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Secondary Traumatic Stress in law Enforcement Personnel

William Carl Heusler

SECONDARY TRAUMATIC STRESS

IN LAW ENFORCMENT PERSONNEL

William Carl Heusler, BS

An Abstract Presented to the Faculty of the
Graduate School of Lindenwood University in
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Abstract

This study was designed to add to the body of empirical knowledge about law enforcement occupational stress utilizing the compassion fatigue/compassion satisfaction model developed by Figley and Stamm. The predictions that intimate contact with trauma victims will increase the risk for compassion fatigue and burnout was evaluated yielding results that established no difference between law enforcement personnel with direct contact and those that had little or no contact with trauma victims. The suggestion that secondary trauma has a cumulative effect on persons exposed over time was also investigated showing that in this population of police officers, a cumulative impact did not appear to exist. The proposition that compassion satisfaction or the degree to which one is supported and feels in some sort of control will reduce the risk factors for compassion fatigue and burnout was assessed yielding results establishing no significant correlation between compassion satisfaction and compassion fatigue. The results regarding a relationship between compassion satisfaction and burnout were evaluated showing a correlation.

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Dedication

To the law enforcement professionals

who have experienced and survived trauma and those who

have sacrificed their lives so that we might enjoy a free and safe society.

Acknowledgements

I want to thank the law enforcement community for including me and allowing me to once again roam about in their world. I wish to acknowledge the tremendous assistance, enthusiasm, and long distance support of Beth Hudnull Stamm, Ph.D.. I want to thank Charles Figley, Ph.D. for the body of work he has inspired and accomplished, and for his personal encouragement, and networking efforts. I wish to acknowledge Randal Beaton, Ph.D., E.M.T. for his help and encouragement. And a special thanks to the faculty and staff of Lindenwood University for the assistance and patience they have shown during my stay with them.

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Chapter I

Introduction

The American Psychiatric Association first recognized Posttraumatic Stress Disorder (PTSD) in 1980 with the publication of Diagnostic and Statistical Manual-III (1980). Charles Figley (1995) marked this as a milestone in a field of research that he traces back to early ancient writing in Egypt in 1900 BC. The idea that traumatic incidents and external events can have a lasting and disturbing impact on an individual has been around in art and literature for many hundreds of years. Recognition of PTSD as a medical disorder by the American Psychiatric Association not once, but again in Diagnostic and Statistical Manual-IV (1994) represents a signal that the medical profession is becoming ready to accept that mental disorders (at least some) are not purely a bio-chemically, genetically determined phenomenon. According to van der Kolk and McFarlane (1996):

> . . . the study of trauma has become the soul of psychiatry: The development of posttraumatic stress disorder. . . as a diagnosis has created an organized framework for understanding how people's biology, conceptions of the world, and personalities are inextricably intertwined and shaped by experience. (p.4)

Figley (1995) pointed out that the publication of DSM-IV (1994) brought about a recognition that simply being a "close associate" or "family member" of a traumatized person may cause an individual to develop PTSD symptoms (APA,

1994, p. 424). There has been considerable work that has attempted to identify various groups or classes of associates as being close enough to be impacted by the traumatic experience of another. The notion that being in close proximity on an emotional and/or physical basis with a traumatized person can cause PTSD-like disorders is a relatively new idea and one that is still not entirely accepted by many in the field and within the medical establishment. It appears to be a stretch for some to accept that primary traumatic events can cause profound and long term psychological and/or psychiatric difficulties. It appears to be an even larger empirical leap to accept that those not directly involved with the primary or precipitating critical incident can be impacted in just as a profound manner as those that suffered under the weight of the direct experience.

Many have picked up the cause of secondary or vicarious traumatization with studies of therapists (Chrestman, 1999), firefighters (Corneil, Beaton, Murphy, Johnson, & Pike, 1999; Beaton & Murphy, Pike, & Jarrett 1995; Murphy, Beaton, Cain, & Pike, 1994), disaster workers (Stamm, 1999; Paton, 1994), and police officers (Patterson, 1999; Follette, Polusny, & Milbeck, 1994). Figley (1995) refers to vicarious or secondary trauma as "compassion fatigue"(p. xv). Figley (1995) brings forth the idea that a person needs to be in close emotional proximity with a traumatized person while having knowledge of the traumatic event(s) or have repeated exposures over time to traumatized persons in order to be

vulnerable to the debilitating effects of compassion fatigue. The question this research never quite seems to answer is how close one needs to be and in what ways does an individual need to be connected with a primary victim(s) in order to be vulnerable to compassion fatigue or developing PTSD symptoms. If the symptoms for compassion fatigue and PTSD are essentially the same, as most seem to be asserting, then all that distinguishes one from another is how the precipitating event(s) are presented. This idea is indirectly supported with research that indicates persons with a history of traumatic experiences from childhood tend to be more vulnerable to developing PTSD symptoms following subsequent exposure to new traumatic events and possibly secondary traumatic symptoms as well (Briere, 1997; Figley, 1995).

Little work appears in the literature regarding law enforcement personnel and secondary trauma. This fact may simply be because it is difficult to distinguish between what is secondary trauma and what is primary trauma in police work. What is the difference between experiencing senseless killing in a war zone or in an apartment complex in a nice neighborhood in Springfield, Missouri? What is the distinction between being shot while on a patrol in enemy territory in Southeast Asia and being shot in a suburb of Cleveland, Ohio while making a routine traffic stop? On the surface there appears to be none, except perhaps the mind-set, point of view, personal history, and/or biology one brings to the experience.

What police officers experience while performing their duties may be hard to distinguish as primary or secondary trauma due to a frequent and intimate contact with the events or with those suffering through such events. Other law enforcement personnel do not have as close a relationship with the events or the victims. Emergency dispatchers and administrative personnel do have knowledge and even a close relationship with police officers who are out in the field being traumatized, but they have little or no routine face-to-face contact with the citizenry who are usually primary victims of critical incidents. Much is often done for police officers who suffer through a catastrophic situation, especially when they themselves are the victims, but little attention is paid to the impact secondary trauma may have on police officers and almost no attention seems to be paid to other critical law enforcement support personnel.

Purpose

The purpose of this study is to shed light on just how far the traumatic ripple travels when a traumatic event hits the water of life. How far out into a given reference group does the significant impact travel? Is it a function of victim contact? Is it a function of some emotional stake or connection to the parties involved? Is it a function of the number and types of exposures? Is it dependent upon locus of control or feelings of empowerment to act? Testing personnel from the same department evaluates a group that shares a good deal of the same events

and experiences in different ways. This study asks the question: How does the trauma impact vary with these different types of contact experienced by various personnel? Does the perception of role, control, occupational satisfaction, or power to act that comes with law enforcement positions provide insulation for police personnel from PTSD, compassion fatigue, or burnout? This study attempted to determine if law enforcement personnel are impacted by compassion fatigue, and if so, does their proximity to a traumatic event(s) or incident(s) in some way increase, decrease, or otherwise change their vulnerability to developing symptoms.

Emergency service organizations are at least talking about such things as debriefing, PTSD, compassion fatigue, counseling, and efforts at establishing prophylactic insulations for our emergency service personnel. The costs of training and maintaining these wondrous people are staggering. The law enforcement community needs studies like this to determine what services and training needs to be in place for all personnel so they can make them better and keep them longer. The department that consented to be a part of this study has done so to help gather a baseline of information that will assist them and others in identifying employee support needs in an effort to reduce employee turnover rates, improve job satisfaction, and increase employee performance.

Hypothesis

This study is designed to add to the body of empirical knowledge about law enforcement occupational stress utilizing the compassion fatigue/compassion satisfaction model developed by Figley and Stamm (1999). This model predicts that intimate contact with trauma victims will increase the risk for compassion fatigue and burnout. It is therefore predicted the compassion fatigue risk and risk for burnout will be elevated significantly in a sample of police officers over that of the civilian support personnel that work with these officers. This theory also predicts that compassion satisfaction or the degree to which one is supported and feels in some sort of control will reduce the risk factors for compassion fatigue and burnout. It is therefore believed that high levels of compassion satisfaction will correlate positively with lower levels of compassion fatigue and burnout. Length of service by police officers will also predict higher levels of compassion fatigue and burnout due to the theorized cumulative effect secondary trauma is believed to have on helpers.

Chapter II

Literature Review

History of Traumatic Stress

The idea that external events can mold, form, and even create behavior(s) and/or some internal psychic structure(s) has been the subject of controversy among researchers, psychologists, and philosophers alike for hundreds of years. This controversy is central to modern thinking and theory regarding the impact traumatic events have on the lives of those that experience them and now those that vicariously experience the trauma of others. The very nature of how trauma is processed and the notion that such events can and do have profound long-term effects on people seems to fly in the face of many core belief systems of western culture. This is not to assert that trauma and the impact it has is a uniquely western cultural phenomenon, but that the resistance that seems evident to the idea that traumatic occurrences really do profoundly impact and change people is.

Notions of blame and causality are an integral part of this dualistic frame of reference. It has been argued (Shaver, 1975) that the need to make dispositional attributions may be anchored in a need to answer the question: why? Shaver (1975) further argues that people generally perceive that the world is just and those bad things happen to bad people and good things happen to those people that deserve them. This may be a social-cultural mechanism that aids in the socialization and enculturation processes and are then functioning outside normal awareness. This

culture often seems bound to blame the victim for whatever befalls a person in the course of events, especially traumatic ones. The tendency to blame victims for the traumatic events that come their way is at the very center of the development of a conception of how the external world influences our internal world and the development of a *self.* It has influenced conceptions about the nature of trauma and stress in the development of personality and views of psychological disturbance since the idea of a *self* first appeared on the landscape of the Greek philosophy 3000 years ago (Murphy & Kovach, 1972). It has inhibited, and at times suppressed, understanding about the impact traumatic events can have on a person and subsequent behavior. This blaming is internalized within western culture to the extent that as van der Kolk and McFarlane (1996) observe, "Many traumatized individuals, particularly children, tend to blame themselves for having been traumatized" (p.15).

