appropriate specialist training. In addition, 150 participants at a recent training for clinicians who work with survivors of torture were invited to participate. For the purpose of this study, trauma counselors were defined as a licensed mental health professional who works in a psychotherapeutic capacity with survivors of psychological trauma.

Participants were sent an email invitation to participate in the research, along with an electronic link to the survey located at the website surveymonkey.com (Appendix C). Individuals were invited to self-select—the criteria for inclusion were a currently licensed mental health professional, have worked in a psychotherapeutic capacity with adult survivors of psychological trauma for at least five hours per week for the last six months. Data was collected between February 15 and March 14, 2014.

The invitation email briefly described the study, its potential benefits to the profession, along with the promise of anonymity of response, description of what participation entailed and encouragement to participate. Encouragement was in the form of expressed appreciation and incentive for participation through the offer of entry into a prize draw for a $50 Barnes & Noble gift card. The informed consent contained information on confidentiality and voluntary participation and contained contact information for the researcher, the researcher’s dissertation committee chair, and the university’s Institutional Review Board (IRB) chair (Appendix D).

Online survey methods have limited response rates and an average return rate of 10-15% (Granello, 2007). This study generated a response rate of 6.7%. However, they are attractive to those who wish to gain large numbers of responses in a cost effective
way and to those who wish the respondents’ responses to remain anonymous (Leedy & Ormrod, 2010). As this was the case in this study, the survey software tool, SurveyMonkey.com was utilized. This is considered more acceptable than to attach the questionnaire to an email.

Confidentiality of participant’s responses via SurveyMonkey.com was secured through the use of secure socket layer (SSL) as an enhanced security option. Data was downloaded over a secure channel using SSL. All surveys were anonymous and the IP address function was disabled. Participants were not contacted again regarding the research study. However, because the participants had the researcher’s contact information, a number of participants requested clarification, or expressed interest in the study and asked for results in due course. The researcher responded to all enquiries.

Participants’ responses were entered directly onto the SurveyMonkey.com form and the data was exported after collection into Microsoft Excel and then imported into a statistical software package (SPSS). The information was securely stored on the researcher’s computer and password protected.

**Data Analysis**

**Independent (Predictor) Variables**

In this study the independent variable was attachment style- secure, and not-secure. The first question of the *Relationship Questionnaire* asks respondents to circle the paragraph that “best describes you or the way you are in close relationships.” Participants were then categorized into a secure or not secure category based on the answer to this
question. The not secure category encompassed the attachment styles of preoccupied, dismissing and fearful attachment styles.

**Dependent (Outcome) Variables**

There were four dependent variables which described growth and change in this study. Posttraumatic growth, measured by the PTGI; and Compassion Satisfaction (ProQOL sub scale) represented growth and positive change. Compassion fatigue/secondary traumatic stress and the Burnout subscales of the ProQOL represented negative psychological changes. A total score for posttraumatic growth was obtained by summing the ten questions of the PTGI-SF. Each of the subscales of the ProQOL had reverse scored items. Once these items were reverse scored, the total score variables were created for each subscale by summing the items. For each of the dependent variables, a higher score meant a greater amount of growth or change.

**Covariates (Predictors used in Multiple Regression Analyses)**

From a comprehensive review of the literature, several personal and professional factors were identified as possibly contributing to positive and negative change in mental health professionals working with survivors of trauma. The intention of this study was to examine if secure attachment style predicted growth or change over and above these identified factors, and also to identify the contribution of each variable. The following covariates were used: Age, gender, specialized training in trauma, attended weekly supervision, have received personal therapy, have a personal history of trauma and sense of coherence.
Participants were asked to answer yes/no to having specialist training; having received personal therapy; and if they had a personal history of trauma. These answers were then coded “yes=1” “no =0” as categorical dummy variables for use in the data analysis. Question 13 of the survey asked about the number of hours spent in supervision – either as an individual, in group supervision, peer supervision or in consultation on the trauma work. Answers were coded into a supervision variable “yes=1” and “no=0” where the answer yes indicated a minimum of one hour or more spent weekly in group/individual/peer supervision or consultation.

A sense of coherence variable was obtained by summing the 13 items on the SOC scale, after first reverse scoring specific items.

Upon completion of the data collection, the data was exported into an Excel spreadsheet and then imported into SPSS Version 22 and the data cleaned. Participants’ responses were examined for missing data; if there were items missing on the four dependent variables then the response was discarded. This reduced the sample size to 381.

All data analysis was conducted using SPSS. Descriptive statistics of all variables were first conducted and checked for assumptions of normality. This included examining the mean, minimum, maximum, standard deviation, and skew statistics. The descriptive statistics were used to summarize information about the sample. Frequencies and percentages were used to describe data at the nominal level and means and standard deviations were used to summarize interval data (posttraumatic growth; compassion satisfaction; compassion fatigue/STS; burnout and sense of coherence).
In order to address the research hypotheses of whether attachment style predicts positive growth or negative change in trauma therapists, four hierarchical multiple regression analyses were run. A four-step hierarchical multiple regression model was used that included the previously identified personal and professional factors that contributed to positive growth and negative change from the literature and could have confounded the relationship between attachment style and the dependent (outcome) variables. The models used the simple entry method to input the variables. Step 1 entered gender and age. Step 2 included specialist training, personal therapy, history of personal trauma and supervision. Step 3 added sense of coherence scores. Step 4 included secure attachment style. Multiple regression analyses were used to identify both the unique contribution of each predictor variable given the other variables controlled for, as well as the overall predictive power of secure attachment style. A multiple regression model was run for each of the four outcome variables. These analyses used the pairwise option of dealing with missing data in SPSS, so sample sizes varied.

The amount of variance in the dependent variable was examined by the $R^2$ value and the change in the adjusted $R^2$ value at each step of the hierarchical multiple linear regression. $R^2$ acted as an indicator of the effect size (Frazier, Tix & Barron, 2004). Significance of the model was determined by the $F$ value and significant $F$ change value at each step (or model) and corresponding $p$-value.

The unique contribution of each variable was determined by the standardized beta values and corresponding $p$-values. A significance level of .05 was used throughout the
data analysis to determine significance because of the exploratory nature of the study. Results of the analyses described in this chapter are presented in Chapter Four.

Chapter Four

The purpose of my study was to explore if secure attachment style was predictive of positive and negative psychological change in a sample of mental health professionals counseling survivors of trauma. In addition, the relevance of personal and professional factors were examined in relation to positive and negative changes indicated by measures of posttraumatic growth, compassion satisfaction, secondary traumatic stress and burnout.

Although the negative changes of working in the field of trauma counseling have been well-documented, there is much less information about the positive effects. In particular the construct of posttraumatic growth is less well researched, and very little research has examined the effects of attachment style on these constructs.

This chapter summarizes the results of the data analysis. First, descriptive data are presented for all variables used in the analyses. Next the results of the hypotheses are presented. Finally, the secondary research question is addressed.

Results

Participants in this study completed a 70-item instrument comprised of a demographic questionnaire and four established scales. The first scale, the Relationship Questionnaire (RQ) is a self-report measure designed to assess individual attachment styles. The RQ asks respondents to choose the attachment style that they perceive as most
appropriate for their general relationship style from four short paragraphs describing attachment style. The respondents are then asked to rate how each description corresponds to their general relationship style on a 7-point Likert scale from 1 (*Not at all like me*) to seven (*Very much like me*).

Participants’ attachment styles, secure or not-secure, were determined by their responses to the first item on the *RQ*. The majority (276, 72.4%) were identified as having a secure attachment style, 50 (13.1%) were identified as having fearful attachment styles, 18 (4.7%) were identified as having preoccupied attachment styles, and 37 (9.6%) were identified as having dismissing attachment styles. This was a similar pattern to that found by Yusof and Carpenter (2013) in a sample of family therapists in the United Kingdom. In that study, nearly three quarters of the respondents chose the ‘secure’ attachment style, with fewer than one in five participants choosing the ‘fearful’ attachment style, and very few describing themselves as either having a ‘preoccupied’ attachment style or a ‘dismissing’ attachment style. A categorical variable for attachment was created by collapsing the categories for fearful, preoccupied and dismissing attachment into the category “not-secure”, providing a “secure” and “not-secure” dichotomous variable. Secure attachment accounted for 72.4% of the sample, with 27.6% being “not-secure” attachment styles (n=381). The second part of the *Relationship Questionnaire* asks participants to rate themselves on a 1-7 Likert scale of how much like them each statement is. These scores were used to verify the answers given in the first part of the measure.
The second scale, the Posttraumatic growth Inventory-Short Form (PTG-SF) measured positive outcomes following traumatic experience. The PTGI-SF contained 10 items and was answered on a 6-point Likert scale ranging from 0 (I did not experience this change as a result of my work with trauma clients) to five (I experienced this change to a very great degree as a result of my work with trauma clients). A total posttraumatic growth score was obtained by summing the scores for each participant. Scores in this study for posttraumatic growth ranged from 0 to 50, with higher scores indicating greater positive change ($M=24.38$, $SD=12.62$). The PTGI-SF is a relatively new scale, adapted from the 21-item PTGI. In a study of psychiatric outpatients with a refugee background in Norway, the mean PTGI-SF total score was 22.6 ($SD=10.1$) (Teodorescu, et al., 2012). With a sample of veterans from the Iraq war, Kaler et al. (2011) found a mean score on the PTGI-SF of 20.40 ($SD=11.88$).

