

**COMPASSION FATIGUE, LEVEL OF EXPOSURE,
EMPATHY AND AFFECT INTENSITY AMONGST
EMPLOYEE ASSISTANCE PROGRAMME
COUNSELLORS**

BY

Eshmin Harinarain

A dissertation submitted to the Faculty of Arts, University of the Witwatersrand,
Johannesburg, in partial fulfillment of the requirements for the degree of Master of Arts
(Community and Counselling Psychology).

January 2007

ABSTRACT

High levels of trauma within the South African society affect the majority of the population either directly or indirectly. In order to assist individuals overcome such traumatic incidents, many companies in South Africa have contracted with Employee Assistance Programme (EAP) Providers to provide counselling to employees. These EAP counsellors are often the first mental health professionals to be exposed to a client's traumatic story. Consequently, such counsellors may be vulnerable to compassion fatigue (CF). The consequences of EAP counsellors working with traumatised clients have been relatively unexplored. Therefore, this study proposed that EAP trauma counsellors are vulnerable within their scope of work and are an important group of professionals to be further investigated. Furthermore, leading authors in the field of trauma argue that both individual characteristics and environmental factors play a role in the development of CF. However, research into the process by which CF develops is extremely limited. Hence, this study attempted to explore this process through identifying possible core variables such as level of exposure, empathy and affect intensity and exploring their link to CF. The study was based on Figley's (1995) Trauma Transmission Model, Dutton and Rubinstein's (1995) Ecological Model and McRitchie's (2006) Refined Model for Trauma Workers. The data was collected from 60 EAP counsellors, through self report measures. Data was analysed using descriptive statistics, correlations, a stepwise regression, two independent sample t-tests, and analysis of variance. Results revealed that 28.34% of the sample fell within the range for CF. There were significant correlations between Level of Exposure to traumatic material and CF; between levels of empathy and CF and between Affect Intensity and Empathy. There was no significant correlation between Affect Intensity and CF. Furthermore, the stepwise regression indicated that 56% of CF may be explained by a combination of four interacting variables, that is, Level of Exposure, Fantasy, Personal Distress and Perspective Taking.

DECLARATION

I declare that this dissertation is my own unaided work. It is submitted for the degree of Master of Arts (Community and Counselling Psychology) at the University of the Witwatersrand, Johannesburg. It has not been submitted before for any other degree or examination in any other university.

Eshmin Harinarain

----- day of ----- 2007

ACKNOWLEDGEMENTS

I would like to extend my sincere gratitude to the following individuals:

My supervisor, Stacey Leibowitz, for her great supervision, encouragement and for her faith in me. She provided a beacon of light and hope when everything else fell apart. I am forever indebted.

Management at the EAP organisation who graciously allowed me to conduct my study on the premises.

The counsellors at the EAP organisation, who so willingly participated in the study.

Mike Greyling for his statistical expertise.

Magda Hamman, a friend and colleague, who assisted me with the editing.

My family, who had to bear with my complaints all these years.

My friends and colleagues who encouraged and supported me to complete this dissertation.

TABLE OF CONTENTS

CHAPTER ONE: INTRODUCTION	1
1.1. Introduction	1
1.2. Concluding Comments	6
CHAPTER TWO: THE FACETS OF COMPASSION FATIGUE	
2.1. The Genesis of Compassion Fatigue	8
2.2. Defining and differentiating Compassion Fatigue	9
2.2.1. Defining Compassion Fatigue	10
2.2.2. Post-traumatic stress symptomatology	11
2.3. Conceptualisations of Compassion Fatigue	13
2.3.1. Compassion Stress	13
2.3.1.1. Differences between Compassion Stress and Compassion Fatigue	13
2.3.2. Burnout	14
2.3.2.1. Differences between Burnout and Compassion Fatigue	16
2.3.3. Vicarious Traumatization	16
2.3.3.1. Differences between Vicarious Traumatization and Compassion Fatigue	17
2.4. Reasons for Trauma Counsellors' Vulnerability to Compassion Fatigue	18
2.5. General Research Findings	19
2.6. Concluding Comments	21
CHAPTER THREE: A THEORETICAL FRAMEWORK FOR COMPASSION FATIGUE	23
3.1. Introduction	23
3.2. Theoretical Models of Compassion Fatigue	23

3.2.1. Trauma Transmission Model	23
3.2.2. An Ecological Framework of Trauma	27
3.3. A Revised Model for Trauma Counsellors	30
3.4. Concluding Comments	33

CHAPTER FOUR: COMPASSION FATIGUE, LEVELS OF EXPOSURE, 34 EMPATHY AND AFFECT INTENSITY

4.1. Introduction	34
4.2. Level of Exposure	34
4.3. Empathy	37
4.4. Affect Intensity	40
4.5. Concluding Comments	44

CHAPTER FIVE: METHODOLOGY 45

5.1. Introduction	45
5.2. Aims of the study	46
5.3. Research Design	46
5.4. Research Questions	47
5.5. Research Hypotheses	47
5.6. Sample	48
5.7. Measurement Instruments	48
5.7.1. Demographic Questionnaire	49
5.7.2. Compassion Fatigue Self-Test	49
5.7.3. The Interpersonal Reactivity Index (IRI)	51
5.7.4. Level of Exposure Checklist	52
5.7.5. The Affect Intensity Measure (AIM)	54
5.8. Research Procedure	54
5.9. Statistical Analysis	55
5.9.1. Internal Reliability: Cronbach's Alpha	55