There seems to be an enduring affection in western culture, philosophy, and psychology with the idea that the psyche or *mind* somehow exists separately from the rest of the world. Indeed this *mind* stands alone and seems only vaguely connected with the body and is inexplicably distinct from all other parts. This dualism in conceiving of the human existence is also traced back to early Greek philosophers (Murphy & Kovach, 1972). This way of seeing the world has entrenched itself and stands self-righteously and defiantly against the onslaughts of

more holistic and inclusive thinking. The conclusion by Spinoza that the mind and soul are but "two aspects of one reality" (Murphy & Kovach, 1972, p. 21) in 1677 is an early attempt to bring this narcissistic conception of humankind into some sort of check. Still the notion that there is some sort of independent experience-proof or resistant mind has persisted. The reality that those bad things do happen to good people, okay people, and bad people alike stands in spite of centuries of culturally chastising those unfortunate people. The fact (and the cultural denial of it) that some of those bad things are traumatic and have a lasting and sometimes indelible impact on those that endure them may be the paradox that has been driving modern psychology and theory for the last century to a new paradigm.

The shattering effect a traumatic event, by definition, has is one that, in part, attacks the idea of personal efficacy that a person tends to normally assume in most situations. A traumatic situation as it unfolds may strip the power of the individual away leaving one feeling as if they have no influence on the events unfolding around them. The need to feel in control may be at the root of the collective historical reluctance to accept traumatic events as first, outside the control of the individual experiencing them, and second, that such events have an uncontrolled impact on the future behavior of the person. van der Kolk, Weisaeth and van der Hart (1996) state that ". . . psychiatry as a profession has had a very

troubled relationship with the idea that reality can profoundly and permanently alter people's psychology and biology" (p. 47).

The period where trauma was first seriously gaining acceptance as a legitimate field of inquiry began around1859 when " . . . the French psychiatrist Briquet started to make the first connections between the symptoms of 'hysteria' and childhood histories of trauma" (van der Kolk, et al., 1996, p. 49). Charcot picked up this ball and ran with it, becoming the first to suggest that hysteria was most often a result of having endured unbearable experiences, often during childhood (van der Kolk, Weisaeth, & van der Hart, 1996).

Prior to Charcot and Briquet arriving on the scene it was a commonly held belief that all psychological symptoms, especially hysteria, were biological symptoms that were caused by some undiscovered lesion or lesions in the brain (Ellenberger, 1970). In fact, Charcot himself felt he discovered many of these lesions during his research at Salpetriere (Ellenberger, 1970). It was during these investigations and inquiries that Charcot began experimenting with hypnosis, which at this time was a taboo subject relegated to charlatans and faith healers since it had fallen out of favor at the end of the prior century with the rejections of Mesmer's theories in 1784 (Ellenberger, 1970). Charcot's research caused him to conclude that there were types of paralyses that were not caused by brain lesions and were nearly as common as those that were. The first was hysterical paralysis. The second

he referred to as posttraumatic paralysis. And the third he called hypnotic paralysis (Ellenberger, 1970). Charcot believed that trauma was inherently capable of having a profound and long term impact on the mind often causing what manifested itself as physical symptoms like paralysis (van der Kolk & McFarlane, 1996; Ellenberger, 1970).

At this stage in the history of trauma, the way seemed open for placing external events in a position of profound influence on the human mind. The very formation of the self was being postulated as, at least partly, the result of events outside individual and internal control.

A brief student of Charcot's, Sigmund Freud, along with Breuer, was one of the early champions of trauma being the cause of hysteria (Freud, 1924). Freud's early agreement with Charcot on the origins of hysteria and the usefulness of hypnosis was short lived. The tendency of the victim to blame themselves and the need to avoid such personal acceptance of responsibility may have had a profound influence on Freud's development of the modern psychological theory, psychoanalysis, and his ultimate rejection of Charcot's thinking. Freud's self-analysis accelerated after he reported, in written correspondence to Wilhelm Fliess on September 21, 1897, that his earlier ideas about childhood seduction (trauma) were wrong and that these reports by his patients were in fact fantasy (Ellenberger, 1970). This disclosure indicated that his whole theory of hysteria up to that point

was therefore based on a false premise. It seems also coincidental that about this time Freud also reported that his first *fantasized* sexual experience was attributed to his nanny at the age of 2 1/2 years (Ellenberger, 1970). The abandonment by Freud of the seduction theory may have been as much the result of trying to come to terms with a sexually abusive experience at the hands of one of his caretakers in his own early childhood as it was fueled by a need to distinguish himself from those that preceded him in study. With Freud and his followers nearly all the progress on this issue was turned back to the same type of thinking as was prevalent before 1850.

Traumatic disorders were subsequently viewed as disorders of the will or a desire (conscious or unconscious) for some sort of compensation (van der Kolk, et al., 1996; Ellenberger, 1970). These throwback ideas that trauma symptoms are within the realm and control of the individual fit with the subsequent wartime military thinking surrounding soldier performance, or lack of it, in World War I and World War II (van der Kolk, et al., 1996). Admitting that being at ground zero in an artillery barrage may cause a soldier's *will* to break and result in uncontrolled behaviors that amounted to a general's definition of cowardice, would mean redefining a tradition of glory and bravery in battle that spans thousands of years.

Posttraumatic Stress Disorder

It took nearly a century for the thinking about traumatic events and their impact on people to be viewed in a favorable light and another half century to come full circle from when Charcot first suggested that trauma does have a profound and lasting impact on people. This full swing back of the pendulum began with the liberation of the Nazi death camps and the realization of the world, in almost living color, the impact such horrid acts may have on people. Many of the survivors along with colleagues conducted countless outcome studies with survivors of the holocaust (van der Kolk, et al., 1996). These studies, together with studies on Japanese concentration camp survivors and other war related traumas, consistently found that, ". . . extreme trauma had severe biological, psychological, social, and existential consequences, including a diminished capacity to cope with both psychological and biological stressors later in life" (van der Kolk, et al.,1996, p. 60). Although studies and observations during and after World War I did demonstrate that soldiers are dramatically changed by combat, McFarlane & De Girolamo (1996) are of the opinion that it was:

> . . . dismissed as consequences of cowardice. Attempts at organic explanations (e.g., the hypothesis that the exploding shells could cause microscopic neuronal damage) were another method of denying that the horror of battle was sufficient cause to explain the psychological toxicity of

> combat. This would have meant that the officers had a responsibility for the psychological well being of their troops, and would have increased the cost of war. (p. 133)

Conclusions from studies of veterans returning from World War II were bolder, but nonetheless fell on often-deaf ears. Many of those studies identified conditions like "traumatic war neurosis" (Kardiner & Spiegel, 1947 as cited in Schnurr, 1991, p. 1) or "combat exhaustion" (Swank, 1949, as cited in Schnurr, 1991, p. 1). Schnurr (1991) concluded after reviewing studies from that time that: "One gets a sense of *déjà vu* when reading the older sources. These authors seem highly insightful, because of the questions asked (and many of the answers) are startlingly similar to those in more contemporary materials" (p.2).

In 1952 the publication of DSM-I brought the acknowledgement, with the diagnostic category of Gross Stress Reaction, that traumatic events might cause symptoms (McFarlane & De Girolamo, 1996). It stopped short of any acknowledgement that long-term symptoms resulting from the impact of trauma independently exists that could not be explained by some other diagnostic category (McFarlane & De Girolamo, 1996). The studies on holocaust survivors persisted and consistently demonstrated that traumatic stress caused profound and lifelong changes in the affective lives of its victims (Krystal & Danieli, 1994).

Studies of veterans and returning prisoners of war from the Korean and Vietnam wars finally seemed to break through all the collective cultural denial of the concept that trauma-based psychological symptoms exist (van der Kolk, et al., 1996). According to van der Kolk, et al., (1996) the 1970s brought an array of work and studies that added descriptions of a number of other trauma-based syndromes including: Rape Trauma Syndrome, Battered Woman Syndrome, Vietnam Veterans Syndrome, and others. These studies also brought with them the recognition of previous work that, among others, described Concentration Camp Survivor's Syndrome identified two decades before (van der Kolk, et al, 1996). All of these conceptualizations of traumatic conditions were subsumed within the diagnostic category of Posttraumatic Stress Disorder (PTSD) in 1980 in DSM-III (1980). The criteria for a diagnosis of PTSD has undergone two revisions since it has been recognized and categorized by the American Psychiatric Association in 1980; once with the revision of DSM-III in 1987, and again with the publication of DSM-IV in 1994.

The DSM-IV (1994) changes in this area went beyond simply revising the diagnostic category for PTSD, it identified and separated out the diagnosis of Acute Stress Disorder as well, which has essentially the same characteristics of PTSD excepting the time frame in which symptoms appear and leave. This represents the clear recognition and acceptance of the impact trauma has on both the

short and long-term by the American Psychiatric Association. DSM-IV (1994) describes and identifies PTSD as follows:

> The essential feature of Posttraumatic Stress Disorder is the development of characteristic symptoms following exposure to an extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one's physical integrity; or witnessing an event that involves death, injury, or threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate (Criterion A1). The person's response to the event must involve intense fear, helplessness, or horror (or in children, the response must involve disorganized or agitated behavior) (Criterion A2). (p.424)

Specific identification by DSM-IV (1994) of what exactly an "extreme traumatic stressor" (p. 424) is or examples of it, are somewhat scarce in the description. This may be the result of the subjective nature of interpreting events through their interaction with cultural norms and definitions of what would bring about a reaction of ". . . intense fear, helplessness, or horror" (p.424) in a person. John Briere (1997) asserts that stressors such as disasters, large-scale transportation accidents, war, rape and sexual assault, spouse or partner battery, torture, and child abuse are

typically viewed as extreme and traumatic. Briere (1997) points out that no traumatic event in and of itself will always produce a Posttraumatic Stress Disorder in a person. He further asserts that no specific victim profile or inherent or learned personal characteristics will necessarily result in a Posttraumatic Stress Disorder upon a person being exposed to a traumatic stressor.