The Professional Quality of Life Scale (ProQOL-5) was also used to assess positive and negative change. The 30-item ProQOL measured burnout, compassion fatigue and compassion satisfaction. It has a response format ranging from 1 (Never) to five (Very often) and has three subscales: Compassion satisfaction, compassion fatigue/secondary traumatic stress and burnout. Each subscale contains ten items. Scores are obtained by reversing specific scores and then summing the total for each subscale. Scores on the compassion satisfaction subscale ranged from 10-50 ($M=42.97$, $SD=4.84$). Compassion satisfaction is about the pleasure you derive from being able to do your work well. Higher scores on this subscale represented a greater satisfaction related to one’s ability to be an effective trauma counselor. For this study the mean score was 42.97.
Using Stamm’s (2010) guidelines for cut-off scores for low, average and high levels of CS, the scores for the current study fell into the average (35.7%) and high (64.3%) compassion satisfaction levels.

The burnout scale is associated with feelings of hopelessness and difficulties in dealing with work or in doing your job effectively. Higher scores on this scale indicates one is at a higher risk for burnout. The respondents in the current study scored in the low range ($M=18.69, SD=4.44$) with 85% in the low range and the remaining 15% in the average range.

The third subscale of the ProQOL measures the other component of compassion fatigue, secondary traumatic stress (STS). It is about work-related, secondary exposure to extremely or traumatically stressful events. Stamm (2010) said “developing problems due to other’s trauma is somewhat rare but does happen to many people who care for those who have experienced extremely or traumatically stressful events,” (p. 28). Using Stamm’s cut-off scores, 81.1% of the sample experienced low STS and the remaining 18.9% average STS ($M=18.18, SD=4.4$). Overall, the mean standardized scores for this study indicated high compassion satisfaction, low burnout and low levels of secondary traumatic stress.

The final scale was the Sense of Coherence 13-item short version. All items had 7-point response scales with the anchors defined. A scale score was computed by adding the scores of all individual items after reverse scoring of five items. Scores on the SOC scale could range from 13 (lowest sense of coherence) to 91 (highest sense of coherence). Scores from the current study ranged from 32-88. The mean score was 72.79 ($SD=10.21$).
This is slightly higher than the mean score for \( SOC (M=67.89, SD=10.88) \) in a sample of therapists working with trauma clients in Great Britain.

**Descriptive Data on the Independent and Dependent Variables**

Before the data was analyzed, checks for violations of assumptions were conducted. Cases with missing data on the dependent variables were removed. The data was screened for outliers, multicollinearity and singularity. Finally, the data were examined for normality, linearity, homoscedasticity and independence of residuals, by a review of the residuals plot. These assumptions were satisfied with this data sample.

Descriptive statistics for the independent variables and covariates are presented in table 2.

Table 2

*Descriptive Statistics for Independent Variables & Covariates*

<table>
<thead>
<tr>
<th>Variable</th>
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<th>%</th>
</tr>
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<tbody>
<tr>
<td>Attachment</td>
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<tr>
<td>Secure</td>
<td>276</td>
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<tr>
<td>Non Secure</td>
<td>105</td>
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</tr>
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<td></td>
</tr>
<tr>
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</tr>
<tr>
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</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>30-39</td>
<td>44</td>
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<td>40-49</td>
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</tr>
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</tr>
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<tr>
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</tr>
<tr>
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Received Personal Therapy

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</tr>
<tr>
<td>Percentage</td>
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Weekly Supervision

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</thead>
<tbody>
<tr>
<td>Total</td>
<td>321</td>
<td>54</td>
</tr>
<tr>
<td>Percentage</td>
<td>85.6</td>
<td>14.4</td>
</tr>
</tbody>
</table>

Note: Where numbers do not add up to $N=381$ indicates missing data for that variable

The age range of the sample was between 30 and 60 plus. Only one case fell into a lower range, and this case was eliminated when the data was screened for missing data on the dependent variables. Inter-correlations between the variables were also calculated and the results are presented in Table 3.

The strongest relationship between the dependent variables was a negative one between burnout and compassion satisfaction $r(379) = -0.608, p < .01$. The second strongest was a positive correlation between burnout and secondary traumatic stress $r(379) = 0.526, p < .01$. Neither of the correlations was so strong that they appeared to be measuring the same construct.

Another strongly significant relationship among the variables was a negative one between burnout and sense of coherence $r(379) = -0.633, p < .001$. Although there were several significant relationships among the other variables, the magnitude of correlations was not sufficient to pose any problems with multicollinearity.
Table 3

Means, Standard Deviations and Correlation Coefficients for PTG, CS, BO, and STS, Predictor Variables and Covariates

<p>| | | | | | | | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
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<td>.086</td>
<td>.293**</td>
<td>-.188**</td>
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<td>.072</td>
<td>.074</td>
<td>.243**</td>
<td>.145**</td>
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<td>-.013</td>
<td>.159**</td>
<td>.086</td>
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<td>3. Burnout</td>
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<td>.086</td>
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<td>.075</td>
</tr>
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<td>-.226**</td>
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<td>-.047</td>
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<td>.014</td>
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<td>.090</td>
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<tr>
<td>7. Age</td>
<td>.072</td>
<td>.159**</td>
<td>-.137*</td>
<td>.041</td>
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<td>8. Specialist Training</td>
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<td>.080</td>
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<td>9. Supervision</td>
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<td>.075</td>
<td>.071</td>
<td>-.047</td>
<td>.087</td>
<td>-.106**</td>
<td>.004</td>
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<td>.078</td>
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<td>10. Trauma Survivor</td>
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<td>.064</td>
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<td>.290**</td>
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<td>11. Personal Therapy</td>
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<td>.078</td>
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<td>-.219**</td>
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<td>.323**</td>
<td>.126*</td>
<td>.078</td>
<td>.027</td>
<td>-.027</td>
<td>-.184*</td>
<td>-.029</td>
</tr>
</tbody>
</table>

*Note: N ranges from 214-381.

*p < .05, **p < .01
Hypothesis Testing

In order to answer the hypotheses outlined in chapter three, four 4-step hierarchical multiple regression analyses were run. Data was analyzed using multiple regression analyses in order to predict the relationship between the predictor variable of secure attachment style and the criterion variables, posttraumatic growth, compassion satisfaction, burnout and secondary traumatic stress, while controlling for personal and professional factors. The overall sample size was 381. However, this was further reduced to 208 for the regression analyses including the SOC scale. This was because a large number of participants did not complete the SOC scale, the last measure in the survey of 70 questions.

The impact of trauma work has been studied to identify possible personal and professional predictors, but the results have been inconsistent. Female therapists have reported greater levels of personal growth (Linley & Joseph, 2004, 2007) but Craig & Sprang (2010) found gender was not a predictor of CS, STS or BO. Maturity likewise was found to be a powerful predictor of CS and youth to be a risk factor for BO (Craig & Sprang, 2010; Sodeke-Gregson, Holttum & Billings, 2013).

A previous personal history of trauma was found by some to indicate higher levels of distress (Kassam-Adams, 1999; Pearlman & MacIan, 1995), although this was not found to be the case by Schauben and Frazier (1995). Previous research had found supervision predicted higher potential for CS (Sodeke-Gregson et al., 2013) whilst Pearlman and Mac Ian (1995) reported that therapists not receiving supervision showed more cognitive disruptions. Therapists with special trauma training have been found to
report significantly more CS and less burnout than those who did not have training (Craig & Sprang, 2010)

SOC has been found to be a positive predictor for growth (Linley & Joseph, 2007; Linley et al., 2005). But Brockhouse et al. (2011) also found that SOC negatively predicted vicarious posttraumatic growth. The following factors were deemed important to investigate further.

On the first step of the model gender and age were entered. Age was coded as a dummy variable for each category (e.g. 30-39yrs =1 everything else =0; 40-49 =1 with everything else =0; 50-59 =1 everything else =0) with the reference category being 60 plus years. On the second step, having a personal history of trauma (yes=1, no =0), having received personal therapy (yes=1, no =0), being a specialist (yes=1, no =0), and having weekly supervision (yes=1, no =0), were entered. Sense of coherence total scores were entered at step 3. On the fourth and final step, while controlling for all other variables, secure attachment style was entered (Secure =1, not secure=0). This was so the value of attachment over and above all the other variables could be measured.

Tables summarize the results by unstandardized regression weights (Bs), standard errors, standardized regression weights (βs), $R^2$ and $R^2$ changes for each step in the hierarchical regression models for the respective dependent variables.

_Hypothesis 1. After controlling for statistically significant demographic variables towards positive psychological growth, there will be a significant relationship between secure attachment style and posttraumatic growth._
The results of the regression are presented in table 4. A significant model emerged: $F (8, 200) = 4.00, p < .001$, explaining 13.7% of the variance in PTG. At the first step of the model, neither age nor gender were a significant contributor to the model. At the second step, weekly supervision was a significant contributor to the model.