5.9.2. Descriptive Statistics	56
5.9.3. Correlations	56
5.9.4. Stepwise Regression	56
5.9.5. Two Independent Sample T-Tests	56
5.9.6. Analysis of Variance (ANOVA)	56
5.10. Ethical Considerations	57
5.11. Concluding Comments	58
 CHAPTER SIX: RESULTS	 59
6.1. Introduction	59
6.2. Reliabilities of the Measuring Instruments	59
6.2.1. Compassion Fatigue Self-Test	59
6.2.2. The Interpersonal Reactivity Index	60
6.2.3. The Level of Exposure Checklist	60
6.2.4. The Affect Intensity Measure	61
6.3. Descriptive Statistics	61
6.3.1. The Sample	61
6.3.2. Means, Standard Deviations and Minimum and Maximum Scores for the measures used	66
6.4. Scoring of the Scales	67
6.4.1. Levels of Compassion Fatigue	67
6.4.2. Levels of Empathy	67
6.4.3. Levels of Exposure to traumatic material and the intensity of impact	68
6.4.4. Levels of Affect Intensity	70
6.5. Statistical Analyses relating to Hypotheses	71
6.5.1. Hypothesis One	71
6.5.2. Hypothesis Two	72
6.5.3. Hypothesis Three	73
6.5.4. Hypothesis Four	74
6.6. Additional Results	76

6.6.1. T-Tests	76
6.6.2. ANOVAs	79
6.7. Concluding Comments	82
 CHAPTER SEVEN: DISCUSSION	 83
7.1. Introduction	83
7.2. Reliabilities of the Measuring Instruments	83
7.3.Descriptive Statistics	84
7.3.1. The Sample	84
7.3.2. Levels of Compassion Fatigue	85
7.3.3. Levels of Empathy	86
7.3.4. Levels of Exposure to traumatic material and the intensity of impact	86
7.3.5. Levels of Affect Intensity	87
7.4. Statistical Analyses Relating to Hypotheses	88
7.4.1. Hypothesis One	88
7.4.2. Hypothesis Two	89
7.4.3. Hypothesis Three	91
7.4.4. Additional Correlation	92
7.4.5. Hypothesis Four	93
7.5. Discussion of Additional Results	95
7.6. Limitations of the Study	96
7.6.1. Research Design	96
7.6.2. Sample	96
7.6.3. Data Collection	97
7.6.4. Measuring Instruments	98
7.6.5. Data Analysis	99
7.6.6. The Revised Model for Trauma Counsellors	99
7.7. Recommendations for Future Research	100
7.8. Conclusion	101

APPENDICES

- Appendix A: Subject Information Sheet
- Appendix B: Demographic Questionnaire
- Appendix C: Compassion Fatigue Self-Test
- Appendix D: The Interpersonal Reactivity Index
- Appendix E: Level of Exposure Checklist

LIST OF FIGURES

Figure 1: A Model of Compassion Stress (Figley, 1995)	24
Figure 2: A Model of Compassion Fatigue (Figley, 1995)	26
Figure 3: An Ecological Model of Compassion Fatigue (Dutton & Rubinstein, 1995)	29
Figure 4: The Revised Model for Trauma Counsellors	31

LIST OF TABLES

Table	Page
1.1. Cronbach alpha coefficient for Compassion Fatigue	59
1.2. Cronbach alpha coefficient for the Interpersonal Reactivity Index	60
1.3. Cronbach alpha coefficient for the Level of Exposure Checklist	60
1.4. Cronbach alpha coefficient for the Affect Intensity Measure	61
2.1. Gender of the Sample	61
2.2. Age of the Sample	62
2.3. Length of service at the organization	62
2.4. Work Status	63
2.5. Length of service experience as a counsellor	63
2.6. Exposure to previous personal trauma	63
2.7. Nature of personal trauma experienced by counsellors	64
2.8. The average number of hours of direct contact with traumatised clients	64
2.9. The average number of hours of indirect contact with traumatised clients	65
2.10. The average number of hours a week on general counselling	65
3. Means, Standard Deviations and Minimum and Maximum Scores	66
4.1. Levels of Compassion Fatigue as measured by the CF Scale	67
4.2. Levels of Empathy as measured by the Interpersonal Reactivity Index	68
4.3. Levels of Exposure to traumatic material and the intensity of impact as measured by the Level of Exposure Checklist	69
4.4. Levels of Affect Intensity as measured by the Affect Intensity Measure	70
5.1. Correlation between Exposure as measured by the Level of Exposure checklist and Compassion Fatigue as measured by the CF Self Test	71
5.2. Correlation between Empathy as measured by the Interpersonal Reactivity Index and Compassion Fatigue as measured by the CF Self Test	72
5.3. Correlation between Affect Intensity as measured by the Affect	