The prevalence of Posttraumatic Stress Disorder is a hotly debated issue and DSM-IV (1994) reflects this by stating:

> Community based studies reveal a lifetime prevalence for Posttraumatic Stress Disorder ranging from 1% to 14% with variability related to methods of ascertainment and the population sampled. Studies of at-risk individuals (e.g., combat veterans, victims of volcanic eruptions or criminal violence) have yielded prevalence rates ranging from 3% to 50%. (p.426)

This broad variability in the prevalence of Posttraumatic Stress Disorder may go beyond the issues of ascertainment and population selection to the very heart of the diagnosis. It seemed to require the combined power and weight of the many previously identified stressors, trauma-related conditions, and syndromes dating back to Charcot to come together to produce the current diagnostic category in DSM-VI (1994). Perhaps this prevalence variation cited in DSM-IV (1994) is simply a reflection of different types of PTSD diagnostic categories yet to be

defined within the structure of the Diagnostic and Statistical Manual of Mental Disorders, many of which gave rise to the general category in the first place.

Yehuda and McFarlane (1995) challenge the notion that PTSD is a natural reaction to unnatural circumstances. They question whether traumatic events are simply triggers that bring out other disorders. They point out that the emergence of pure PTSD without the presence of other disorders is an infrequent exception rather than the rule. Yehuda and McFarlane (1995) suggest "As such, the emergence of PTSD following exposure to a trauma may represent the manifestation of an underlying diathesis rather than a normative adaptation to environmental challenge" (paragraph 23). This could explain the broad variation in prevalence as being a function of subjective interpretations of clinicians about diagnostic criteria for PTSD. Yehuda and McFarlane (1995) contend that the diagnostic category of PTSD was politically convenient for those in the field wishing to champion victims' rights. They go on to conclude that:

> The contribution of PTSD to psychiatry is that it provides an observational framework for studying the effects of stress and trauma. From a social and political perspective, PTSD as a concept has done much to assist in the recognition of the rights and needs of victims who have been stigmatized, misunderstood, or ignored by the mental health field. The existence of this diagnosis has allowed the emergence of the much needed data about the

> effects of trauma that did not previously exist and could not have been systematically collected without this diagnosis. (Yehuda & McFarlane, 1995, paragraph 29)

They go on to conclude that the basis of the development of the PTSD diagnosis may be empirically flawed, but are politically convenient (Yehuda & McFarlane, 1995). This line of thinking is vaguely reminiscent of the victim blaming mentality that has, in the past, suppressed the importance of the influence traumatic stress has on psychological development.

Briere (1997) contends that consideration needs to be given dividing PTSD into subtypes such as adding a category for *Posttraumatic Depression* because of the often close and even indistinguishable relationship between the events precipitating PTSD and many situations precipitating a Depression. He also gives argument to the idea of a diagnosis of *Complex PTSD* which is felt to be the result of prolonged and repeated exposure to trauma like that evidenced in concentration camps and in victims of long-term and severe child abuse (1997). McFarlane and Girolamo (1996) assert that ". . . the time has come to reopen the question as to whether there exists subtypes of PTSD that are determined by the nature of the stressors" (p.130). They assert that there are very real differences between surviving the horrors of extended combat and an automobile accident and that those differences are reflected in the types of reactions experienced by victims. Both situations can and

do produce PTSD, but these authors point out that the prevalence and types of symptoms may differ widely and merit greater inquiry and study in the future (McFarlane & De Girolamo, 1996).

Compassion Fatigue

One proposed subtype of PTSD that has caught the attention of researchers during the last decade is what has become known as compassion fatigue (Figley, 1995). This concept has been identified by many names including vicarious traumatization (Pearlman & Saakvitne, 1995). Figley (1995, 1999) has gone so far as to argue for a new diagnostic label of Secondary Traumatic Stress Disorder (STSD). This is a construct that involves the idea that a person's exposure to the traumatic experiences of another may cause them to develop PTSD symptoms.

The revisions to the diagnostic criteria for PTSD in DSM-IV, as mentioned earlier, clearly recognized that a person could suffer symptoms as a result of being in close emotional proximity to an individual suffering with a primary traumatic issue or event (Figley, 1995). The idea that secondary or vicarious exposure to trauma may cause PTSD-like symptoms surfaced with studies on the offspring of holocaust survivors and families of war veterans from World War II, Korea, and Vietnam (Yehuda, Schmeidler, Elkin, Houshmond, Siever, Binder-Brynes, Wainberg, Aferiot, Lehman, Guo, & Yang, 1997; Krystal & Danieli, 1994; Williams, 1993; Danieli, 1997; Figley, 1995).

A considerable amount of writing and research has been accomplished during the last decade on the topic of secondary or vicarious trauma and compassion fatigue (Figley, 1995, 1999; Stamm, 1999; Valent, 1995, Beaton & Murphy, 1995; Dutton & Rubinstein, 1995; Pearlman & Saakvitne, 1995). Nearly all these scholarly works and studies tend to focus on two issues. The first is determining if compassion fatigue is a viable construct and is it a threat to the well being, productivity, self-efficacy, and mental health of those who encounter it. The second then attempts to expand the circle of those that might be affected by the stress of a critical incident beyond family members, to persons such as therapists (Figley, 1995, 1999; Stamm, 1999; 1996; Pearlman & Saakvitne, 1995; Steed & Downing, 1998; Cornille & Meyers, 1999; Jones, Robinson, Minatrea, Hayes, 1998) and emergency services personnel (Beaton & Murphy, 1995; Corneil, Beaton, Murphy, Johnson, & Pike, 1999; Beaton & Murphy, Pike, & Jarrett 1994; Murphy, Beaton, Cain, & Pike, 1994 ; Violanti & Paton, 1999; Follette, Polusny, & Milbeck, 1994).

A third area of inquiry is consists of research about what persons who are likely to encounter stressors that give rise to compassion fatigue can do to insulate themselves from it or resist its intrusion into their lives (Yassen, 1995). Some of this effort attempts to assert that training (Paton, 1994; Maggio & Terenzi, 1993), specific types of communication (Harris & Linder, 1999), information (Stamm,

1999, Williams & Sommer, 1999;), debriefing (Terry, 1999; McCammon & Allison, 1995; Dyregrov, 1998; Mitchell & Everly, 1997; Solomon & Mastin, 1999; Rothberg & Wright, 1999; Mitchell, 1999; Dunning, 1999), team therapy approaches with trauma victims (Munroe, Shay, Fisher, Makary, Rapperport, & Zimering, 1995), and peer supervision/support groups (Catherall, 1999) will assist people in fending off compassion fatigue or STSD. Another construct that has been suggested may assist in combating the ill effects of exposure to secondary and even primary trauma is life or compassion satisfaction (Rudolph, Stamm & Stamm, 1997; Stamm, 1999). Compassion satisfaction is thought to be a combination of factors involving locus of control, commitment, and seeing change as a challenge as opposed to it being a problem (Stamm, in press).

Compassion Fatigue in Mental Health Workers

Studies involving mental health care providers and compassion fatigue are scarce and at the same time perhaps the most numerous of those populations that are being investigated. They seem to consistently show a transfer of trauma from clients to helper. One recent inquiry found that as many as one in three caregivers at high risk for developing compassion fatigue symptoms (Rudolph, et al., 1997).

Another qualitative exploration revealed that the majority of therapists in a study of caregivers working with victims of sexual abuse in Australia report PTSD

like symptoms (Steed & Downing, 1998). The sample was small and the gender was limited to female therapists.

Chrestman (1999), in a self report survey of members belonging to several professional organizations that represent therapists that come into regular contact with trauma victims, revealed an increase in symptoms resulting from secondary exposure to trauma, but that none were found to be in the clinical range. Further, these symptoms and the time that they were perceived to be at all problematic trended down in relationship to issues like training, income, and experience (Chrestman, 1999).

Nancy Kassam-Adams (1999) found in a study of one hundred therapists that over 50% scored in the clinical range on Impact of Event Scale. These elevated scores were correlated positively with the amount of career exposure they had with sexually traumatized victims (Kassam-Adams, 1999). Further, there was no significant relationship with any other client type and elevated symptoms of PTSD (Kassam-Adams, 1999). This study also showed a positive correlation between showing PTSD symptoms and being of the female gender as well as a positive correlation between PTSD and a personal childhood trauma history (Kassam-Adams, 1999). The risk of burnout was also measured and shown to be no higher for this sample than for the norm group of other professionals from mixed occupational fields (Kassam-Adams, 1999). This tends to support another

distinction in the field of secondary trauma and that is that compassion fatigue and burnout may represent two distinctly different phenomena.

Cornille and Meyers (1999) conducted a study of 183 child protective workers and found that a significant number have PTSD symptoms of a level equal to or greater than persons utilizing the services of out patient mental health clinics. This study also indicated that levels of trauma exposure combined with long work hours were significant factors in symptom development as well as having a personal childhood history of trauma and having been the victim of an assault on the job (Cornille & Meyers, 1999).

Emergency Service Workers and Compassion Fatigue

Another area of concentration in the study of secondary stress has been with emergency service workers. This population consists of disaster workers, firefighters, paramedics, and emergency service dispatchers. A study of two groups of disaster relief workers by Paton (1994) revealed that firefighters did not fare as well as specifically trained disaster volunteers from varied backgrounds in dealing with the stress of search and rescue work after an Armenian earthquake. The author concluded that a disaster event presents situations to rescue workers that are contextually different enough so as to overcome the experience and training of professionals and that experience and training may in fact become a liability as opposed to an asset (Paton, 1994). The study did not report what specific training

the group of firefighters had obtained as a part of their normal duty preparation, but it did specify the volunteer training that generally occurred just prior to departure for the disaster site (Paton, 1994).

The notion that context difference can overwhelm the training and experience is sound in the formulation, but the failure to account for the specific type of prior training obtained by the firefighter group and its time proximity to the rescue operation presents an alternate and equally plausible explanation. Specifically, that training regarding a specific type of work establishes in advance an appropriate context and expectation set so as to enhance performance (competency) thereby reducing the impact of stress in the volunteer group. Further, the results of the firefighters may have actually been quite good if they had been compared to the general population or to another sample of volunteers who received no training as to disaster expectations. It should also be noted that Paton (1994) reported that nearly 25% of the volunteer sample (n=21) were also firefighters. What it appears this study does give us is that the importance of training cannot be over estimated especially when it occurs in close proximity to the situations for which the training is designed to address.