For the third step, age became a significant contributor, and sense of coherence. At the fourth step no additional contribution was made. Age, supervision and sense of coherence were significant predictors of posttraumatic growth. This indicated that as therapists age they have potential for more PTG. A higher level of SOC, and receiving weekly supervision also gave therapists potential for greater posttraumatic growth. Attachment style did not contribute to PTG in this sample. This hypothesis was not supported.
### Table 4

**Summary of Hierarchical Regression Analysis for Variables Predicting Posttraumatic Growth**

<table>
<thead>
<tr>
<th>Variable</th>
<th>B</th>
<th>SE B</th>
<th>β</th>
<th>( R^2 )</th>
<th>( \Delta R^2 )</th>
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<tbody>
<tr>
<td><strong>Step 1</strong></td>
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<td></td>
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<td>.005</td>
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<td>Gender(^a)</td>
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<td>.073</td>
<td></td>
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<tr>
<td><strong>Step 2</strong></td>
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<td></td>
<td></td>
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<td>.098***</td>
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<td>Gender</td>
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<td></td>
</tr>
<tr>
<td>Age</td>
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<td>.844</td>
<td>.096</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Survivor(^b)</td>
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<td>1.811</td>
<td>.086</td>
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<td></td>
</tr>
<tr>
<td>Therapy(^c)</td>
<td>4.245</td>
<td>2.336</td>
<td>.127</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialist(^d)</td>
<td>2.131</td>
<td>2.703</td>
<td>.053</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supervision(^e)</td>
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<td>2.424</td>
<td>.238**</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Step 3</strong></td>
<td></td>
<td></td>
<td></td>
<td>.137*</td>
<td>.034*</td>
</tr>
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<td>-.035</td>
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<tr>
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<td>.138*</td>
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<tr>
<td>Therapy</td>
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<td>2.304</td>
<td>.112</td>
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<tr>
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<td>2.667</td>
<td>.068</td>
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<td>.237***</td>
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<td>-.192**</td>
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</tr>
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<td><strong>Step 4</strong></td>
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<td></td>
<td></td>
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<td>.000</td>
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<td>2.215</td>
<td>-.035</td>
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<td></td>
</tr>
<tr>
<td>Age</td>
<td>1.723</td>
<td>.852</td>
<td>.137*</td>
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<td>2.674</td>
<td>.068</td>
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<tr>
<td>Supervision</td>
<td>8.524</td>
<td>2.390</td>
<td>.238***</td>
<td></td>
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</tr>
<tr>
<td>SOC</td>
<td>-.240</td>
<td>.089</td>
<td>-.194**</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Secure Attach(^f)</td>
<td>-.157</td>
<td>2.010</td>
<td>-.078</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: \( N = 208 \)

\(^a\)Female=1, Male=0; \(^b\)Survivor of personal trauma=1, not a survivor=0; \(^c\)Received personal therapy=1, no therapy=0; \(^d\)Specialist trauma training=1, no training=0; \(^e\)Weekly supervision/consultation=1, none=0; \(^f\) Secure attachment =1, not secure=0

\( *p<.05 \) **\( p<.01 \) ***\( p<.001 \)
Hypothesis 2. Secure attachment style will be positively related to compassion satisfaction.

A hierarchical regression analysis was run for the dependent variable of compassion satisfaction. Results of the analysis are presented in Table 5.

The same blocks of independent variables were entered as for PTG, in the same order. A significant model emerged $F(8, 200)=13.03$, $p<.001$, explaining 34.3% of the variance in CS. Age was the only significant contributor at steps one and two of the model, but disappeared at step three when SOC was added. At step 3, being a trauma survivor and sense of coherence were significant predictors of compassion satisfaction. This indicated that having a personal history of trauma predicted higher levels of compassion satisfaction, possibly because of the help individuals may offer to someone in a similar situation to one they experienced. Having a high SOC was a more powerful predictor than becoming older or having been a survivor. Secure attachment did not significantly contribute to the model, so this hypothesis was not supported.
Table 5

Summary of Hierarchical Regression Analysis for Variables Predicting Compassion Satisfaction

<table>
<thead>
<tr>
<th>Variable</th>
<th>B</th>
<th>SE B</th>
<th>β</th>
<th>( R^2 )</th>
<th>( \Delta R^2 )</th>
</tr>
</thead>
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<td><strong>Step 1</strong></td>
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<td>Gender(^a)</td>
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<tr>
<td><strong>Step 2</strong></td>
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<td>0.721</td>
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<td>Therapy(^c)</td>
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<tr>
<td>Specialist(^d)</td>
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<tr>
<td>Supervision(^e)</td>
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<td>0.579***</td>
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</tr>
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<td>0.046</td>
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<td>0.895</td>
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<td>0.030</td>
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<tr>
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<td>0.356</td>
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</table>

Note: \( N=208 \)

\(^a\)Female=1, Male=0; \(^b\)Survivor of personal trauma=1, not a survivor=0; \(^c\)Received personal therapy=1, no therapy=0; \(^d\)Specialist trauma training=1, no training=0; \(^e\)Weekly supervision/consultation=1, none=0; \(^f\)Secure attachment =1, not secure=0

\(* p<.05 \quad ** p<.01 \quad *** p<.001 \)
Hypothesis 3. Other attachment styles will be positively related to compassion fatigue and burnout.

For the dependent variable of compassion fatigue/secondary traumatic stress a significant model was indicated: $F(8, 200) = 12.33, p < .001$. At step 2, having received personal therapy was a significant contributor to CF/STS. Age and sense of coherence were significant predictors at step 3, with SOC being a strong negative predictor of STS. At step four, the three contributing factors were age, having received therapy and SOC contributing 33% of the variance in STS scores. Attachment did not contribute significantly to the model, and thus this hypothesis was not supported.

Therapists who were older, had received personal therapy and who had lower sense of coherence had the potential for higher levels of compassion fatigue/secondary traumatic stress.

The results are presented in table 6.

For the dependent variable of burnout a significant model was obtained: $F(8, 200) = 17.57, p < .001$, explaining 41.3% of the variance in burnout. The only significant predictor was sense of coherence. Age was significant at step 1 with younger therapists being more at risk of burnout, but this disappeared when other factors were entered into the model at step 2. A lower sense of coherence predicted higher burnout scores. Results from this analysis are presented in table 7. Attachment was not significant for burnout or for secondary traumatic stress, therefore this hypothesis was not supported.
### Table 6

*Summary of Hierarchical Regression Analysis for Variables Predicting Secondary Traumatic Stress*

<table>
<thead>
<tr>
<th>Step</th>
<th>Variable</th>
<th>B</th>
<th>SE B</th>
<th>β</th>
<th>R²</th>
<th>Δ R²</th>
</tr>
</thead>
<tbody>
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<td>1</td>
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<td>.010</td>
<td>.002</td>
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<td>.041</td>
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<td></td>
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<td>2</td>
<td>Gender</td>
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<td>.805</td>
<td>.000</td>
<td>.040</td>
<td>.038</td>
</tr>
<tr>
<td></td>
<td>Age</td>
<td>.218</td>
<td>.307</td>
<td>.049</td>
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<td>.658</td>
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Note: N=208

⁹Female=1, Male=0; bSurvivor of personal trauma=1, not a survivor=0; cReceived personal therapy=1, no therapy=0; dSpecialist trauma training=1, no training=0; eWeekly supervision/consultation=1, none=0; fSecure attachment =1, not secure=0

*p<.05 ** p<.01 ***p<.001
Table 7

*Summary of Hierarchical Regression Analysis for Variables Predicting Burnout*

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Note: \( N = 208 \)

*Female=1, Male=0; bSurvivor of personal trauma=1, not a survivor=0, cReceived personal therapy=1, no therapy=0, dSpecialist trauma training=1, no training=0, eWeekly supervision/consultation=1, none=0, f Secure attachment =1, not secure=0.

*p<.05 ** p<.01 ***p<.001*
Hypothesis 4. Other attachment styles will be negatively related to posttraumatic growth.

Secure attachment style did not relate to posttraumatic growth, either positively or negatively, as shown in the regression analysis run for Hypothesis 1.

Secondary Research Question

The secondary research question in this study was to look at the personal and professional factors contributing to positive and negative psychological change in trauma therapists. There were seven factors that were identified in the research literature as contributing to these changes (described in Chapter Two). These were: age, gender, being a survivor of trauma, having received personal therapy, having undertaken specialist trauma training, receiving weekly supervision and the personality construct sense of coherence.

As can be seen by the multiple regression models in Tables 4-7, the following results were identified. In this study gender and having specialist trauma training were not significant predictors in either positive or negative change. Age was relevant for posttraumatic growth and secondary traumatic stress. It was also a significant predictor at step 1 for compassion satisfaction and burnout, but disappeared from the model when other factors were added.

Having received personal therapy was a significant predictor for secondary traumatic stress only. Being a survivor of trauma was a significant predictor for compassion satisfaction. Attending weekly supervision was a significant predictor of posttraumatic growth.
The only common factor that contributed to change and growth across the models was sense of coherence. Sense of coherence was positively related to compassion satisfaction and negatively related to burnout, secondary traumatic stress and posttraumatic growth. That is, a lower sense of coherence predicted a higher level of burnout, compassion fatigue and posttraumatic growth.

In summary, individuals having a lower sense of coherence, being older, and receiving supervision resulted in more posttraumatic growth. For compassion satisfaction, being a trauma survivor and having a greater sense of coherence were significant predictors. For negative psychological change, a lower sense of coherence predicted both higher levels of secondary traumatic stress and burnout; and for STS only, older people and those who had received personal therapy also had higher levels of STS.