Table	Page
Intensity Measure and Compassion Fatigue as measured by the CF Self Test	73
5.4. Correlation between Affect Intensity as measured by the Affect Intensity Measure and Empathy as measured by the Interpersonal Reactivity Index	74
5.5. Empathy Moderating the effects for Compassion Fatigue	75
5.5.1. Strength of the Regression	76
6.1. T-Tests for Gender	76
6.2. T-Tests for Work Status	77
6.3. T-Test for Exposure to Personal Trauma	78
7.1. ANOVA for Age	79
7.2. ANOVA for Length of Service at the Organisation	80
7.3. ANOVA for Experience as a Counsellor	81

CHAPTER ONE: INTRODUCTION

1.1. Introduction:

South Africans have for decades been victims of political, criminal and social violence. Current levels of violence have spurred some scholars into arguing that South African society views violence as an acceptable means to resolve their problems (Hamber & Lewis, 1997). Concomitantly, the high levels of trauma within South African society are experienced through different forms such as rape, robbery, murder, hijackings, domestic violence, child abuse, muggings, assault, motor vehicle accidents, natural disasters and loss of loved ones. Subsequently, the term trauma in its common usage in South Africa has come to depict the daily emotions of the majority of its citizenry (Hamber & Lewis, 1997).

Due to the high incidence of violence, the chances of being exposed to violence are also high. Therefore, the majority of the population are traumatised either directly or indirectly in all sectors of the South African society. It is believed that the current levels of violent crime will affect most, if not all, South Africans in some way or another (Hamber & Lewis, 1997). This belief is further supported by research conducted in the area (McRitchie, 2004 and Ortlepp & Friedman, 2001). This level of violence necessitates the need for trauma counsellors in all communities.

In order to assist individuals overcome such traumatic incidents, many companies in South Africa have contracted with Employee Assistance Programme (EAP) Providers to provide counselling to employees. An EAP is a worksite-focused programme to assist in the identification and resolution of employee concerns, which affect or may affect performance. EAP programmes provide a broad range of services to employees to improve their health and well-being. Professional counsellors of the EAP are often the first mental health professionals to be exposed to a client's traumatic story through initial assessment and short term counselling. These

counsellors' case loads differ from the usual trauma counsellor population as they are exposed to a variety of presenting problems and not only to trauma counselling. Once the initial assessment and telephone counselling is over, the clients are referred to psychologists for face to face counselling. Therefore, these EAP counsellors are the first mental health professionals to hear the experiences of different clients and there is no follow up by these telephone counsellors. Consequently, such professional counsellors may be vulnerable to compassion fatigue and the current study proposes to make this population the focus of the study.

Individuals become trauma counsellors as such work may prove to be enriching and rewarding (McCann & Pearlman, 1995; Meyer & Ponton, 2006). It may lead to positive effects such as an enhanced sense of meaning, respect for the strength of others, a deeper sense of connection with humanity and increases feelings of self esteem from helping victims regain a sense of wholeness and meaning in their lives (Cerney, 1995 & Dietrich, 2003).

However, counselling trauma victims is also argued to be a risky endeavour for the counsellor (Meyer & Ponton, 2006). While counselling invites trauma workers to participate with their clients in their process of growth and healing, it may also threaten their well being through exposure to their client's trauma and its painful consequences. Research is beginning to show that for some individuals, working with trauma survivors may have physical, emotional and cognitive negative effects (Stamm, 1997). These individuals begin to display signs of stress disorders ranging from sleeping difficulties to intrusive thoughts, avoidance and heightened reactivity.

Trippany, Kress and Wilcoxon (2004) postulate that such traumatisation can alter the counsellors basic psychological needs, such as those of safety, trust in self and others, esteem for self and others, intimacy and control. Such drastic changes in one's view of the world are related to the counsellor's existential and spiritual beliefs and traumatisation can have devastating effects upon the foundation of one's life. They

indicated that “without a sense of meaning, counsellors may become cynical, nihilistic, withdrawn, emotionally numb, hopeless and outraged” (Trippany, Kress & Wilcoxon, 2004, p.35).

The majority of trauma literature has focused on the primary victim’s experience of the traumatic incident with there being minimal research in relation to the secondary victims. Figley (1999) posits that individuals can be traumatised without actually being physically harmed or threatened with harm. This belief is also consistent with the Diagnostic and Statistical Manual of Mental Disorders IV-TR (2000). Learning about a traumatic event carries traumatic potential and he believed that the indirect victims are the family members, friends, neighbours, lawyers and counsellors. It is argued that the stories of human suffering may cause psychological symptoms in these individuals (Steed & Bicknell, 2001). Figley (1995) acknowledged the minimal attention that trauma workers have received in literature. He espoused that counsellors are vulnerable to experiencing stress and yet very few studies can identify the active ingredients that are connected to their job related stress. The lack of empirical research concerning trauma counsellors identifies a gap in the trauma literature and provides reason for the current research. Therefore, this study proposes that trauma counsellors are vulnerable within their scope of work and are an important group of health mental professionals to be further investigated.