In a relatively early study of gender differences in symptoms of stress in firefighters and paramedics Murphy, et al., (1994) found little in the way of differences between gender except greater stress about harassment and higher

reports of depression among female firefighters and paramedics. This higher reporting of depression in female paramedics and firefighters is consistent with other studies on other helping professionals reported earlier. Another large survey study conducted by Beaton, et al., (1995) showed that male firefighters and paramedics reported higher levels " . . . on nearly all of the stress-factor scales" (p.240). The sample consisted of 1950 paramedics and firefighters and it did not specifically measure for vicarious trauma or secondary traumatic stress, but it did show overall elevations to stress as compared to a convenience sample of non fire fighting or paramedic personnel. Beaton et al., (1995) also concluded that only " . . .15% to 20% of firefighters and paramedics are at risk and in need of intensive stress management treatment. Perhaps by studying the mediating variables that seem to be protective for the majority of firefighters and paramedics . . ." (p. 243) methods could be developed to insulate and provide prevention programs for this profession.

A 1999 study of northwestern American and Canadian firefighters demonstrated that the firefighters from these samples reported PTSD symptoms to be more prevalent and severe than Vietnam era veterans and at levels not significantly different from Vietnam veterans wounded in combat (Corneil, et al., 1999). One of the striking conclusions of this study was that presence of PTSD was predicated more on job stress issues than on the frequency of traumatic incidents:

"Both firefighter samples had high odds ratios for PTSD due to the work strain variable" (p. 139).

Context specific training and reduction in or control of job stress issues may be indicative of factors that may reduce vulnerability to compassion fatigue and burnout based on these studies of emergency service workers. It has also been shown that experience or length of service seems to have no impact on PTSD symptom development or prevention (Corneil, et al., 1999).

Law Enforcement Personnel and Compassion Fatigue

Law enforcement personnel are probably especially vulnerable to PTSD and STSD (Briere, 1997; Figley, 1995; Violanti & Paton, 1999). While experts agree and point out what appears to be an obvious conclusion, it is based on little empirical evidence. Although the construct of compassion fatigue is barely half a decade in age the notion of PTSD has been around as a formal diagnostic category since 1980. One of the professions most likely to suffer under the burden of this disorder is that of law enforcement. The very nature of what is demanded of a police officer puts these people in harms way at any time they are perceived to be in the role of law enforcer. Every traffic stop, domestic disturbance, and report of a prowler holds the potential of a police fatality. Police work seems to be a paradoxical profession of routine calls that demands there can be no routine call if an officer's safety is to be at all considered. John Violanti (1999) points out that,

"Just like their Vietnam veteran counterparts, traumatic stress, and even PTSD, can be a reality for officers dealing with civilian combat" (p.5). This reality may give rise to a police subculture. This police culture is suggested to be a source of concern when it comes to dealing with trauma. Violanti (1999) suggests that, ". . . assimilation of officers into the police role restricts cognitive flexibility and the use of other life roles, thus impairing their ability to deal with psychological trauma" (p. 92). Ingrid Carlier (1999) asserted that, "Of all the high-risk occupations, police work is probably the most trauma sensitive" (p.227). The studies that have been conducted show mixed results, but do represent a start in the process of teasing out what factors are consistent in law enforcement with other helping professions and what might be different.

One early study in 1988 by Anson and Bloom set out to determine if the occupational stress of police officers was different than that of other occupations, specifically correctional officers, probation officers, firefighters, or emergency medical technicians. The authors found that overall the effects of negative stress tended to be greater in police officers, corrections personnel, and probation personnel than in firefighters or emergency medical technicians (Anson & Bloom, 1988). They also found little or no difference between police officers, corrections personnel, and probation officers regarding occupational stress with the most similarity being between correctional officers and police officers (Anson &

Bloom, 1988). They attributed this to exposure to potentially violent criminals on a regular basis. They also suggest that the lower stress levels of firefighters and emergency medical personnel may have to do with the duration of exposure to stressful situations and the normally protected environment in which they tend to be found most of the time during working hours. On the other hand, the three occupations involving law enforcement tended to have more constant exposure to stressful situations (Anson & Bloom, 1988).

Another study targeting the impact the "police culture" has on officer performance and coping strategy by Pogrebin and Poole (1991) found that many time honored traditions and ways of dealing with each other and the public may be harmful to police and the populations they serve. This unique qualitative inquiry into the issues of emotions and the impact they have on police personnel examined the enculturation process of new officers within the "police culture" and the role or lack of it that emotions play in the professional and personal lives of law enforcement officers. The topics addressed were the police culture and emotion management strategies employed by law enforcement officers including: emotion work (changing emotional intensity to fit a context) and the use of humor in enabling police officers to maintain their professional composure (Pogrebin & Poole, 1991).

The authors concluded that police officers are discouraged by their context to express any emotion beyond humor in the conduct of their professional lives, as well as, eventually, in their personal lives. Pogrebin and Poole (1991) point out that this context was a function of the so-called police culture and the expectations of the public they are entrusted to serve. It was further suggested that although emotional detachment and suppression may enable a police officer to conduct their duties in the face of highly emotionally charged events and situations it may also hinder abilities to serve the public interest. Pogrebin and Poole (1991) indicated that emotional detachment may be contraindicated while dealing with victims during the process of information gathering and may inhibit or discourage a suspect's confession. The researchers further suggested that failure to display and express emotions on the part of a police officer could have a negative impact on mental health and the officer's ability to function professionally and personally (Pogrebin & Poole, 1991).

A study by Follette, et al., (1994) had three objectives. The first was to explore the impact of providing services for sexual abuse victims in a mental health and a law enforcement capacity and whether or not service providers were in some way experiencing secondary traumatization. The second consisted of an effort to determine if personal traumatization may influence career choice and/or how service providers conduct themselves professionally when providing services to

sexual abuse victims. Thirdly, the study intended to provide replication data on the issues of prevalence of trauma histories in mental health professionals, professional's psychological adjustment, and clinical practices related to the inquiry by therapists about the sexual abuse histories of their clients.

A total of 558 mental health and law enforcement professionals were sent two questionnaires (Follette, et al., 1994). The responding mental health professionals consisted of 164 psychologists and 307 marriage and family therapists that were given the Therapist Response Questionnaire (TRQ). The TRQ is a 110 item self-report inventory that assesses issues including professional background, demographics, clinical workload, the nature and variety of clinical case load, a self impact assessment of working with various types of clients, and personal stress levels (Follette, et al., 1994). The responding law enforcement professionals consisted of 46 officers whose duties included investigating sexual abuse cases as a part of their regular work. These officers completed a modified version of the TRQ referred to as the Law Enforcement Response Questionnaire (LERQ) (Follette, et al., 1994). Both groups were given the Trauma Symptom Checklist-40 (TSC-40).

Follette, et al., (1994) found that overall 29.8% of mental health professionals and 19.6% of police surveyed reported a history of childhood sexual or physical abuse. In the case of mental health professionals the authors found no

significant difference between those that had a personal history of abuse and those that do not have such a history in their career choice, type of case load distribution, and effective responsiveness to sexual abuse victims. They did note that mental health professionals with personal abuse histories reported utilizing more positive coping strategies than did their non-abused counterparts (Follette, et al., 1994).

The researchers found that law enforcement personnel reporting a personal abuse history had caseloads involving sexual abuse that tended to be significantly higher, reported greater use of negative coping strategies, as well as a greater number of positive coping strategies than their non-abused counterparts (Follette, et al., 1994).

The stepwise multiple regression revealed that mental health professionals showed significant correlation between trauma symptoms and use of negative coping strategies, levels of personal stress, and negative clinical response to sexual abuse cases. The percentage of caseload reporting a sexual abuse history did not show a significant correlation with trauma symptoms. Significant results were found with law enforcement professionals and trauma symptoms having positive correlation with, negative response to investigating sexual abuse, level of personal stress, and personal trauma history (Follette, et al., 1994).

The researchers found no remarkable difference between the general populations reporting of personal abuse histories as they discovered in the literature

and either of the groups that were surveyed in this study. They did point out that law enforcement professionals were significantly more distressed on all measures of psychological symptoms than were mental health professionals (Follette, et al., 1994).

Follette et al., (1994) concluded that steps need to be taken to further confirm their results and to educate law enforcement personnel about the impact sexual abuse investigations may have on investigators. Further, they recommended that steps be taken to remove the stigma from personal counseling that seems to be prevalent in the law enforcement community.

A 1995 study out of Australia suggests that police work may in fact have lower psychological stress associated with such work than that of teachers or other non-police occupations (Hart, Wearing & Headey, 1995). The study suggests a four factor interactive model for evaluating occupational stress which consists of "Organizational Hassles, Operational Hassles, Operational Uplifts, and Organizational Uplifts" (Hart, et al., 1995, p.142). It is proposed that the *Organizational Hassles* are a function of seven dimensions consisting of communication, administration, supervision, ratings, coworkers, morale, and workload (Hart, et al., 1995). Frustration, external (other operations and organizations), victims, activity, complaints, and danger drive *Operational Hassles* (Hart, et al., 1995). *Operational Uplifts* are derived from offenders (making

arrests), victims (advocating and protecting) (Hart, et al., 1995). *Organizational Uplifts* are determined by ones decision making, workload (accomplishments), coworkers (support), administration (efficiency), amenities (rewards, privileges), supervision (organizational support and caring) (Hart, et al., 1995). Each of these dimensions interacts with the other factors through the primary factor with which each is associated. In the author's (Hart, et al., 1995) words:

> "It would not be surprising if police officers experienced some degree of psychological distress (dissatisfaction) when dealing with a traumatic case of child abuse. At the same time, however, police officers may derive satisfaction as a result of doing something about the abuse" (p. 144).

The study was part of a longitudinal study into police stress and well being and selected a sample of 330 police officers from the Victoria, Australia Police Department in 1988 and a similar sample of 372 officers from the same department in 1990. The samples had six "perceived quality of life indicators" (Hart, et al., 1995, p. 137) administered to them. They were also given the Police Daily Hassles and Uplift Scales, the Coping Response Inventory and the NEO Personality Inventory (Hart, et al., 1995).