Some caution is needed however in the interpretation of the results with very small coefficients for some findings. Although showing statistical significance, for a very small coefficient size, the implications may not be meaningful without further research replicating results with larger sample sizes. The sample size for the regression analyses was also reduced to an $N$ of 208 because of the number of participants who completed the SOC scale. A missing data analysis run in SPSS did not find any systematic pattern of missing data. The SOC scale was the last 13 items of the survey of 70 questions and participant fatigue may have been a factor at this point.
Chapter Five

Working with trauma survivors is difficult work and brings therapists into contact with the consequences of cruelty and suffering. Counselors can be profoundly impacted by this work especially in the first five years of practice (Pack, 2014). However, the work can also transform trauma therapists from experiencing sadness, depression and shattered assumptions about their world into hope and a renewed sense of purpose (Figley, 1999; Linley, Joseph & Loumidis, 2005). Traumatic stress, compassion fatigue and burnout are not the only possible responses to trauma counseling with survivors. These benefits are further defined as positive feelings from helping others, finding meaning in one’s efforts and challenges, fulfilling one’s potential, contributing to the work setting and even the greater good of society, and the overall pleasure of being able to do one’s work well (Stamm, 2010). Thus, the consequences of working with survivors of trauma are not only negative, but can contain positives as well.

Much of the research on the negative effects of vicarious trauma has focused on the predictors of potential negative consequences of trauma work resulting from exposure to the client’s traumatic material. Beliefs about one’s safety also impact the development of vicarious trauma, and much of the research to date have focused on the trauma-related and organizational factors that contributed to therapist distress (Devilly, Wright & Varker, 2009). Fewer research studies have focused on how individual differences effected the development of vicarious trauma, why some people thrive as trauma therapists but others become emotionally exhausted and burnt out. The relative contribution of personal, professional or organizational factors is unclear.
On the other hand, there is a potential for positive change and growth for mental health professionals in this field, even though it has not been explored as frequently (Arnold et al., 2005; Kjellenberg, Nilsson, Daukantaité, & Cardeña, 2013). With the advent of the positive psychology movement in the 1990s, there has been an increase in research interest in studying people who are healthy, and the better and brighter aspects of human behavior. Initially, the literature had focused on resilience, or how individuals bounce back after a trauma, but it is only recently that the literature is beginning to focus on the benefits of experiencing trauma (Haidt, 2006).

Therefore, in this study I examined the role of predictors of positive change and growth on mental health professionals in this field. In particular, I was interested in examining if a secure attachment style, for those professionals with such a style, would predict more positive change, and what other personal and professional resources might contribute to positive change and growth, or to negative psychological changes.

A total of 381 licensed, mental health professionals completed an online survey comprised of 70 items, including information on demographics and four published measures. These measures included the Relationship Questionnaire for attachment style; the Posttraumatic Growth Inventory-Short Form measuring vicarious posttraumatic growth; the Professional Quality of Life scale measuring compassion satisfaction, compassion fatigue/secondary traumatic stress, and burnout; and the Sense of Coherence scale. Data from the survey were used for statistical analysis to compare variables and to assess contributions of different variables for predicting positive and negative changes in trauma therapists.
A total of 436 participants opened the survey; 395 completed it. After deleting participants who had missing data on the dependent variables, the overall sample included 381 participants. However, this was further reduced to 208 when regression analyses including the SOC scale were included. This was because a large number of participants did not complete the SOC scale, the last measure in the survey of 70 questions.

The sample was comprised of predominantly White, female professionals over the age of 50, who had obtained specialist training in trauma work and were currently in private practice. The majority had also received personal therapy, and were receiving weekly supervision (individual/peer or group) and/or consultation on their trauma work. Over two thirds of the sample reported secure attachment styles.

In this chapter I review the implications of the results presented in chapter four. The results of the analyses will be discussed in reference to developing a fuller understanding of both the significant and non-significant findings, as well as their relationship to previous research findings. Also included are sections on implications for practice, suggestions for future research and the limitations of this study.

Discussion

This study included four hypotheses and a secondary research question. The main focus of the four hypotheses required examining if a secure attachment style related to psychological growth or negative psychological change as a result of mental health professionals counseling trauma survivors. The secondary research question investigated the potential contribution of various personal and professional factors to positive
psychological growth and negative change. This was an important focus because of the
lack of studies on what contributed to positive growth, and the inconsistent nature of
those findings (Sodeke-Gregson et al., 2013).

In therapeutic relationships, it has been suggested that attachment theory provided
a framework for understanding the inner resources that sustained helpers as they dealt
with the emotional strains of caring for traumatized people (Pardess et al., 2013;
Racanelli, 2005; Yusof & Carpenter, 2013). Theoretically, each individual possesses an
intrinsic behavioral system which aims to seek proximity to caring and supportive others
(“attachment figures”) when feeling threatened (Bowlby, 1980). The extent to which an
attachment figure is caring, sensitive and responsive to the proximity-seeking need of the
individual contributes to the creation of a sense of attachment security. Attachment
security facilitates the internal stance that the world is generally a safe place, and that one
can rely on the attachment figure(s) to be available when needed (Bretherton, 1985;
Sroufe & Waters, 1977). When engaging empathically with traumatic disclosures in their
work with trauma survivors, mental health professionals run the risk of being traumatized
themselves, and developing vicarious traumatization, but also the means of building
vicarious posttraumatic growth (Arnold et al., 2005; Brockhouse et al., 2011, Linley &
Joseph, 2007). Trauma can overwhelm one’s sense of safety and challenge a sense of self
and so a person’s response in times of ‘threat’ is related to their internal working models
such that they may, for example, seek to reduce the anxiety by seeking closeness if
securely attached or by avoidance if not securely attached (Yusof & Carpenter, 2013).
The therapists own attachment insecurity might be activated under stressful conditions.
An individual with secure attachment would know when and where to seek support or protection with confidence, whereas an insecurely attached person may view the world as “comfortless and unpredictable, and they respond either by shrinking from it or doing battle with it” (Bowlby, 1973, p.208). Therefore, it was hypothesized that securely attached therapists would show less vicarious trauma in the form of compassion fatigue and burnout and more growth as in compassion satisfaction and posttraumatic growth.

**Significant Findings**

I hypothesized that a secure attachment style would significantly contribute to PTG and CS. After accounting for the personal and professional factors related to compassion satisfaction, secure attachment did not show a predictive value. Therefore, an in-depth discussion of attachment theory and positive psychological growth and change is included under the section on non-significant findings.

The significant findings in this study involved the predictive value of various personal and professional factors that related to both positive and negative psychological changes in trauma therapists. The factors that were examined were gender, age, being a survivor of trauma, having received personal therapy, received specialist trauma training, attended weekly supervision and an individual’s sense of coherence. These factors were examined in four separate hierarchical regression analyses for each of the outcome variables of PTG, compassion satisfaction, compassion fatigue/secondary traumatic stress and burnout.

The most significant and strongest predictor of growth and change across the models in this sample was the personality construct sense of coherence. Antonovsky
(1996) claimed that the stronger a person’s SOC when confronted with a stressor, the more likely it is that the person will: 1) be motivated to cope (meaningfulness), 2) believe that the challenge is understood (comprehensibility) and 3) believe that the resources to cope are available. An individual’s SOC strength can be regarded as a vital element in the structure of an individual’s personality that facilitates the coping and adaptation process. According to Antonovsky’s theory this ability depends on the strength of an individual’s SOC which is determined by an individual’s general resistance resources (resources that can aid resistance to stressors) and their effective deployment.

In this sample, sense of coherence strongly predicted compassion satisfaction ($\beta=.561$, $p<.001$) where higher levels of sense of coherence were associated with greater compassion satisfaction. Lower levels of sense of coherence predicted greater compassion fatigue/secondary traumatic stress and more burnout. By definition, a higher SOC might help trauma therapists access their resources and reach out for help when required. Therapists with a higher SOC can appraise a situation and choose appropriate ways to deal with demands and difficulties despite highly stressful circumstances.

These findings supported the conclusions drawn by other researchers. For example, Linley, Joseph and Loumidis (2005) also found that therapists scoring higher on SOC endorsed fewer negative changes and more positive changes (as measured by the Changes in Outlook questionnaire). They suggested that the SOC personality construct was a potentially useful way of conceptualizing personality factors that influenced positive and negative adaptation to dealing with the trauma experience of others. These findings also supported Antonovsky’s (1979) conclusion that individuals with high levels
of SOC are less likely to perceive stressful situations as threatening and anxiety-provoking than individuals with lower levels of SOC. The findings of my study appear to corroborate that suggestion.

Sense of coherence also negatively predicted secondary traumatic stress ($\beta = -0.580, p<0.001$) and burnout ($\beta = -0.638, p<0.001$). These findings are in line with other studies that found a negative relationship between SOC and burnout and STS/CF among trauma counselors (Ortlepp & Friedman, 2002), psychotherapists (Linley et al., 2005) and residential child care workers (Zerach, 2013). As counselors, these professionals are often the first to hear about the trauma and traumatic experiences that their clients have experienced. However, being able to explain these emotionally intense situations as more manageable, more comprehensible and to find more meaning in the work they do might alleviate the anxiety they feel and thus less chance of a negative change in the therapist.