Furthermore, it is argued that trauma counsellors are at great risk of developing negative effects due to: the relatively high levels of crime in South Africa create the possibility of survivors being re-traumatised and generating the need for trauma counselling; trauma counsellors may be at risk of being directly exposed to non-work related trauma and the trauma counsellor may feel helpless in protecting their clients and keeping them safe (McRitchie, 2006). All these factors are believed to impinge on the trauma counsellors’ state of mind and impact on their reactions to their work load (Wilson, 1998).

Currently, the research literature describes the adverse impact of working with clients who have a history of trauma under a variety of terms, namely, vicarious traumatisation (VT), counter transference (CT), secondary traumatic stress (STS) and compassion fatigue (CF) (Stamm, 1997; Boscarino, 2004). Jenkins and Baird (2002) postulate that research on compassion fatigue has suffered from conceptual limitations as the terms have remained vague. For the present study, the term compassion fatigue which is consistent with the most current usage will be used. Compassion fatigue has been identified as an ‘occupational hazard’ and has been associated with adverse psychological outcomes for the counsellors as well as for the clients (Figley, 1995). Counsellors who display symptoms of compassion fatigue would not be in a position of offering the best quality of service to their clients, hence preventing their clients from reaching optimal levels of recovery as quickly as possible. However, a paucity of data prevents conclusive findings about the impact of these traumatic incidences in EAP counsellors (Jacobson, 2005) and provides motivation for this study.

Leading authors in the field of trauma argue that both individual characteristics and environmental factors play a role in the development of compassion fatigue (Adams, Boscarino & Figley, 2004). Although several models exist mapping this interplay, research into the process by which compassion fatigue develops is extremely limited (McRitchie, 2006). Hence, this study attempts to explore this process through identifying possible core variables such as level of exposure, empathy and affect intensity and exploring their link to compassion fatigue.

A key variable in the development of compassion fatigue is believed to be the counsellor’s level of exposure to traumatic material (Dutton & Rubinstein, 1995). The level of exposure would include previous trauma history, the nature of the traumatic incident (i.e. the type of trauma and the severity of the traumatic experience) and the frequency of exposure to traumatic material (Adams, Boscarino

& Figley, 2004). A review of fifteen studies which investigated the impact of working with clients who had experienced trauma concluded that individuals who provide services that result in them being exposed to the traumatic experiences of their clients are at risk of developing symptoms ranging from sub-clinical psychological distress to traumatic stress symptoms (Bride, 2004). The severity of symptoms in the affected individuals appeared to be related to the intensity of exposure rather than to the length of exposure (Bride, 2004). Previous studies have provided limited research to assess the relationship between level of exposure to traumatic material and compassion fatigue and the counsellor's subjective perception of the intensity of the traumatic material (Jenkins & Baird, 2002). This presents a further area for investigation.

Figley (1995) believes that empathy is a key personality characteristic for effective counselling, but it also plays a vital role in the development of compassion fatigue. He asserted that empathy is a paradox. Figley (1995) stated that it is required by counsellors to provide care and support to clients, but by having an emotional connection to someone increases the counsellor's vulnerabilities to symptoms of compassion fatigue. There are minimal empirical studies on the relationship between compassion fatigue and empathy. The current study will explore the role that empathy plays in the development of compassion fatigue to address some of the gaps in the literature.

Counsellors who work with individuals who are in psychological pain are subject to emotional stress, but this emotional stress may be experienced differentially by these helpers. If affect intensity is regarded as an individual personality attribute, it would be important to investigate whether counsellors who tend to experience emotional events more intensely experience more stress than those counsellors who experience emotional events less intensely. Prior research has focused on the situational and environmental sources of stress, but little attention has been focused on analyzing individual differences such as affect intensity. Therefore, affect intensity and its

relationship to compassion fatigue will be addressed in this study in order to advance knowledge in this domain.

1.2. Concluding Comments:

The main purpose of this introductory chapter was to provide an introduction to the current study and to introduce key variables which are important for this research. Below is an outline of chapters in the study.

Chapter Two examines the literature in the field of compassion fatigue. It begins by introducing the genesis of compassion fatigue; defining and differentiating compassion fatigue and expanding on the most commonly used terms in the field of compassion fatigue. This chapter explores the concepts of burnout, vicarious trauma and compassion stress. The major symptoms of Post Traumatic Stress Disorder (PTSD) are explored, as theoretically compassion fatigue is believed to have the same symptomatology as PTSD, except that it manifests through an indirect source. The differences between compassion fatigue and burnout and compassion fatigue and vicarious traumatization are clearly conceptualized, as burnout is often confused with compassion fatigue.

Chapter Three provides a theoretical framework of compassion fatigue. The Trauma Transmission Model and the Ecological Framework of Trauma are described. The researcher proposes a Revised Trauma Model for Trauma Counsellors which is based on McRitchie's (2006) study.