Aside from concluding that police officers tend to suffer less psychological distress than most other occupations Hart et al., (1995) also concluded organizational factors have a far greater impact on officers well being and stress

levels than do operational factors. This conclusion indicates that the context defined by the organization is more important to the psychological health of the police officer than the type of work and experiences that are operationally endured (positive and negative), including primary and secondary traumatic experiences.

Chapter III

Method

Subject Selection

The sample that has been selected for this study was a convenience sample that consisted of two groups of law enforcement personnel. The first was direct law enforcement personnel (police officers) that have regular contact with persons who have or are experiencing traumatic events or critical incidents. The second group consisted of law enforcement support personnel (dispatchers, administrative support personnel, clerical, and forensic support personnel) who have little or no face-to-face contact with trauma victims.

The sample of fifty-two direct contact personnel utilized was a volunteer sample drawn from a population of approximately eighty police officers with varying amounts of tenure in law enforcement from a mid-west suburban sheriff's department. All these officers work within the same geographical area.

The sample of thirty-one law enforcement support personnel was obtained from the same department and was selected from a group numbering approximately fifty. Persons in support positions from the same department were utilized so that the experience and knowledge of the subjects about the victims the department contacts or has dealings with will be the same or very similar. Further, the influence of history might also be minimized in an effort to keep potentially confounding variables to a minimum.

Of the fifty-three direct contact personnel who were asked to participate, fifty-two agreed (one declined indicating a need to depart to deal with an illness in his family). The fifty-two participants consisted of forty-seven males and five females (see Table 2). All female direct law enforcement personnel within the department participated. Forty-nine of the direct contact personnel were white with the remaining three consisting of two African Americans and one Native American (see Table 1).

Table 1 Ethnic groups

Personnel type	Ethnic origin	Frequency	Percent
Direct Law Enforcement	Am. Indian	1	1.9
	African Am.	2	3.8
	White	49	94.2
	Asian	0	0
Law Enforcement Support	Am. Indian	1	3.2
	African Am.	1	3.2
	White	28	90.3
	Asian	1	3.2

Thirty-five support personnel were invited to participate with thirty-one consenting. Four declined without volunteering an explanation. Only seven of the

support personnel were male with the remaining twenty-four being female (see Table 2). Twenty-eight of these participants were white. There was one African American, one Native American, and one Asian (see Table 1).

Table 2 Gender distribution

Personnel type	Gender	Frequency	Percent
Direct Law Enforcement	Male	47	90.4
	Female	5	9.6
Law Enforcement Support	Male	7	22.6
	Female	24	77.4

The distributions and mean ages of both groups were nearly identical with the pooled ages ranging from nineteen to sixty-seven and a mean age of forty-two (SD = 10.02). There were no direct law enforcement personnel who were under the age of twenty-one.

The groups differed on educational achievement with only 13% of the support personnel obtaining an associates degree or higher and over 50% of the direct contact personnel obtaining a post high school degree or higher (see Table 3 for details).

Table 3: Education

Personnel type	Highest degree earned	Frequency	Percent
Direct Law Enforcement	HS/GED	25	48.1
	A A	11	21.2
	BA/BS/BSN/RN	14	26.9
	MA/MS/MSW	2	3.8
Law Enforcement Support	HS/GED	27	87.1
	A A	1	3.2
	BA/BS/BSN/RN	1	3.2
	MA/MS/MSW	2	6.5

There was a larger number of support personnel that reported being currently divorced or separated (33%) while only 17.3% of direct contact personnel reported being currently divorced or separated. The number of direct contact personnel reporting a multiple marriage status (married two or more times) was twelve while the support personnel reported multiple marriages in six instances.

The residence patterns reported by the two groups found approximately 70% have the perception that they live in an urban area as opposed to a rural or frontier area. The length of service for both groups ranged from one year to a maximum of thirty-three years (Mean=9.7; SD=7.24) with this department.

Table 4: Marital status

Personnel type	Marital status	Frequency	Percent
Direct Law Enforcement	Single	3	5.8
	Married	40	76.9
	Separated/divorced	9	17.3
	Single	2	6.5
Law Enforcement Support	Married	17	54.8
	Separated/divorced	12*	38.8

(*2 were widowed)

Procedures

The direct contact law enforcement personnel were contacted at the regular shift musters. The support law enforcement personnel were contacted in their regular office/work areas. The fact that a study about stress and law enforcement was being conducted was disclosed and they were asked to participate by taking a survey. All that consented completed a consent form (Appendix A) and were informed that the results and surveys were to be kept confidential on the consent form and by directly telling them this would be the case. The consent forms and surveys were collected separately and were each placed in a separate envelope. All participants were instructed to leave their names off the survey instrument and all complied. The instructions for the survey were read out loud as the participants read along and any procedural questions were answered. The consent form

indicated that the individual results of participants would not be retrievable and identifiable with any given individual. It was further indicated that if any participant was interested in taking a self-test and scoring version of the survey they could indicate this desire by checking the appropriate place indicated on the consent form. Any participants expressing this desire on the consent form were later given a self test and scoring version with a list of referral sources that might be of assistance if they had any concerns about their scores on the instrument. Of the 83 persons consenting to participate, 24 requested self-scoring versions of the test upon the conclusion of the study.

All participants were also asked to complete a demographic survey as part of the their participation in the study (Appendix B).

Instrument Selection

The instrument selected for this study is the Compassion Fatigue & Satisfaction Self-Test for Helpers (Stamm, 1999). The original instrument was a self-report measure for practitioners developed by Charles Figley and published in 1995 that consisted of 40 items with two sub-scales. The first is intended to measure the risk of Secondary Traumatic Stress (STS) symptoms or compassion fatigue and the second measures the risk of burnout or job dissatisfaction. The test is a semantic differential scale requiring one of six responses ranging from a zero to five, with zero meaning never, and five representing very often. Recently, Stamm

(in press), with the encouragement of Figley, revised the instrument adding another sub-scale consisting of 16 additional items. The test was generalized to persons in helping professions and now consists of the following three sub-scales: Compassion fatigue (CF), burnout (BO), and a new scale of compassion satisfaction (CS). The test authors have hypothesized that CS may account for the many people in high stress positions who deal with all sorts of traumatic material both directly and indirectly who do not suffer symptoms (Stamm, in press). The degree of payoff or satisfaction and support they feel in their position may have a vaccinating effect against STS (Stamm, in press).

The original measure reported test retest reliability findings ranging from .76 to .94 for CF and BO. The revised Compassion Fatigue & Satisfaction Self-Test for Helpers reports alphas of .87 for CS, .90 for BO, and .87 for CF. This information was based on a pooled sample of 370 persons and it is reported that there was no evidence of variation "based on country of origin, type of work, or sex when age was used as a control variable" (Stamm, 1999, p. 5). These findings appear consistent with earlier reliability findings on the CF and BO scales by Stamm (in press) of .85 CF and .94 BO on a sample of 142 psychotherapy professionals. The mean age of the more recent sample was 35.4 years with 33% males, 56% females and 11% unknown. The type of work of the test volunteers ranged from trauma professionals (16%), business persons (35%), Red Cross

volunteers (8%), and caregivers in training (27%) (Stamm, in press). Evidence for test retest reliability is given with a sample of 16 health care givers in South Africa. The CF and BO scales were administered to the same workers with at least three months on the job, three months apart with very little difference in scoring reporting mean scores of 45 and 44 respectively for CF, and means of 32 and 28.86 on the BO scale. Adding the item responses from each sub-scale yielding a score that ranks the individual for potential or risk scores the instrument. On the compassion satisfaction sub-scale the scores range from extremely high potential, high potential, good potential, modest potential, and low potential. On the burnout and compassion fatigue sub-scales the scores yield a risk of extremely low; moderate; high; or extremely high.

Although there is little or no data available for whether this instrument is consistent with others that measure the same variables and constructs, there is also a definite lack of instruments available that measure these constructs because the field of inquiry is so new. Further, this makes reliability and consistency of measure across time difficult to the extent that more time and testing must occur to validate the findings thus far. The early indications and widespread use in studies currently underway indicate good face validity and also a lack of available alternatives (Stamm, March 2000, personal communication). Use of this instrument in the current study may also serve the dual purpose of adding to the database being

compiled by the authors at the present time (Stamm, March 2000, personal communication).

Modifications (see Appendix C and D for original and modified test instruments) were made to the instructions on the instrument with the permission of the test author to eliminate statements in the test instructions about it being a self-test or any reference to scoring instructions or data (Stamm, March 2000, personal communication). These modifications are consistent with those made by the test author when it has been administered in the context of a study (Stamm, March 2000, personal communication), and were made to avoid contextual confusion on the part of the participants.

Design/Data Analysis

A t-test was conducted to determine if the gender difference in the participant groups represented a source of bias in the sample. The study itself consisted of five predictions. The first three involved the prediction that the compassion fatigue and burnout scores will be higher for direct contact law enforcement personnel than those in the support personnel they work with. T-tests comparing means were selected because the groups and variables being analyzed were interval and continuous data. The remaining two predictions were that the scores on the compassion satisfaction scale would have an inverse correlation with the compassion fatigue and burnout scores and that longevity of employment in law

enforcement would have a positive correlation with elevated compassion fatigue and burnout potential. Because these variables were on an interval level, Pearson-r correlations were selected and performed to make these determinations.

Chapter IV

Results

The results are divided into two sections. The first section consists of the results of the t-tests for significant difference between means. The second section consists of the Pearson-r correlational analyses of score relationships.

The vast majority of the support personnel were female and women were dramatically under represented (see Table 5) in the direct law enforcement personnel group, therefore t-tests were conducted to test for gender differences. It was determined that in this sample there appeared to be no significant difference in scores based on the gender of the respondents (summarized in Table 6). This is consistent with the original test norms (Stamm, March 2000, personal communication).