On the other hand, SOC was also significantly negatively associated with posttraumatic growth, although weakly ($\beta = -0.194, p<0.01$). Brockhouse et al., (2011) found that trauma therapists with higher SOC experienced lower levels of growth, as measured by the Post Traumatic Growth Inventory (PTGI) whereas previous studies (Linley & Joseph, 2007; Linley et al., 2005) had found no relationship with growth or a positive relationship. They suggested that this may be due to differences in the coherence level between samples. The sample in Brockhouse et al.’s study, similar to mine, had moderate to high levels of coherence, which they suggested may help therapists cope with an initial “seismic disruption” to their schemas caused by vicarious exposure to trauma. Therefore, the highly coherent therapist would have less opportunity to positively
accommodate new information and less opportunity for growth (Brockhouse et al., 2011, p.740) as they are not being challenged sufficiently by the new information. My results showed that as SOC increased, so growth levels decreased, following Brockhouse et al.’s conclusions.

According to researchers (Calhoun & Tedeschi, 2006; Joseph & Linley, 2008) for posttraumatic growth to occur the initial disruption of the assumptive world is processed through ruminative cognitive work, followed by growth and ultimately, well-being. However, it is possible that people who are higher in the dimensions of coping such as secure attachment, and a high sense of coherence will report relatively little growth as they already hold coping strategies that allow them to be less challenged by the trauma, a necessary component of PTG. A correlation between PTG and CF/STS also indicated that a person needed to experience a certain amount of trauma before experiencing growth, and that PTG developed only after a certain amount of compassion distress is experienced (Shiri, Wexler, Alkalay, Meiner, & Kreitler, 2008). The low levels of STS and burnout in this sample may thus have contributed to the low levels of PTG.

Because the sample was comprised of older, more experienced clinicians, with specialist training it is possible that this group had already developed good coping skills and therefore reported less PTG. If the sample had included younger therapists, and those new to the profession, there might have been different results and more PTG.

As discussed in chapter two, one’s sense of coherence is shaped by early childhood experiences. Sense of coherence may be one way that one’s attachment style influences well-being as there may be an integral relationship between the forming of an
individual’s personal coherence arising from his/her early positive attachment experiences.

One of the longitudinal studies on attachment found that young adults who were securely attached to their mothers in infancy displayed a stronger SOC compared to young adults whose attachment in infancy was insecure (Sagi-Shwartz & Viezer, 2005). This corroborated Antonovsky’s (1998) claim that one’s early experiences constitute a crucial context for the molding of one’s inner strength when dealing with the challenges of life. In particular, the SOC construct represented individuals’ ability to cope with stress in their lives based on their feelings that the world makes sense, is meaningful, and that they have the means at their disposal to manage it.

In my study, the factors of age and supervision were significant predictors of positive change. Age was a significant positive predictor of posttraumatic growth ($\beta=.137$, $p<.01$), and for compassion satisfaction at the first two steps of the regression model ($\beta=.157$ and $.127$, $p<.05$). Age was also significant in the regression models for secondary traumatic stress ($\beta=.169$, $p<.01$) and in step one for burnout ($\beta=-.136$, $p<.01$). For PTG and CS there was a small positive relationship, as age increased so did levels of growth. This disappeared at step 3 for CS, when other factors were entered. For burnout, at step one of the model, younger people experienced more burnout, but this relationship disappeared as more factors were added to the model. For STS there was a small relationship between increased age and increased levels of stress. Craig and Sprang (2002) also found that younger people were at significant risk of burnout.
In a study by Nilsson and Leppert (2010) there was a relationship between SOC and age, with stronger SOC in the older age groups and a larger proportion of individuals who experienced well-being as a function of age. Education and knowledge have also been linked to a stronger SOC (Antonovsky, 1987). In my sample, it is possible that the stage of life many therapists were in – middle to later mid-life- is one where reflective thinking and a desire to give back to society through their work also played a part in the relevance of predictors like age, supervision and strong sense of coherence for positive change and growth. Erikson’s (1956) stages of psycho-social development include that of generativity and ego integrity for the middle and later years. Adults at this point of their lives need to create or nurture things that will outlast them. One way to do this is to create positive change that benefits other people. Older adults’ stage of ego integrity leads to feelings of wisdom and reflecting on life and a feeling of fulfilment if this stage is successfully resolved.

Supervision was found to be the most significant predictor for the criterion variable of posttraumatic growth. Supervision has been found to be an important variable in promoting therapists’ well-being (Killian, 2008; Schauben & Frazier, 1995) and vicarious posttraumatic growth in other professions such as police officers (Huddleston, Paton & Stephens, 2006). Linley & Joseph (2007).also found clinical supervision to be a factor in therapists reporting higher levels of PTG. This finding reinforces the value of clinical supervision, consultation or peer support for the work of trauma therapists. This may be of particular importance for this sample, as the high proportion of therapists in
private practice may reduce the opportunities for discussion with professional colleagues than those working in community settings tend to have.

Being a trauma survivor was a predictor of CS, but not of CF/STS, burnout or PTG. This suggested that for those who have experienced trauma, being able to help and counsel other trauma survivors was particularly satisfying and rewarding. However, having received personal therapy was predictive of secondary traumatic stress. This was contrary to Linley & Joseph’s findings that therapists who either had been, or are receiving personal therapy in respect of their therapeutic work, reported more positive psychological change and less burnout. However, my findings were in line with Linley and Joseph’s (2007) conclusion pointing to the value of supervision in facilitating personal growth in therapists, and suggesting that a personal trauma history may be a facilitator of greater personal growth.

Results suggested that a high sense of coherence was more important than secure attachment in this sample. It is difficult to account for the strong and substantial effect SOC has on positive and negative change because clear causal inferences cannot be drawn from this cross-sectional study. But it does suggest the possible centrality of a high sense of coherence to positive change and growth in trauma therapists, and to its protective value against compassion fatigue and burnout.

It is probable that these mental health professionals could rely on personal and social resources in order to cope with any traumatic stress they feel. In addition, it was discovered that personal and professional factors have different impacts on the different outcome variables.
Results of Hypotheses

Despite the theoretical considerations outlined in chapters one and two suggesting that a secure attachment style would be predictive of positive psychological change in therapists as a consequence of their work with trauma survivors, this did not prove to be the case in this sample. Secure attachment was not a predictor of posttraumatic growth, compassion satisfaction, burnout, or secondary traumatic stress. Insecure attachment also did not predict any negative changes. The four hypotheses were not supported.

Previous research demonstrated inconsistent findings. Salo et al. (2005) found that exposure to torture and ill treatment were associated with high levels of growth in securely attached individuals. But Arikan and Karanci (2012) found no link between secure attachment and PTG in a sample of Turkish university students. They suggested that a secure attachment style may serve as a buffer against stress, protecting the secure individual from feeling as much stress as insecure individuals. Secure individuals may therefore develop strategies to cope with trauma (Dekel, 2007). The PTGI was designed to measure growth after direct exposure to a traumatic event. It may be that experiencing the traumatic events vicariously via clients’ narratives is not a sufficient challenge for securely attached therapists and does not activate their attachment systems.

Zerach (2013) found attachment-avoidance predicted compassion satisfaction in a sample of residential childcare workers using a different measure of attachment, the Experiences in Close Relationships measure. However, Tosone et al. (2010) found participant social workers who experienced 9/11 in Manhattan, experienced more trauma as a result of insecure attachment.
Racanelli (2005) found greater compassion satisfaction among clinicians with low attachment anxiety. However, in Dekel’s (2007) study of wives of prisoners of war, the more anxious and avoidant the wife’s attachment the greater her distress and the higher her level of PTG.

One possible theory for not finding a relation between attachment and positive and negative change in this sample may be found in the idea of shared trauma. In the studies where a relationship between attachment style and PTG, CS and STS was found, the clinicians involved evinced a much closer experience of recent trauma themselves. Tosone, Nuttman-Shwartz, & Stephens (2012) used the term “shared trauma” to describe narrative accounts of clinicians who are exposed to the same collective trauma as their clients – e.g., 9/11 for the social workers; Israeli clinicians chronically exposed to terrorist attacks (Racanelli, 2005). Therapists who work in traumatogenic environments such as areas prone to tsunamis, cyclones, hurricanes, tornadoes, earthquakes, floods, bushfires, as well as chronic acts of terrorism may find themselves impacted so deeply, both by their own experience and those of their clients, that they may undergo transformative changes, including the activation of their attachment systems.

Other studies provide evidence that secure attachment buffers the detrimental psychological effects of traumatic stressors, such as missile attacks (Mikulincer, Florian, & Weller, 1993), extreme life-endangering conditions (Mikulincer, Horesh, Eilati, & Kotler, 1999), captivity (Solomon, Ginzburg, Mikulincer, Neria, & Ohry, 1998), and September 11th (Fraley, Fazzari, Bonanno, & Dekel, 2006). This may be explained, in part, by the behavioral strategies developed over time to maximize closeness to the
attachment figure and aid in the regulation of affect. Secure people can mobilize caring qualities within themselves, qualities modeled on those of their attachment figures, as well as representations of being loved and valued. They can remain relatively unperturbed, even under stress.