Chapter Four discusses the key predictors of compassion fatigue. Literature suggests that key variables such as level of exposure and empathy influence the development of compassion fatigue and the researcher has also included the concept of affect intensity, as it is known that individuals differ in the intensity with which they

respond to emotional stimuli. This chapter elaborates on each of these key variables and the relevant studies conducted with regards to these variables.

Chapter Five describes the methodology of the study, which is a discussion on how the research was conducted, the research aims, the research design, the research questions, the hypotheses, the sample, the procedure, the ethical considerations and the statistical analyses that were carried out.

Chapter Six examines the results of the various statistical analyses which were performed on the data.

Chapter Seven synthesizes the research findings, provides a discussion of the limitations of the study and implications for future research are suggested.

CHAPTER 2: THE FACETS OF COMPASSION FATIGUE

2.1. The Genesis of Compassion Fatigue:

According to Gentry (2005), the notion that working with people in pain extracts a significant cost from the human service professionals is not new. However, it has only been in recent years that there has been a substantial effort to examine the effects on the human service professional of bearing witness to the indescribable wounds inflicted by traumatic experiences.

Literature on psychological trauma has emerged from the investigation of the long term effects of war, torture, rape natural disasters, accidents and death of loved ones. There has been an enormous amount of attention on Vietnam Veterans and the most effective treatment for the psychological scars inflicted upon them by the war. Therefore, research focused on post-traumatic stress disorder (PTSD) experienced by those individuals directly affected by traumatic incidences.

However, Figley (1999) asserts that individuals can be traumatised without actually being physically harmed or threatened with harm. He postulated that merely knowing about a traumatic event carries traumatic potential. It is not a first hand traumatisation, but one could call it a second hand traumatisation. Figley (1996) maintained that the difference between post-traumatic stress disorder and secondary traumatisation is that secondary traumatisation can be more directly connected to adjustment and recovery of the traumatised individual, that is, as the sufferer improves, then the individual experiencing the secondary traumatisation also improves. Just as post-traumatic stress disorder can be regarded as a normal reaction to an abnormal event, so too can secondary traumatisation be viewed as a normal reaction to exposure to the traumatic material of clients (Dietrich, 2003).

2.2. Defining and differentiating compassion fatigue

Researchers agree that working with clients who have been traumatised has certain long-term and often negative effects on counsellors (Edelwich & Brodsky, 1980). However, the researchers examining this issue do not all agree on what to call this phenomenon or how to define it. Many use the terms "secondary traumatisation", "vicarious trauma", "compassion stress" and "burnout" interchangeably to mean the effects on a counsellor of any work with traumatised clients (Hesse, 2002). Most of the constructs and concepts are neither clearly differentiated nor operationalised.

Figley (1995) defines secondary traumatisation as the natural consequent behaviours and emotions which result from knowing about a traumatising event experienced by a significant other and the stress resulting from helping or wanting to help the traumatised or suffering person. In 1999, Figley referred to the Diagnostic and Statistical Manual of Mental Disorders (DSM-III), Third Edition, (1980) which included the diagnosis of post-traumatic stress disorder (PTSD). The DSM-III viewed common symptoms experienced by a wide variety of traumatised individuals as a psychiatric disorder. PTSD, therefore at that point in time, represented the latest in a series of terms that described the harmful biopsychosocial effects of emotionally traumatic events. However, through a subsequent revision of the DSM - III, the concept of professionals working with traumatised individuals developing PTSD reactions grew and the diagnosis has been widely applied in mental health research.

Figley (1999) argues that these subsequent writings lacked clarity as the authors rarely considered the contextual and circumstantial factors in the traumatising experience. The reports exclude those individuals who were traumatised indirectly or secondarily and focus on those individuals who were directly traumatised. He further asserts that the descriptions of what constitutes a traumatic event in the DSM-III and the DSM-III-R clearly indicate that the mere knowledge of another's traumatic experience can be traumatising. According to the latest revision of the DSM, which is the DSM - IV-TR (2000), an essential feature of PTSD is learning about

unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or close associate. The likelihood of developing this disorder may increase as the intensity of, and physical proximity to the stressor increase (DSM-1V-TR, 2000).

Figley's (1999) stipulation that individuals can be traumatised without actually being physically harmed, but learning about the traumatic experience carries traumatic probability is therefore presently recorded and acknowledged in the DSM-1V-TR.

Figley, in 1995, renamed secondary traumatic stress disorder to compassion fatigue, indicating it is a natural occupational hazard for trauma workers and mental health professionals. He explained that this term is preferable as it is less stigmatising (Jenkins & Baird, 2002) and feeling the stress and fatigue of compassion in the line of duty better describes the causes and signs of their duty related experiences. Figley (1995) considered compassion fatigue to be identical to secondary traumatic stress disorder and to be an equivalent of post traumatic stress disorder. Over the years, there have been a few concepts which have been used interchangeably with compassion fatigue. For the purposes of this study, these concepts will be further explored.