Table 5: Summary of gender differences

Sub-scale	Gender	Sample size	Mean	S.D.
Compassion Satisfaction	Male	54	90.90	11.80
	Female	29	87.69	15.56
Burnout	Male	54	29.61	11.51
	Female	29	30.48	12.77
Compassion Fatigue	Male	54	32.30	14.77
	Female	29	30.45	11.74

Table 6: Summary of independent samples t-test for gender differences

Sub-scale	t	p-value
Compassion Satisfaction	1.057	.294
Burnout	-.316	.752
Compassion Fatigue	.582	.562

* p< .05 ** p<.001

As a result, further analyses were conducted on the two groups without regard for gender.

The first hypothesis predicted that the group of direct contact law enforcement personnel would score higher for compassion fatigue and burnout than the law enforcement support personnel. Table 7 shows a summary of the data collected for each group on the burnout and compassion fatigue sub-scales. These group mean scores were then compared with the sub-scale standardized norms for burnout and compassion fatigue (Tables 8 and 9).

Table 7: Sub-scale data summary for burnout & compassion fatigue by group

Sub-scale	Type of Personnel	Sample Size	Mean	SD
Burnout	Direct Law Enforcement	52	29.44	10.92
	Law Enforcement Support	31	30.71	13.54
Compassion Fatigue	Direct Law Enforcement	52	32.71	13.20
	Law Enforcement Support	31	30.55	14.77

Table 8: Burnout risk scoring key (Stamm, 1999)

Burnout Risk	Extremely High	High	Moderate	Extremely Low
Score*	76-85	51-75	37-50	36 or less

*Lower scores are desirable on this sub-scale.

Table 9: Compassion fatigue risk scoring key (Stamm, 1999)

Risk for CF	Extremely High	High	Moderate	Low	Extremely Low
Score*	41 or more	36-40	31-35	27-30	26 or less

*Lower scores are desirable on this sub-scale.

The mean scores for both groups of personnel for burnout places them in the "Extremely Low Risk" range on the burnout sub-scale. The mean score for the direct law enforcement group is within the "Moderate Risk" range for the compassion fatigue sub-scale while the law enforcement support personnel were within the "Low Risk" range. Although there is a difference in the mean scores between the groups on the burnout scale it runs contrary to the prediction of the directional alternative hypothesis and the difference is slight. The difference in mean scores on the compassion fatigue scale is greater and concurs with the directional alternative hypothesis for this comparison. The mean scores for both sub-scales were subjected to an independent samples test (t-test) to determine the degree that the two groups differ from one another on the sub-scales of compassion fatigue and burnout. These findings are summarized in Table 10. It was found that

there is not sufficient enough difference between either group's mean scores on the burnout or the compassion fatigue sub-scales to reject the null hypothesis in support of the directional alternative hypothesis in either case.

Table 10: Independent samples test results for burnout and compassion fatigue

Sub-scale	t	p-value
Burnout	-.467	.642
Compassion Fatigue	.562	.576

* p< .05 ** p<.001

The third hypothesis predicted that the level of compassion satisfaction has an inverse relationship with the risk for burnout and compassion fatigue. Prior to testing this construct, the compassion satisfaction mean scores for the two law enforcement groups shown in Table 11 were compared to the compassion satisfaction standardized norms (Table12).

Table 11: Sub-scale data summary for compassion satisfaction

Sub-scale	Type of Personnel	Sample Size	Mean	SD
Compassion Satisfaction	Direct Law Enforcement	52	90.51	11.42
	Law Enforcement Support	31	88.55	15.94

Table 12: Compassion satisfaction potential scoring key (Stamm, 1999)

Potential for CS	Extremely High	High	Good	Modest	Low
Score*	118 or more	100-117	82-99	64-81	63 or less

*Higher scores are desirable on this sub-scale.

The mean scores for both groups of personnel were in the "Good" range on the compassion satisfaction sub-scale indicating high levels of support and feelings of being in control in their positions as helpers. An independent samples t-test was conducted (see Table13 for results) to determine if there was a significant difference that may influence or represent a confounding variable relating to the next set of predictions.

Table 13: Independent samples t-test results for compassion satisfaction

Sub-scale	t	p-value
Compassion Satisfaction	.654	.515

* p< .05 ** p<.001

Once again there was shown to be no significant difference in the responses between the groups compared.

The prediction that high potential scores for compassion satisfaction would predict low scores for risk of burnout and compassion fatigue and the prediction that the length of law enforcement service would cause the burnout and compassion fatigue risk factors to increase was then analyzed. To make these determinations, Pearson-r correlations were conducted for each of the three sub-scales while pooling the scores of the direct law enforcement group with the support personnel there were no significant differences between means of these two groups on all other comparisons. The results are recorded in Table 14.

Table 14: Pearson-r correlations for compassion fatigue, burnout, compassion satisfaction, & length of service

Sub-scale		COMFAT	BRNOUT	COMSAT
BRNOUT	Pearson-r	.749**		
COMSAT	Pearson-r	-.035	-.204	
LENGTHSE	Pearson-r	.009	.10	-.04

* p< .05 ** p<.001

COMFAT= Compassion fatigue; BRNOUT= Burnout; COMSAT= Compassion satisfaction; LENGTHSE= Length of service

The sub-scales of burnout and compassion fatigue were highly correlated and this is not surprising in that the two issues are related conceptually. There was no significant correlation between compassion satisfaction and compassion fatigue, which suggests that there was insufficient evidence to reject the null hypothesis in this instance.

There was also no significant relationship detected between compassion satisfaction and burnout, but there seemed to be a trend (p= .06) in the direction of the alternative hypothesis that as compassion fatigue scores went up then burnout risk would go down. This warranted further investigation into the data. It was noted that two outliers were extremely low on the compassion satisfaction and burnout sub-scales were present and atypical when compared to the rest of the respondents. It was decided to remove those two surveys reducing the sample size to 81 and conduct another Pearson r correlation. These results are summarized in Table15.

Table 15: Revised Pearson-r results

Sub-scale		COMFAT	BRNOUT
BRNOUT	Pearson-r	.740**	
COMSAT	Pearson-r	-.132	-.353**

* p< .05 ** p<.001

COMFAT = Compassion fatigue; BRNOUT = Burnout; COMSAT = Compassion satisfaction

The revised analysis does not appear to significantly change the correlation between any of the sub-scales except the relationship between compassion satisfaction and burnout which was significant (r=-0.35). The revised analysis supports the alternative hypothesis that a relationship exists between compassion satisfaction and burnout. It was further noted during the data inspection that all the compassion satisfaction scores were higher than sixty thus creating a limited range of response. The limited range of response for compassion satisfaction may also support an inference that this relationship between compassion satisfaction and burnout is in fact stronger that indicated here.

The fourth hypothesis that length of service would have a relationship to compassion fatigue and burnout did not provide sufficient evidence to reject the null hypothesis. In fact the relationship between compassion fatigue and length of service approaches zero (r= .009). A slightly larger value was determined with respect to length of service and burnout (r= .10), but still falls far from the mark of

being significant, thus failing to reject the null hypothesis that there is no relationship.

Chapter V

Discussion

The discussion section is divided into three sections. The first addresses the implications and limitations of this study. The second makes recommendations for future study in light of this one. The third section discusses issues that in light of this study counselors might consider in counseling law enforcement personnel and others in high-risk populations.

Study Implications and Limitations

The fact that none of the predictions of this study provided significant results except one, and only after the removal of two atypical outlier scores is surprising in light of all the theory, conventional wisdom, and what most of the few studies of law enforcement personnel have shown in the past (Anson & Bloom, 1988; Pogrebin & Poole, 1991; Follette, et al., 1994). This situation merits a close examination of the potential confounding variables and threats to the validity of this study.

One possible confounding variable may be the fact that all the personnel were tested on the job. This placed them in the work environment under the scrutiny of the supervisory staff. This may have had an indirect influence on the answers to questions that seemed directly related to the job. This may have also influenced the high level of participation in that the supervisory personnel informed the employees that the sheriff and the command staff had approved of the study.

This fact may have also encouraged cooperation and honesty in response. The fact that the surveys were all given on the job site also means that not every participant took the survey under identical conditions in that they work in three different buildings on as many as five different floors. The opportunity to pull individuals off the job to participate in a neutral place was not a practical consideration given the nature of the work that they perform. Therefore, the fact that different physical environments can yield different responses to test items is one possible threat to validity that could not be eradicated in this study. What can be said is that at no time were surveys given when officers or support personnel had to be directly engaged in performing their duties (surveys were conducted at musters, lunch breaks, afternoon breaks, and evening breaks).

Another source of bias may be found in a possible lack of trust the respondents may have had in the confidentiality of their specific responses. Several steps were taken to insure that anonymity would be maintained, and many steps were made intentionally visible to the respondents to demonstrate that identification of an individual with any particular survey would be next to impossible. All surveys were collected separately from the consent to participate forms. The consent to participate form spelled out the confidentiality of the results and the specific circumstances under which the overall results, but not individual results, would be shared and/or published (see Appendix A). Further, the

confidential nature and all the information expressed on the consent to participate forms was explained by this author in each and every instance where the surveys were distributed and participation was solicited. It is arguable that since the overwhelming majority of individuals who were asked to participate did participate in the study (83 out of 88 solicited) the participants felt confident that their answers would remain anonymous and confidential. The possibility that a bias existed as a result of distrust of the process would in all likelihood have been demonstrated by a less cooperative attitude about participating in the study (fewer persons consenting to take the survey), still this issue cannot be completely dismissed.

Another potential source of problems might exist in the selection process. The participants were selected in a convenience fashion and specific individuals were not targeted for any other reason then they happened to be working at the times that the surveys were given. All three shifts were represented with individuals from every division and job category with a proportional representation of supervisory and line personnel. The total population of employees in this department numbers 130. This sample represents approximately 64% of the total group. The possibility remains that the other 36% of employees might show very different responses. These responses would have to vary dramatically in order to have a significant impact on the overall results.

Another variable that was not controlled for in this study was that participants might have provided what they believe are socially acceptable answers. Some of the participants attend the same university as the author and there may have been an experimenter effect bias of desiring to impress or alter responses to make a positive impression on this author. The measures put in place to ensure anonymity should have minimized this possible source of interference, but there is the possibility that it was not effective. The number of individuals that fit this situation is estimated to be less than five and probably would not have had a dramatic impact on the outcome.