This sample had a high percentage of securely attached individuals. This may be because of the use of a self-report measure and a degree of social desirability or “faking good” (Baer & Schwartz, 1991) in answering the RQ. However in Leiper and Casares’ (2000) study of clinical psychologists, attachment styles were measured using a quick self-categorization measure consisting of three statements (Hazan & Shaver, 1987) and three-quarters of the respondents (N=196) also rated themselves as secure. Similarly, about three-quarters of family therapists in the UK categorized themselves as secure using the RQ (Yusof & Carpenter, 2013). It may be that the RQ items and the underlying construct of “Attachment” are well understood by therapists and therefore the social desirability factor may be high. The use of an anonymous online survey may encourage more honest reporting, however, it could also be that therapists know that “secure” attachment is seen as psychologically healthy as it helps maintain a secure relationship with the client (Daniel, 2006). Participants in this study were educated, experienced and knowledgeable, and have had specialist training in their field. This may have been significant when answering questions on their personal and professional reactions to clients and relationship styles. However studies using different measures of attachment (self-report and interviews) have found similar results. In normal populations, the majority of individuals have a secure attachment style. A review of 10,000 attachment
interviews examined normative data on adult attachment in clinical and non-clinical populations and found 58% of individuals rated as secure (Van Ijzendoorn & Bakermans-Kranenburg, 1996).

Additionally, the participants in this study were grouped as either secure or not-secure for the statistical analysis. The not-secure group consisted of participants who were classified as preoccupied, fearful and dismissing types. Marmaras, Lee, Siegel and Rich (2003) suggested that dismissive-avoidant therapists may be in denial of any emotional distress and thus underreporting the negative changes they feel. Wilson and Thomas (2004) reported that avoidance and detachment was one of five specific types of reactions reported by trauma therapists.

It was also possible that experienced trauma therapists may be experiencing levels of desensitization to the trauma work, and thus their attachment systems may not be activated, or no longer activated by this work.

One reason for the surprising failure of therapists’ attachment style to predict positive or negative change, may be because the therapist may not view the client as an attachment object and therefore, the therapeutic relationship may not be activating the therapist’s attachment system (Farber, Lippert & Nevas, 1999). Hazan and Zeifner (1999) claimed that adult attachments are observed almost exclusively in “pair-bond” relationships. In adult romantic relationships, people occupy not only the “needy” position and expect to gain security and comfort from their partner but also the “caregiver” position, in which they are expected to provide care and support to their needy partner. The pair shift optimally between roles as required. Although Bowlby
(1988) and Ainsworth (1989) both depicted the therapeutic relationship as an attachment relationship, they also emphasized the therapist’s nonreciprocal role as an attachment figure, stating that the function of the therapist is to act as a secure base for the client’s attachment needs. Ligiero and Gelso’s (2002) suggested explanation for the lack of a significant relationship between therapists’ attachment style and both working alliance and countertransference behaviors was because the therapist does not see the client as an attachment figure, the therapist’s attachment style is not activated during sessions. Similarly, in my sample the therapists’ attachment systems may not be being activated. It may be that there are different role expectations of the therapist than those with an attachment figure.

Other non-significant findings related to gender and specialist training. Being female had been suggested as a predicting factor in higher levels of psychological change (Linley & Joseph, 2007), but my finding did not suggest this as no association between being female and the criterion variables were found. This was also true of Craig and Sprang’s (2009) study where female gender was not predictive of compassion satisfaction, compassion fatigue and burnout in a national sample of trauma therapists.

Compared with Craig and Sprang’s (2009) sample of trauma therapists where the respondents self-identified as trauma specialists, only 62 % reported that they had received trauma specific training and this training was predictive of less burnout. In my study, 88.9% reported having received specialist trauma training. This is perhaps not surprising as the sample used the EMDRIA as a source for participants. However, having received specialist training was not predictive of positive or negative change in this study.
Participants did report both secure attachment and high levels of compassion satisfaction and evidence of posttraumatic growth. Burnout and compassion fatigue/secondary traumatic stress were low. Stamm (2010) suggests that this combination of higher CS and low BO and STS is the most beneficial for professionals. Approximately two thirds of the respondents indicated a high level of compassion satisfaction (64.3%) based on the cut off scores provided by Stamm, with the remaining percentage falling in the average compassion satisfaction levels. Similarly, over 89% of the participants indicated low levels of secondary traumatic stress and burnout. Compared to Craig and Sprang’s study of trauma therapists where 46% scored in the high range for compassion satisfaction, my sample had somewhat higher compassion satisfaction. This was an encouraging result indicating that the vast majority of those therapists who responded enjoyed their work with survivors of trauma. This added to the research evidence suggesting that there is a positive impact of trauma work for mental health professionals.

Posttraumatic growth was also evident within the sample, with a mean score of 24.38, (range 0-50). Because the PTGI-SF is relatively recent, information concerning mean scores and thresholds indicating the presence of growth have not yet been published by the scale developers. However, other studies using the PTGI-SF found mean scores of 20.40 for national guards deployed to Iraq (Kaler et al., 2011) and 20.61 amongst undergraduate students who had experienced a highly stressful life event within the past two months (Cann et al., 2010). The current sample had higher growth levels than these other studies.
Positive change and growth were present as evidenced by the levels of compassion satisfaction and posttraumatic growth; as were burnout and secondary traumatic stress although at lower levels than might have been expected.

The findings of this study may be generalized to that population of therapists who share the characteristics of my sample (that is, older, White female trauma therapists in private practice). For future research a more representative and diverse sample would be desirable.

**Implications for Practice**

An understanding of how experienced trauma therapists cope with the stressors of the work can contribute to the future training, recruitment and supervision of trauma therapists and increase the possibility of future positive work experiences.

**Practitioners**

Therapists who work with or intend to work with trauma clients should be informed of the risks of working with these clients, such as vicarious traumatization and compassion fatigue. However, alongside this they should be made aware of the potential for compassion satisfaction and personal growth and the probability that they will experience both positive growth and possible negative change as well. Trauma work appears to have both negative and positive effects on the counselors. Difficult experiences can lead to growth but require time so that they can be processed individually and with others (Calhoun & Tedeschi, 2006). Therapists may well require therapy themselves at different points in their career.
Sense of coherence emerged as a strong predictor of positive change and growth. Therefore, as suggested by Linley & Joseph (2008) it may usefully be considered for assessment and screening of therapists who, low in sense of coherence, may find themselves at risk of for the negative psychological effects of providing therapy to trauma survivors. As many of the therapists in this sample had received specialist training for trauma work, this is one way that screening for a low SOC could occur. Professionals with a lower SOC might want to 1) identify coping strategies during their work to avoid potential negative changes; and 2) determine strategies to enhance their SOC, which would create a stronger potential for positive change; or decide for themselves if trauma clients are the types of clients with whom they want to continue to work with considering the potential for negative changes.

Interventions to strengthen or restore one’s sense of coherence in adulthood are proposed. The quality of social support has been defined as a crucial coping resource for the positive development of SOC (Antonovsky, 1987) and for the restoration of a person’s SOC (Langeland & Wahl, 2009; Skärsäter, Langius, Ågren, Häggström, Dencker, 2005). Opportunities for supervision, consultation on cases, and peer support groups are all ways that support therapists with their work. Mental health counselors are mandated to engage in reflective self-monitoring to assess and address their own state of well-being (ACA, 2014; AMHCA, 2010), and social support from supervisors and colleagues is one way to do this. Particularly when one’s sense of meaning in life is threatened or weakened having opportunities to reflect are important. Social support is the cornerstone of the environmental resource dimension of sense of coherence, which is
important in order to view demands as challenges worth facing, rather than threats or stressors (Skärsäter et al., 2005). Supervisors are in a key position to identify individuals at risk, to highlight the strengths and weaknesses in a person’s networks, as well as indicate any intervention as necessary. In this way, SOC is an important concept in assessing people’s ability for self-care.

Another intervention that is gathering evidence in improving SOC is to practice mindfulness and/or to participate in mindfulness and stress reduction (MBSR) programs. Martin-Asuero and García-Banda (2010) described a MBSR program that increased self-awareness and the health professionals’ ability to provide empathetic care. MBSR has been shown to reduce rumination and prevents obsessively ruminating on aspects of the past, reducing the perception and negative evaluation of daily stress (Ramel, Goldin, Carmona, & McQuaid, 2004; Vossler, 2012). Ando, Natsume, Kukihara, Shibata, and Ito (2011) demonstrated that nurses were able to reflect on the meaning of their life and work through meditation and their SOC scores showed a significantly greater increase compared to a control group, particularly in the sub-domain of meaningfulness. Finding a sense of meaning in the work one does is important to positive change. This enabled them to cope better with the stress of their job. The potential of staff who engaged in self-care through mindfulness practice and contexts that enabled mindfulness in day to day work resulted in the building of resilience for individuals and the workplace in general (Foureur, Besley, Burton, Yu, & Crisp, 2013).
Workplace

Yamazaki, Togari and Sakano (2011) proposed ways in the workplace to enhance workers’ SOC. Greater job discretion, good communication, a supportive atmosphere and respect shown to workers were all ways to enhance workers SOC. These recommendations are important because they show that the onus is not just on the individual to make changes, but that SOC can be enhanced by changing the environment rather than the individual.

Counselor Educators

Self-care is recommended by counselors’ professional associations (ACA, 2014; AMHCA, 2010), yet little may be processed as part of the existing curriculum with respect to self-care on dealing with special populations such as trauma survivors and the effect of this work on the counselor her/himself. One way to ensure that beginning therapists know about the implications of trauma work is for counselor educators to include discussions about the impact of this work in their classes, and to normalize the negative effects of compassion fatigue/secondary traumatic stress.