2.2.1. Defining compassion fatigue

Compassion fatigue in its simplest form has been described as the stress, strain and weariness of caring for others who are suffering from a medical or psychological problem (Thomas & Wilson, 2004).

Figley (1995) defines compassion fatigue as “the natural consequent behaviours and emotions resulting from knowing about a traumatising event experienced by a significant other - the stress resulting from helping or wanting to help a traumatised or suffering person” (p.7). He further describes compassion fatigue as “a syndrome

of symptoms nearly identical to PTSD”, except that exposure to knowledge about a traumatising event experienced by a significant other is associated with the set of secondary traumatic stress disorder (STSD) symptoms and is directly connected to the sufferer, the person experiencing primary traumatic stress (Figley, 1995, p.8). Essentially, the only difference between a person experiencing STSD and an individual experiencing PTSD is that the former is experiencing the symptoms as a result of working with the traumatised person, rather than experiencing the traumatic event personally. Therefore, the symptoms of PTSD will be further explored as these symptoms will also manifest as compassion fatigue.

2.2.2. Post - traumatic stress symptomatology

PTSD is described by a constellation of symptoms that can arise when a person is exposed to a traumatic stressor. These symptoms can be grouped into three categories: intrusions, avoidance and hyper arousal (DSM-1V-TR, 2000).

Intrusions involve the re-experiencing of the traumatic event through different ways, including images, thoughts or perceptions. There may be reoccurring dreams of the incident, hallucinations, illusions, flashbacks; and/or psychological distress to the exposure of an internal or external reminder that represent the traumatic event and physiological reactivity on exposure to internal and external cues that symbolize or resemble an aspect of the traumatic event.

There is avoidance of stimuli associated with the trauma and numbing of general responsiveness as indicated by at least three of the following:

- efforts to avoid thoughts, conversations or feelings associated with the trauma
- efforts to avoid activities, places or persons that remind the individual of the trauma
- inability to remember an important aspect of the trauma

- diminished interest or participation in significant activities
- feeling of detachment or estrangement from others
- restricted range of affect
- sense of a foreshortened future

There are persistent symptoms of increased arousal as indicated by at least two of the following:

- difficulty falling or staying asleep
- irritability or outbursts of anger
- difficulty concentrating
- hyper vigilance
- exaggerated startle response

The disturbance has a duration of more than one month and the disturbance causes clinically significant distress or impairment in social, occupational and other important areas of functioning (DSM-1V-TR, 2000).

Further symptoms of PTSD include depression, grief and loss, helplessness, guilt and fear of the traumatic event recurring. These symptoms appear shortly after the trauma, but some victims may be symptom free for weeks before symptoms begin to surface (DSM-1V-TR, 2000).

Hartman and Jackson (1994) interviewed trauma counsellors who were involved in long term therapy with rape victims. They discovered that more than seventy five per cent of this group revealed they were experiencing or had acute symptoms of post traumatic stress. Many of these counsellors reported elevated levels of hyper arousal and sleep disturbances (Hartman & Jackson, 1994).

Literature reflects that Post Traumatic Stress symptoms manifest stronger in individuals who experience a number of traumatic events and that PTSD symptoms are affected by the intensity of the exposure to trauma (Lauterbach & Vrana, 2001). This is an important fact for the current research.

2.3. Conceptualisations of compassion fatigue:

In order to understand how traumatic work affects trauma counsellors, it is important to understand the most commonly used terms such as compassion stress, burnout and vicarious traumatisation and to compare these concepts to compassion fatigue.

2.3.1. Compassion stress

Figley (1995) coined the term compassion stress as a non-clinical, non-pathological way to characterise the stress of helping or wanting to help a trauma survivor. Compassion stress is described as the natural behaviours and emotions that arise from knowing about a traumatising incident experienced by a significant other, that is, a client, friend or family member. The onset can be sudden and the symptoms include helplessness, confusion and isolation from supporters (Figley, 1995).

2.3.1.1. Differences between Compassion stress and Compassion fatigue

It is important to understand the clear distinction between compassion fatigue and compassion stress as declared by Figley (1995). Compassion stress is the less pathological variant of response to indirect exposure to traumatic material (Figley, 1995) whereas compassion fatigue is a state of exhaustion and dysfunction – biologically, psychologically and socially – as a consequence of prolonged exposure to compassion stress. In order to appreciate this view of compassion stress; it can be argued that EAP counsellors are definitely at risk of developing compassion stress.

2.3.2. Burnout (BO)

Pines and Aronson (1989) proposed that BO is “characterised by physical depletion, by the feeling of helplessness and hopelessness, by emotional drain, and by the development of negative self – concept and negative attitudes towards work, life and other people” caused by intense involvement in emotionally demanding situations (Pines and Aronson, 1989, p.5).

Freudenberger (1974) coined the term burnout in the mid 1970s to describe the individual condition of physical and emotional exhaustion resulting from excessive demands on energy, strength and resources.