All these potential sources of interference may in part or whole contribute to an explanation of the unexpectedly high scores on the compassion satisfaction sub-scale and the moderate to low scores on the compassion fatigue sub-scale and very low scores on the burnout sub-scale of this group. These threats to validity might be sufficient to explain the lack of significant differences found between the two groups on any of the sub-scales. At the same time it may be safe to assume that, for the most part, those threats had a similar influence on all the participants as a whole. It could be argued that the influence on answers in a direction of being more socially appropriate would be relatively constant for all respondents. All subjects were surveyed by the same individual within similar work environments at the same facilities within a few days of each other under similar conditions and

circumstances (without interruption in office situations). No particularly horrendous crimes or investigations were initiated or brought to resolution during the survey period. Thus minimizing the effect of history and experience on the groups. It may be reasonable to suggest that the external influences from the surveying environment on respondents is somewhat controlled for when looking at these group differences.

One possible explanation for the lack of differences between groups might lie in what the survey did reveal. The test utilized in this study postulates that high scores on the compassion satisfaction sub-scale should correlate with low scores on both the compassion fatigue sub-scale and the burnout scale (Stamm, in press). Although no significant relationship between compassion satisfaction and compassion fatigue was found, there was at the very least a trend regarding the predicted inverse relationship between compassion satisfaction and burnout. This relationship may in fact be much stronger than indicated on the surface by these results. A close examination of the test scores on this scale reveal that seventy-seven (92%) respondents scored within the good and high ranges on the compassion satisfaction sub-scale (between sixty-four and one hundred and seventeen). The scores for the burnout and compassion fatigue sub-scales were more evenly distributed yielding a very high correlation between these two factors (r= .749). It can be inferred that a relationship similar to the original prediction that high

compassion satisfaction scores will accompany low scores for burnout exists and at a higher level of correlation than -0.35, found in this study, if there had not been a restricted range of scores. This correlation would have reflected the construct that compassion satisfaction may in some way inoculate an individual from the effects of burnout and compassion fatigue. In this instance the notion that such an inoculation is occurring may be supported by the significant correlation with burnout, but only very tentatively.

The possibility that other factors may be at work influencing all three sub-scales does exist. The argument that the relationship between the three sub-scales is being moderated by other factors needs to be examined. This may be supported by the fact that there is such a strong correlation between compassion fatigue and burnout and moderate relationship between compassion satisfaction and burnout while little to no relationship is apparent between compassion fatigue and compassion satisfaction. The current results suggest that as compassion fatigue rises so does burnout. Burnout rise might be mitigated by other factors of which compassion satisfaction might be one. It also follows that compassion satisfaction is exaggerated or supported by the same factors that inhibit burnout on the job, but they have little or no impact on the relationship with compassion fatigue.

Perhaps factors within this department are at work in minimizing the impact of burnout and compassion fatigue and increasing compassion satisfaction.

One prior study had results contrary to the predictions made for the current study and for the preponderance of the studies of stress in law enforcement performed in recent history. Hart et. al., (1995) concluded in his extensive study of over 527 police officers in Victoria Australia that organizational factors have a much greater impact on stress and development of symptoms then any operational issues (of which dealing with trauma victims is one). This implies that what an organization does that makes an employee's work situations positive, predictable, fulfilling, and supportive is of greater influence on the mental health and well being than all other environmental factors (Hart et. al., 1995). Hart goes on to conclude that many of the individuals that end up showing symptoms are predisposed by other issues such as personality and personal history, but that even these situations are more influenced by the organizational context then the operational one (Hart et. al., 1995). Corneil et al., (1999) noted in the study of firefighters that the presence of PTSD was predicated more on job stress issues rather than dealing with the traumatic events of others.

This line of thinking is consistent with that of the proponents of the idea that compassion satisfaction may have some sort of inoculating effect against burnout and secondary traumatic stress symptoms. Perhaps those aspects of the compassion satisfaction sub-scale that measure satisfaction and support from the organization are the real factors that relates to burnout. The issues influencing the

lower burnout scores as well as the compassion fatigue scores might be sought out within the organizational work context as opposed to how satisfied an individual seems to feel about helping others.

After the data analysis was completed several officers (5) from the department currently in question were asked by this author what they thought the overall morale of the department has been during the last year or so. They unanimously responded that morale has never been better. They indicated that the current sheriff had been the president of the deputy's association prior to taking this office and that he had taken many positive stands on behalf of the employees. They indicated they feel strongly supported in their jobs by the sheriff and his command staff. Although this is anecdotal information that was not scientifically collected it does support the findings and is mentioned because of that fact.

Many of the other studies that indicate police officers were at high risk for PTSD and other stress related problems were done in larger police agencies (Anson & Bloom, 1988; Pogrebin & Poole, 1991). This fact is another possible explanation for the disparity of results. These departments, by definition, are likely to deal with a larger density population and more crime thus having a greater impact on the personnel. Further, larger departments might be likely to become detached from their employees leaving them feeling unsupported and in less control over their own work situations. The results of this department reflect

the situation in medium-sized police agencies dealing with middle class suburban populations.

This is also the first time this particular instrument was utilized for a police population. The other studies reviewed all utilized a wide array of different measures with different operational definitions of what PTSD or other stress issues consist of. Thus the possibility exists that this instrument does not measure the same variables as the others used in prior studies.

The limitations that are implied in all this are several. First, the fact that this sample consists of members of a medium sized police agency in the mid-west that serves a middle to upper middle class suburban population means that one should use caution in generalizing these results to other police agencies. Secondly, this sample comes from a department with reportedly high morale and a low turnover rate in employees. Thus comparisons with other similar departments should attempt to take these issues (discovered anecdotally here) into consideration in advance. Third, a sheriffs department is usually saddled with additional responsibilities, not generally found in other policing agencies. The services of civil process, court security, jury selection and security, and county-wide services for forensics, laboratory, tactical teams, and other specialized units are often found to be the responsibility of a sheriffs department and are often not typically found in similar sized law enforcement agencies serving municipalities.

Recommendations

One fact became clear as the process of constructing and executing this study unfolded. This inquiry examined a population of people that have been under perhaps more scrutiny from the courts, the media, and the public than any other group, and has been subjected to almost none from the social sciences. It is hoped that this research encourages more research about police agencies.

Another issue that merits further investigation is the examination of the law enforcement job context and how it influences the issues of burnout, PTSD, compassion fatigue, and premature retirement. The disparity of results between the various studies including this one to date provides fertile ground for inquiry as well as far more questions than answers on these issues. Can a police department take steps from an organizational standpoint to somehow inoculate and/or minimize the impact of stress and traumatic stress on the personnel they employ? Is the paramilitary nature of most police organizations one that promotes employee well being or is it one that is doing harm? Is the often talked about police culture a safe shelter from the trauma storms raining down on police officers or is it the last stand in a futile and recurring effort to hold off the devastating effects of traumatic stress and events? In short, the investigation into the context in which police work is conducted merits investigation if only to help our police do a better job of protection. It can be argued that it is the context that often determines whether an

event is perceived to be traumatic and the degree to which it impacts those exposed to it. The current study may well represent an example of this, but further investigation is a must to make this determination.

Some agreement also seems in order about the nature of these various issues from an operational definition point of view. The very real possibility that the differences in results and conclusions of the various research efforts is a function of a different understanding of what is being evaluated is as likely to explain all the disparity in results as anything else. More study and research is needed to establish significant common ground and agreement in what exactly and precisely is being measured.

If the police organization can provide a prophylactic shield for traumatic stress and/or burnout is this shield portable to other contexts, such as the military, firefighters, crime victims, other trauma victims? This is the bottom line question that most future investigations ought to address.

Counseling Implications

This study clearly indicates that counselors should use caution in assuming that a police officer presenting for counseling will more often than not have some stress or traumatic stress issues needing to be processed. This study is a demonstration that quite the contrary may in fact be the case. Counselors might also be mindful of the implications of this study and others (Hart et al., 1995;

Corneil et al., 1999) when police officers or other high-risk professionals spend their time talking about organizational stress issues. These issues may indicate the real source of problem or be the resource where solutions to problems might be more readily available. Conversations with clients about the context of their high stress occupations may be the most beneficial conversations a counselor might engage in and may not represent avoidance or resistance on the part of a client.

Encouraging our law enforcement agencies in practices that support officers and personnel through providing training on reducing workplace stress and enhancing organizational communication and positive development are critical issues counselors with specific expertise might consider offering. Serving in a consulting role to police human resources divisions or policy-making boards are other areas counselors might exert a positive influence.

Appendix A

Compassion Fatigue/Stress Study
Consent to Participate

I hereby consent and volunteer to participate in the Compassion Fatigue/Stress Study that is being conducted by William Heusler as part of a Master's Thesis with the Lindenwood University Counseling Program with the consent and cooperation of the -xx name of department xx-. I have been informed that my individual results and individual answers will be kept anonymous and will not be revealed to my employer or anyone outside the actual study staff which consists of William Heusler, Lindenwood University faculty and adjunct professors, and Lindenwood University student helpers. I understand that the overall results of this study will be made available to the -xx name of department xx, and may be published in part or whole. I further understand and consent to have my results entered into a national database anonymously for the purposes of scholarly research. I hereby release William Heusler, Lindenwood University, its faculty and students, the test authors, the -xx name of department xx and any and all publications that may publish this study from all claims and any harm as long as my anonymity is reasonably protected. I further understand that I will not be able to retrieve the answers I may provide to any questions in that my name will be separated from any tests I take from this point forward. I have been informed that if I wish to take a self-test version of the test given in this study a blank copy with scoring instructions will be made available to me at the conclusion of this study if I check the box below indicating my desire for a blank copy of the test.

_____

Signature

_____

Print name

_____

Date

☐ Check this box if you wish to have a blank self-test version of the test you are about to take at the conclusion of the study. A copy will be provided through the department at the conclusion of the study for your personal use unless you indicate differently to the test moderator. Thank you.