Antonovsky (1979) theorized that sense of coherence is fully developed by the age of 30 and remains rather stable, with only major life events upsetting and altering it. Although this assertion has been challenged (Weissbecker et al., 2002, Langeland et al., 2006) since then, it reiterates the importance of strengthening SOC in counselor graduate students, many of whom may be around this age or younger. Additionally, many graduate counseling students face major changes around this time, often for the first time, such as loss of parents, marriage/divorce, birth of a child, etc. Individual SOC can be affected
positively or negatively by major life events and varies with life circumstances (Weissbecker et al., 2002). Positive SOC changes may be more likely if a person seeks counseling themselves during a life-changing transition period when familiar meanings and orientations become fragile and questionable (Vossler, 2012). Encouraging counselors-in-training to undertake their own personal therapy may be one of the best ways for counselor educators to ensure their students’ SOC is strengthened and they become more effective therapists.

My study comprised mostly White therapists. But one study using a national clinic based sample found that non-Whites were less likely to seek treatment for PTSD than Whites (Koenen, Stellman, Stellman & Sommer, 2003). Also Black and Hispanic individuals had a higher risk of witnessing domestic violence as children; Black individuals had higher risk of active combat; and Asian individuals had a higher risk of having been in a war zone than White people (Koenen et al., 2003). It is imperative that trauma therapists of all cultural backgrounds are trained and have the expertise to work with diverse clients. Counselor educators may want to consider the need for a more diverse group of students when recruiting potential counselors to ensure this need is met.

Supervisors

A trainee therapist’s sense of coherence could also be an important focus for supervision. Perceptions of experiences at work, evaluation of one’s resources to cope with demands and work goals and values are frequently the focus of attention in clinical supervision. Howard (2008) suggested ways that the supervisor might contribute to strengthening the trainee’s SOC. Reflection on casework to make it more understandable
and effectiveness would increase comprehensiveness and reviewing workload and adjusting the numbers and types of cases could contribute to manageability.

It has been proposed that the therapeutic relationship is the context in which healing from trauma occurs (Herman, 1997; Pearlman & Saakvitne, 1995) and for that reason, supervision might best be focused on the therapeutic relationship rather than on the client. However, Etherington (2009) suggested that supervision is at its most useful for people working in the field of trauma, when it focuses on the interrelationship between the trauma itself, the person of the counselor, the helping relationship (including supervisee-supervisor relationship) and the context in which the work is offered.

**Implications for Future Research**

While the findings from my study can enhance our understanding of the factors that contribute to positive and negative change in trauma therapists resulting from their work with clients, more research is warranted.

For example, anecdotal evidence in the form of emails to the researcher suggested that individuals trained and using EMDR techniques to work with trauma survivors were subjected to less traumatic material from clients than those using other techniques. EMDR practitioners do not need the client to repeat in detailed narration the specifics of the trauma and therefore therapists may have less exposure to distressing information. Although my study asked for information concerning the primary theoretical orientation used by the therapist, feedback suggested that therapists did not want to identify their work this way. Many respondents used multiple styles, and about 20% noted EMDR as their orientation to working with trauma survivors (in the “other” category). Over 50%
used CBT as a theoretical orientation. It would be interesting to examine the use of trauma interventions specifically related to change and growth.

Over 90% of the sample identified as White and so there was very little racial/ethnic diversity in this sample so these results cannot be generalized to other more racially diverse samples of therapists. Because minority persons were more likely than Whites to engage in PTG according to Helgeson, Reynolds and Tomich’s (2006) meta-analysis, future research should explore whether PTG is interpreted differently across ethnic groups.

The demographics of the client population worked with was not known in my study, but maybe important information to be collected in future research. A study looking at the racial/ethnic background of the clients coming in for treatment, how their needs may be different and what impact this may have on the therapist, particularly in cross-cultural counseling, would be valuable.

Additionally, approximately 80% of the sample were female. A future study is suggested, that only looks at the experiences of male trauma therapists to ascertain if similar results ensue for growth and change.

My study’s participants were overwhelmingly working in private practice. Future research could compare therapists’ levels of growth and change in different work settings. This type of study is important to examine whether environmental or workplace factors may play a role in positive or negative change. For example, in my study it may be that the control over their own work conditions experienced by private practitioners led to the high levels of compassion satisfaction.
I was not able to ascertain the level of trauma experienced by the clients, and vicariously by their therapists. Therefore, it is not known if this would have been a relevant factor in contributing to growth and change, and so this is also an area for future research. Additionally, examining the type of trauma therapists work with and if this has a greater relationship to attachment style would be worth further consideration.

In considering the variable of having received personal therapy, a future study might consider if the therapy was in connection with their trauma work or their own past trauma and whether it was ongoing or in the past. Personal therapy was a significant factor (although a small coefficient of .128) for predicting STS and this result may change with the duration of time as therapy progresses.

**Limitations**

This study used a convenience sample of mental health professionals who self-selected on the basis of criteria offered. Of the 436 who opened the survey, 395 completed it. The sample might be biased because the individuals who did not complete the survey could have different characteristics to those who did participate. Also, I limited participation in the study to therapists working with adult clients which excluded professionals working with child trauma victims. Therefore, the discussion about my results is limited to that population, and those professionals working with children may have different characteristics or needs from my sample.

A majority of the sample were White women over fifty. Although this represents a similar demographic to other research conducted on trauma therapists (e.g. Craig & Sprang, 2010; Sprang, Clark & Whitt-Woosley, 2007) it limits generalizability to trauma
therapists from different racial/ethnic populations. It also raises important questions about a lack of diversity among trauma therapists who responded. This sample also did not include many men or younger therapists just beginning their career. If it had the results may have been very different.

I used self-report measures for the study and there is the possibility of response bias and social desirability in responding. For many reasons, the participant may consciously or unconsciously respond in a way that yields a score that reflects a response bias, rather than the construct being measured (Heppner, Wampold & Kivlighan, 2008). Social desirability may have had particularly impacted responses to attachment styles because a majority of the respondents reported being securely attached, even though approximately 1/3 of the participants fell into the “not-secure category”. However, these results are similar to the results in other studies (e.g., Yusof & Carpenter, 2013) related to attachment styles and mental health counselors. It is also possible that the participants were unaware of the impact of their work and thus underreported the effects.

**Conclusion**

Trauma work can have negative effects, and consistent with the evidence on empathy and emotional contagion which shows that humans can experientially share the emotions of someone else (Kjellenberg et al., 2013), one would expect to see these negative effects experienced in mental health professionals who work with survivors of trauma. However, a paradoxical finding is that exposure to vicarious trauma can also have positive effects on these professionals.
This study hypotheses were that attachment style would be related to positive and negative changes in mental health professionals working with trauma survivors. However, rather than attachment style, sense of coherence proved to be the most significant predictor of both positive change defined as compassion satisfaction, and negative change in secondary traumatic stress and burnout. For posttraumatic growth, sense of coherence had a slightly negative significant effect. This study sampled mainly trauma therapists who worked in private practice. It found high levels of compassion satisfaction and low levels of compassion fatigue/secondary traumatic stress and burnout.

My findings may be related to the demographic make-up of the sample in the present study. Participants were experienced, had received specialist training and were in private practice, yet they sought support from colleagues through supervision/consultation or peer supervision. They were securely attached, so had supportive and responsive attachment figures in their lives and found meaning and satisfaction through their work.

This study is one of the few that has attempted to study potential positive changes and negative effects simultaneously and adds to the research evidence that both positive and negative changes can co-exist in trauma therapists as a result of working with trauma. My study also adds to the research literature on the personality resources that are predictors of positive psychological changes in trauma therapists and confirms the relevance of sense of coherence as a predictive factor for positive and negative changes in this sample.
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Appendix A

Instrument

Please read the following questions carefully and check what applies to you:

1. Please indicate your age:  __25-35  __36-45  __46-55  __56-65  __66 and over

2. Please indicate your gender: female______ male_______ other__________

3. Please indicate your race/ethnicity:
   __African/American  __Asian  __Caucasian  __Hispanic  __Native American
   __Other (tick as many as apply)

4. Please indicate your highest level of education:
   __EdD  __EdS  __MA/MS  __MD  __PhD  ___PsyD

5. Please indicate the profession you are licensed in:
   __Counseling  __Marriage and Family  __Psychology  __Psychiatry
   __Social Work  __________ Other (specify)

6. Please indicate number of years practicing:
   __1  __2-5  __6-10  __11-15  __16-20  __20+

7. Please indicate the number of hours per week that you spent providing direct therapy to adult trauma clients within the last year:
   __1-5  __6-10  __11-15  __16-20  __21-25  __25+

8. Please indicate your work setting:

9. Please indicate the % of each population of trauma cases in your current caseload:
   (Adults only)
   __survivors of child sexual abuse  __survivors of physical abuse
__ survivors of emotional abuse   __ survivors of domestic violence
__ survivors of violent crimes   __ survivors of serious illness
__ survivors of natural disasters   __ survivors of political oppression
__ survivors of other trauma   __ survivors of combat exposure

10. Please indicate your theoretical orientation with trauma clients:

__ Cognitive /Behavioral  __ Family Systems  __ Humanistic/Existential
__ Interpersonal  __ Psychopharmacology  __ Psychoanalytic/Psychodynamic
__ Other specify________

11. Please indicate if you have any specialist trauma training:  __ Yes   __ No

12. Please indicate the number of hours per week you spend in supervision on your trauma cases:  __ Group hrs/wk   __ Individual hrs/wk  Informal Peer hrs/wk
__ Consultation hrs/wk

13. Please indicate whether you are a trauma survivor:  __ Yes   __ No

14. Please indicate if you are or were engaged in your own personal therapy:

__ Yes   __ No

Following are four general relationship styles that people often report. Place a checkmark next to the letter corresponding to the style that best describes you or is closest to the way you are.