Eldwich and Brodsky (1980) referred to burnout as the progressive loss of idealism, energy and purpose experienced by helping professionals due to conditions of their work. Maslach (1978) agreed with this suggestion that the nature of the job and not the nature of the person performing the job may precipitate burnout. Maslach (1978) preferred to focus on the stressful context rather than on the stress prone person.

Although it may be true that certain work environments may be more stressful than others, Elkins and Kearny (1992) have proposed that individuals differ in their cognitive appraisal of apparently similar stressful situations. Therefore, suggesting that the individuals’ experience of the event may carry specific meaning for that individual only. This may explain why the environment may cause burnout in some individuals and not others.

Maslach and Jackson (1981) identified three components of the burnout syndrome: emotional exhaustion, depersonalization and a reduced sense of accomplishment. These authors indicated that emotional exhaustion occurs as a result of emotional overload in interpersonal contact situations. There is an increased demand for high levels of affect which results in lower affectual responses, concern, trust, interest and motivation. Depersonalisation manifests as the psychological distancing of oneself.

This may include unfeeling, callous and indifferent attitudes towards clients. These attitudes may be expressed by treating clients as impersonal objects or by nonchalant and hostile behaviour. In addition, burnout has been associated with a reduced sense of personal accomplishment and discouragement as an employee. There are feelings of incompetence, personal inefficiency and a lack of successful achievement (Maslach & Jackson, 1981).

Burnout is a process that undergoes several stages from onset to a recognized climax. Models of burnout are mainly unidirectional models of progression, comprising three distinguishable phases: the emergence of stress, the emergence of stress – induced experiences, and the emergence of reactions to the stress – induced experiences (Friedman, 2000).

Friedman (1996) suggested that burnout progression consists of two distinct tracks leading from the emergence of stressors to the reactions to stress – induced experiences. The tracks include a cognitive pathway, involving a sense of personal and professional unaccomplishment, and an emotional pathway that evolves into an initial sense of overload, followed by a sense of exhaustion. Human service professionals affected by stress may follow the cognitive or emotional route, or both. In the cognitive track, high expectations for self fulfillment may give way to a sense of personal unaccomplishment, followed by a sense of professional unaccomplishment as a result of which the individual feels a deep sense of inconsequentiality.

In the emotional track, a sense of overload appears first and leads the individual to feel that his or her job is excessively burdensome. Consequently, the individual feels emotionally exhausted and disappointed.

The combined cognitive–emotional tracks may begin with a sense of personal unaccomplishment and overload. A sense of personal unaccomplishment combined with a feeling of overload gives rise to secondary stress – induced experiences such as a deep feeling of inconsequentiality. However, individual differences in personality,

prior experiences and social support may play important roles in deciding which of the tracks will be taken.

2.3.2.1. Differences between Burnout and Compassion Fatigue

Figley (1995) identified four primary differences between burnout and compassion fatigue. One difference is that burnout emerges over time whereas compassion fatigue symptoms may emerge more suddenly. A second difference between these symptoms is that compassion fatigue may result in a greater sense of helplessness, confusion and isolation. Furthermore, compassion fatigue is likely to be disconnected from the real cause whereas an individual experiencing burnout is more likely to be able to identify the cause of the symptoms. A fourth difference is that individuals are likely to recover more quickly from compassion fatigue than from burnout.

2.3.3. Vicarious traumatisation

Pearlman and McCann (1995) define vicarious traumatisation as the cumulative effects on a therapist of engaging in therapeutic relationships with trauma victims. It is a process through which the counsellor's inner experience is negatively changed through empathic engagement with the client's traumatic material. Vicarious traumatisation is construed as being specific to professionals working with trauma survivors. Literature reveals that many of the symptoms experienced by the counsellor parallel those of the client and the counsellors self protective beliefs about safety, control, predictability and attachment are challenged through their engagement with clients.

Pearlman and Saakvitne (1995) identify two factors that contribute to vicarious traumatisation: aspects of the counsellors' work and aspects intrinsic to the individual counsellor. Aspects of the work include the nature of the client base, facts of the traumatic incident, organizational contextual issues and social factors. The counsellor characteristics include personality, personal history and level of professional

development. It is indicated that vicarious traumatising involves an interaction between these multiple influences and therefore the effects are unique to each counsellor (Pearlman and Saakvitne, 1995).

McCann and Pearlman (1990) argue that vicarious traumatising impacts on four major areas of the counsellors functioning, which is, the cognitive schemata, psychological needs, the memory system and frame of reference. They postulate that schemata are cognitive manifestations of psychological needs such as trust, safety, power, esteem, intimacy, independence and frame of reference. These needs are sensitive to disruption by vicarious traumatising and can cause from subtle to acute effects depending on the discrepancy between the client's traumatic memories and the counsellor's existing schemas. Therefore, Dutton (1992) notes that counsellors may develop some of the following beliefs: there is no safe place in the world; the counsellor is helpless to take care of the self or to help others; one's personal freedom is limited; or working with victims sets one apart from others.