Appendix B

Compassion Fatigue/Stress Study

Thank you for agreeing to participate in this study of compassion fatigue and stress among helping professionals. All information you provide in this survey will be held in the strictest of confidence and your identity will not be revealed to your employer or anyone outside of the staff conducting this survey. Your name is not to be placed on this paper or on any of the survey instruments. Do not separate this paper from the papers attached to it. This survey will take only a few minutes to complete and it is important that you answer all questions and provide the most accurate answers possible about yourself and your situation. Upon completing this survey please place it in the envelope provided and turn it into the survey staff person that asked you to participate.

Participant Information

Position/job classification: _____

Age: _____ Gender: _____

How long in this position (years/months): _____ How long with this agency: _____

How many prior law enforcement positions: _____ Please list type(s) of prior positions:

_____

_____

If you have experience with another law enforcement agency please list all with position held:

_____

_____

Current shift (1st-days; 2nd-evenings; 3rd-nights): _____

Prior shifts worked: _____

Marital Status: _____(Married, Widowed, Divorced, Separated, if married, divorced or widowed indicate 1st, 2nd, 3rd, or 4th marriage)

Education (highest completed): _____ (High School, AA, BS/A, MS/A/eD/M Div, Ph.D./MD)

Live in(check one):_____Urban Area_____Rural Area_____Very Rural/frontier/bush area

Primary language at work: _____Language of Choice: _____

Ethnic Origin/Race (check one):

____ Black/African American
____ Caucasian/White
____ Hispanic
____ Asian
____ American Indian
____ Pacific Islander
____ Other (specify) _____

Appendix C

Original Test:

Stamm, B. H. (in press). Measuring Compassion Satisfaction as Well as Fatigue: Developmental History of the Compassion Fatigue and Satisfaction Test. In C.R. Figley (Ed.). Treating Compassion Fatigue. New York:
Brunner/Mazel. © B. Hudnall Stamm, Traumatic Stress Research Group, 1995 -1999
http://www.isu.edu/~bhstamm/rural-care.htm.

Compassion Fatigue and Satisfaction Self-Test for Helpers

(this is a printable copy for off-line use)

Helping others puts you in direct contact with other people's lives. As you probably have experienced, your compassion for those you help has both positive and negative aspects. This self-test helps you estimate your
compassion status: How much at risk you are of burnout and compassion fatigue and also the degree of satisfaction with your helping others. Consider each of the following characteristics about you and your current
situation. Print a copy of this test so that you can fill out the numbers and keep them for your use. Using a pen or pencil, write in the number that honestly reflects how frequently you experienced these characteristics in
the last week. Then follow the scoring directions at the end of the self-test.

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

Items About You

_____1. I am happy.
_____2. I find my life satisfying.
_____3. I have beliefs that sustain me.
_____4. I feel estranged from others.
_____5. I find that I learn new things from those I care for.
_____6. I force myself to avoid certain thoughts or feelings that remind me of a frightening experience.
_____7. I find myself avoiding certain activities or situations because they remind me of a frightening experience.
_____8. I have gaps in my memory about frightening events.
_____9. I feel connected to others.
_____10. I feel calm.
_____11. I believe that I have a good balance between my work and my free time.
_____12. I have difficulty falling or staying asleep.
_____13. I have outburst of anger or irritability with little provocation
_____14. I am the person I always wanted to be.

_____15. I startle easily.
_____16. While working with a victim, I thought about violence against the perpetrator.
_____17. I am a sensitive person.
_____18. I have flashbacks connected to those I help.
_____19. I have good peer support when I need to work through a highly stressful experience.
_____20. I have had first-hand experience with traumatic events in my adult life.
_____21. I have had first-hand experience with traumatic events in my childhood.
_____22. I think that I need to "work through" a traumatic experience in my life.
_____23. I think that I need more close friends.
_____24. I think that there is no one to talk with about highly stressful experiences.
_____25. I have concluded that I work too hard for my own good.
_____26. Working with those I help brings me a great deal of satisfaction.
_____27. I feel invigorated after working with those I help.
_____28. I am frightened of things a person I helped has said or done to me.
_____29. I experience troubling dreams similar to those I help.
_____30. I have happy thoughts about those I help and how I could help them.
_____31. I have experienced intrusive thoughts of times with especially difficult people I helped.
_____32. I have suddenly and involuntarily recalled a frightening experience while working with a person I helped.
_____33. I am pre-occupied with more than one person I help.
_____34. I am losing sleep over a person I help's traumatic experiences.
_____35. I have joyful feelings about how I can help the victims I work with.
_____36. I think that I might have been "infected" by the traumatic stress of those I help.
_____37. I think that I might be positively "inoculated" by the traumatic stress of those I help.
_____38. I remind myself to be less concerned about the well being of those I help.
_____39. I have felt trapped by my work as a helper.
_____40. I have a sense of hopelessness associated with working with those I help.
_____41. I have felt "on edge" about various things and I attribute this to working with certain people I help.
_____42. I wish that I could avoid working with some people I help.
_____43. Some people I help are particularly enjoyable to work with.
_____44. I have been in danger working with people I help.
_____45. I feel that some people I help dislike me personally.

Items About Being a Helper and Your Helping Environment

_____46. I like my work as a helper.
_____47. I feel like I have the tools and resources that I need to do my work as a helper.
_____48. I have felt weak, tired, run down as a result of my work as helper.
_____49. I have felt depressed as a result of my work as a helper.
_____50. I have thoughts that I am a "success" as a helper.
_____51. I am unsuccessful at separating helping from personal life.
_____52. I enjoy my co-workers.
_____53. I depend on my co-workers to help me when I need it.
_____54. My co-workers can depend on me for help when they need it.
_____55. I trust my co-workers.
_____56. I feel little compassion toward most of my co-workers
_____57. I am pleased with how I am able to keep up with helping technology.
_____58. I feel I am working more for the money/prestige than for personal fulfillment.
_____59. Although I have to do paperwork that I don't like, I still have time to work with those I help.
_____60. I find it difficult separating my personal life from my helper life.
_____61. I am pleased with how I am able to keep up with helping techniques and protocols.
_____62. I have a sense of worthlessness/disillusionment/resentment associated with my role as a helper.
_____63. I have thoughts that I am a "failure" as a helper.
_____64. I have thoughts that I am not succeeding at achieving my life goals.
_____65. I have to deal with bureaucratic, unimportant tasks in my work as a helper.
_____66. I plan to be a helper for a long time.

Scoring Instructions

Please note that research is ongoing on this scale and the following scores should be used as a guide, not confirmatory information. Cut points are theoretically derived and should be used with caution and only for
educational purposes.

1. Be certain you respond to all items.
2. Mark the items for scoring:

a. Circle the following 23 items: 4, 6-8, 12, 13, 15, 16, 18, 20-22, 28, 29, 31-34, 36, 38-40, 44.

b. Put a check by the following 16 items: 17, 23-25, 41, 42, 45, 48, 49, 51, 56, 58, 60, 62-65.

c. Put an x by the following 26 items: 1-3, 5, 9-11, 14, 19, 26-27, 30, 35, 37, 43, 46-47, 50, 52-55, 57, 59, 61, 66.

3. Add the numbers you wrote next to the items for each set of items and note:

a. Your potential for Compassion Satisfaction (x): 118 and above=extremely high potential; 100-117=high potential; 82-99=good potential; 64-81=modest potential; below 63=low potential.

b. Your risk for Burnout (check): 36 or less=extremely low risk; 37-50=moderate risk; 51-75=high risk; 76-85=extremely high risk.

c. Your risk for Compassion Fatigue (circle): 26 or less=extremely low risk, 27-30=low risk; 31-35=moderate risk; 36-40=high risk; 41 or more=extremely high risk.

Appendix D

Modified Test

Stamm, B. H. (in press). Measuring Compassion Satisfaction as Well as Fatigue: Developmental History of the Compassion Fatigue and Satisfaction Test. In C.R. Figley (Ed.). Treating Compassion Fatigue. New York: Brunner/Mazel. © B. Hudnall Stamm, Traumatic Stress Research Group, 1995 -1999 http://www.isu.edu/~bhstamm/rural-care.htm.

Compassion Fatigue & Satisfaction Self-Test for Helpers

Helping others puts you in direct contact with other people's lives. As you probably have experienced, your compassion for those you help has both positive and negative aspects. This test helps estimate your compassion status: How much at risk you are of burnout and compassion fatigue and also the degree of satisfaction with your helping others. Consider each of the following characteristics about you and your current situation. Using a pen or pencil, write in the number that honestly reflects how frequently you experienced these characteristics in the last week.

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

Items About You

_____1. I am happy.
_____2. I find my life satisfying.
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_____4. I feel estranged from others.
_____5. I find that I learn new things from those I care for.
_____6. I force myself to avoid certain thoughts or feelings that remind me of a frightening experience.
_____7. I find myself avoiding certain activities or situations because they remind me of a frightening experience.
_____8. I have gaps in my memory about frightening events.
_____9. I feel connected to others.
_____10. I feel calm.
_____11. I believe that I have a good balance between my work and my free time.
_____12. I have difficulty falling or staying asleep.
_____13. I have outburst of anger or irritability with little provocation
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_____19. I have good peer support when I need to work through a highly stressful

experience.

_____20. I have had first-hand experience with traumatic events in my adult life.
_____21. I have had first-hand experience with traumatic events in my childhood.
_____22. I think that I need to "work through" a traumatic experience in my life.
_____23. I think that I need more close friends.
_____24. I think that there is no one to talk with about highly stressful experiences.
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_____62. I have a sense of worthlessness/disillusionment/resentment associated with my role as a helper.
_____63. I have thoughts that I am a "failure" as a helper.
_____64. I have thoughts that I am not succeeding at achieving my life goals.
_____65. I have to deal with bureaucratic, unimportant tasks in my work as a helper.
_____66. I plan to be a helper for a long time.

You are finished with your test. Thank you for your participation. Please do not separate these documents. Place them in the envelope provided and turn them into the test moderator. Please do not discuss the items on this test with anyone until the study data testing is completed for the entire department. Thank you.

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