_____ A. It is easy for me to become emotionally close to others. I am comfortable depending on them and having them depend on me. I don’t worry about being alone or having others not accept me.

_____ B. I am uncomfortable getting close to others. I want emotionally close relationships, but I find it difficult to trust others completely, or to depend on them. I worry that I will be hurt if I allow myself to become too close to others.
C. I want to be completely emotionally intimate with others, but I often find that others are reluctant to get as close as I would like. I am uncomfortable being without close relationships, but I sometimes worry that others don’t value me as much as I value them.

D. I am comfortable without close emotional relationships. It is very important to me to feel independent and self-sufficient, and I prefer not to depend on others or have others depend on me.

Now please rate each of the relationship styles above to indicate how well or poorly each description corresponds to your general relationship style.
For the next set of questions, please indicate for each of the statements below the degree to which this change occurred in your life as a result of your work with trauma clients, using the following scale.

0 = I did not experience this change as a result of my work with trauma clients.
1 = I experienced this change to a very small degree as a result of my work with trauma clients.
2 = I experienced this change to a small degree as a result of my work with trauma clients.
3 = I experienced this change to a moderate degree as a result of my work with trauma clients.
4 = I experienced this change to a great degree as a result of my work with trauma clients.
5 = I experienced this change to a very great degree as a result of my work with trauma clients.

1. I changed my priorities about what is important in life.
2. I have a greater appreciation for the value of my own life.
3. I am able to do better things with my life.
4. I have a better understanding of spiritual matters.
5. I have a greater sense of closeness with others.
6. I established a new path for my life.
7. I know better that I can handle difficulties.
8. I have a stronger religious faith.
9. I discovered that I'm stronger than I thought I was.
10. I learned a great deal about how wonderful people are.

When you counsel people you have direct contact with their lives. As you may have found, your compassion for those you counsel can affect you in positive and negative
ways. Below are some questions about your experiences, both positive and negative, as a trauma counselor/therapist. Consider each of the following questions about you and your current work situation. Select the number that honestly reflects how frequently you experienced these things in the \textit{last 30 days}.

\begin{tabular}{|c|c|c|c|c|}
\hline
1=Never & 2=Rarely & 3=Sometimes & 4=Often & 5=Very Often \\
\hline
\hline
1 & 1. I am happy. & \hline
2 & 2. I am preoccupied with more than one person I counsel. & \hline
3 & 3. I get satisfaction from being able to counsel people. & \hline
4 & 4. I feel connected to others. & \hline
5 & 5. I jump or am startled by unexpected sounds. & \hline
6 & 6. I feel invigorated after working with those I counsel. & \hline
7 & 7. I find it difficult to separate my personal life from my life as a counselor. & \hline
8 & 8. I am not as productive at work because I am losing sleep over traumatic experiences of a person I counsel. & \hline
9 & 9. I think that I might have been affected by the traumatic stress of those I counsel. & \hline
10 & 10. I feel trapped by my job as a counselor. & \hline
11 & 11. Because of my counseling, I have felt "on edge" about various things. & \hline
12 & 12. I like my work as a counselor. & \hline
13 & 13. I feel depressed because of the traumatic experiences of the people I counsel. & \hline
14 & 14. I feel as though I am experiencing the trauma of someone I have counseled. & \hline
15 & 15. I have beliefs that sustain me. & \hline
16 & 16. I am pleased with how I am able to keep up with counseling techniques and protocols. & \hline
17 & 17. I am the person I always wanted to be. & \hline
18 & 18. My work makes me feel satisfied. & \hline
\hline
\end{tabular}
Next is a series of questions relating to various aspects of your life. Each question has seven possible answers. Please mark the number, which expresses your answer, with number 1 and 7 being the extreme answers. If the words under 1 are right for you, circle 1; if the words under 7 are right for you, circle 7. If you feel differently, circle the number which best expresses your feeling. Please give only one answer to each question.

1. Do you have feeling that you don’t really care about what goes on around you?
   
   1  2  3  4  5  6  7
   
   very seldom  very often or never
2. Has it happened in the past that you were surprised by the behavior of people whom you thought you knew well?

1  2  3  4  5  6  7

*never happened*  
*always happened*

3. Has it happened that people whom you counted on disappointed you?

1  2  3  4  5  6  7

*never happened*  
*always happened*

4. Until now your life has had:

1  2  3  4  5  6  7

*no clear goals*  
*very clear goals and purpose*

5. Do you have the feeling that you’re being treated unfairly?

1  2  3  4  5  6  7

*very often*  
*very seldom or never*

6. Do you have the feeling that you are in an unfamiliar situation and don’t know what to do?

1  2  3  4  5  6  7

*very often*  
*very seldom or never*

7. Doing the thing you do every day is:

1  2  3  4  5  6  7

*a source of deep pleasure and satisfaction*  
*a source of pain and boredom*

8. Do you have very mixed-up feelings and ideas?
1. Does it happen that you have feelings inside you would rather not feel?

2. Many people – even those with a strong character – sometimes feel like sad sacks (losers) in certain situations. How often have you felt this way in the past?

3. When something happened, have you generally found that:

4. How often do you have the feeling that there’s little meaning in the things you do in your daily life?

5. How often do you have feelings that you’re not sure you can keep under control?

THANK YOU. YOUR HELP IS APPRECIATED!
Appendix B

Pilot Survey

Thank you so much for completing my survey on trauma counseling.

The following questions are for the purpose of this small pilot study, and are about your experience of taking the survey.

1. How long approximately did it take you to complete the survey?

2. Were you comfortable answering all the questions? If not, were there specific questions that gave you trouble?

3. Did you find it easy to navigate and answer the questions in the response format given?

4. Were the questions clear and easy to answer? If not, please highlight any question that you were unsure about.

5. Please add any other comments below:

Thank you for your help, I am very grateful. - Claire
Appendix C

Email Invitation to Participate in Research Study

Hello,

My name is Claire Wooloff and I am a doctoral candidate in Counselor Education at Montclair State University, New Jersey. Together with Dr. Larry Burlew, a professor in the Department of Counseling, we would like to invite you to take part in my research study on the effects of working with survivors of trauma on the counselors involved. The title of the study is “Vicarious Posttraumatic Growth and Attachment Style in Mental Health Professionals” (IRB#001471).

Link to the survey: https://www.surveymonkey.com/s/TRAUMACOUNSELING

As mental health professionals who treat clients who have experienced trauma, you hear traumatic material as part of your work. We are hoping to explore the role of attachment style and positive and negative changes in mental health professionals who work with trauma clients.

If you are a licensed mental health professional who works with survivors of trauma (at least five clients per week), and have done so for at least 6 months, you are eligible to participate.

By participating in this study you are providing information that can help us better understand, and prepare therapists for, the important work of helping those in need and how it might affect us. On completion of the survey you have the option of entering into prize draw to win a $50 Barnes & Noble gift card.

Participation is anonymous, and you may withdraw from the study at any time.

More information and the survey can be found by clicking this link: https://www.surveymonkey.com/s/TRAUMACOUNSELING

Thank you for your time and willingness to participate.
Sincerely,

Claire J. Wooloff, M.A.
Doctoral Candidate
Counselor Education Ph.D. Program
Montclair State University

Dr. Larry D. Burlew
Faculty Sponsor
Montclair State University
1 Normal Avenue
Upper Montclair, NJ 07043

To unsubscribe send an email to wooloffc1@mail.montclair.edu with UNSUBSCRIBE in the subject line.
PO Box 161931, Austin, TX 78716
Appendix D - Institutional Review Board Approval

January 24, 2014

Ms. Claire Wooloff
812 Beardsley Lane
Austin, TX 78746

Re: IRB Number: 001471
Project Title: Vicarious Post Traumatic Growth and Attachment Style in Trauma Counselors

Dear Ms. Wooloff:

After an expedited 7 review, Montclair State University’s Institutional Review Board (IRB) approved this protocol on December 16, 2013. The study is valid for one year and will expire on December 16, 2014.

Before requesting amendments, extensions, or project closure, please reference MSU’s IRB website and download the current forms.

Should you wish to make changes to the IRB-approved procedures, prior to the expiration of your approval, submit your requests using the Amendment form.

For Continuing Review, it is advised that you submit your form 60 days before the month of the expiration date above. If you have not received MSU’s IRB approval by your study’s expiration date, ALL research activities must STOP, including data analysis. If your research continues without MSU’s IRB approval, you will be in violation of Federal and other regulations.

After your study is completed, submit your Project Completion form.

If you have any questions regarding the IRB requirements, please contact me at 973-655-5189, reviewboard@mail.montclair.edu, or the Institutional Review Board.

Sincerely yours,

Dr. Katrina Bulkley
IRB Chair

cc: Dr. Larry Burlew, Faculty Sponsor
Ms. Amy Aiello, Graduate School