McCann and Pearlman (1990) assert that these and other cognitive shifts that result from exposure to traumatic material may also create emotional distress in counsellors, including, anger, guilt, fear, irritability and an inability to contain these intense emotions. Dutton (1992) espouses that the cognitive shifts may impact on the counsellors ability to effectively assist the client.

2.3.3.1. Differences between Vicarious traumatising and Compassion fatigue

Figley (1995) focuses on observable PTSD symptomatology, whereas McCann and Pearlman (1990) emphasize the theoretical underpinning of vicarious traumatising as a process of self-perceived change. Although Figley (1995) appreciates trauma-related cognitive shifts, PTSD symptoms with rapid onset are central. McCann and Pearlman (1990) do acknowledge tangible PTSD symptoms, but they emphasize their content

rather than intensity within the context of profound belief system changes. Compassion fatigue gives less attention to context and etiology. Figley (1995) also asserted that one severe exposure to only one other person's traumatic material can lead to symptoms of compassion fatigue, but McCann and Pearlman (1990) believe that vicarious traumatisation occurs from cumulative exposure to trauma over time. Figley's (1995) understanding of the symptoms is considered in this study.

Theory suggests that trauma counsellors affected by compassion stress are at a higher risk to make poor professional judgments than those professionals who are not affected (Pearlman & Saakvitne, 1995). Examples of such poor professional judgments could include mis-diagnosis of clients, poor treatment planning or abuse of clients. However, personal, professional and organisational support may provide protective factors to mediate some risks for developing compassion stress (Rudolph, Stamm & Stamm, 1997).

2.4. Reasons for Trauma Counsellors' Vulnerability to Compassion Fatigue:

Figley (1995) proposed four reasons as to the reason trauma counsellors are vulnerable to compassion fatigue: empathy, traumatic events experienced at some point in their lives, unresolved trauma and trauma work with children.

Empathy: Empathy is important in assessing the problem and formulating a treatment approach as the perspectives of the clients are considered. However, empathy is the key factor in the induction of traumatic material from the primary to secondary individual.

Trauma History: As trauma counsellors are exposed to a wide variety of traumatic events, it is inevitable that they would work with the traumatised that experienced events that were similar to those experienced by themselves. There is a danger of over-generalising and the counsellor may not listen as carefully as he/she should be listening

to the client. The counsellor may suggest what worked well for him/her, but this may be inappropriate for the client.

Unresolved Trauma: It is possible that the trauma counsellor may be a survivor from a previous traumatic event and may harbour unresolved traumatic conflicts. Their issues may be triggered as a consequence of the traumatic incident of the client.

Children's Trauma: Research indicates that trauma counsellors are especially vulnerable to compassion fatigue when dealing with the pain of traumatised children (Figley, 1999).

Janoff-Bulman (1980) purports that when a client's traumatic experience and post traumatic responses are the focus of counselling, then the counsellor must come face-to-face with the reality of trauma and the existence of terrible and traumatic events in the world. Acknowledgement of this reality interrupts the counsellor's adaptive assumptions of personal invulnerability and of the world as meaningful and comprehensible (Kassam-Adams, 1999), which results in compassion fatigue symptoms.

2.5. General Research Findings

Research conducted by Simon, Pryce, Roff and Klemmack (2005) found that Oncology social workers experienced compassion fatigue and burnout and that these variables were inversely related to compassion satisfaction.

A study carried out by Boscarino, Figley and Adams (2004) investigating the impact of counselling on social workers following the World Trade Disaster, supported the hypothesis that a group of mental health professionals working with traumatised victims were at greater risk for compassion fatigue, controlling for demographic factors, personal trauma history and work environment factors. They suggested that the

important variables in predicting compassion fatigue include degree of exposure, personal history, social support and environmental factors. Hence, this study examines the risk of compassion fatigue taking into account the degree of exposure and previous personal trauma.

A study conducted by Rudolph, Stamm and Stamm (1997) which explored the level of compassion fatigue in mental health workers found that those individuals who had higher qualifications displayed lower risk of experiencing compassion fatigue (Steed & Bicknell, 2001). However, previous research has indicated that working in the field of trauma on a continuous full time basis may make trauma workers more susceptible to developing compassion fatigue (Ortlepp, 1998). Munroe, Shay, Fisher, Makary, Rapperport and Zimmering (1995) also indicated that the development of compassion fatigue is not prevented by the level of experience or qualification of the trauma worker. This would be an interesting aspect for the current research taking into consideration that all the participants are highly qualified individuals.

Wilson (1998) conducted a study which investigated compassion fatigue in trauma counsellors in South Africa and the results of the study revealed that they suffered from compassion fatigue. These counsellors reported feelings of helplessness, powerlessness, and a sense of alienation from others.

Nkosi (2002) assessed the levels of compassion fatigue among a group of trauma unit nurses. Results of the research indicated that nurses occupied an extremely high risk position for developing compassion fatigue. Although this sample group did not constitute trauma counsellors, the results are relevant to the present study as the participants were also exposed to highly traumatic incidents.

Jacobson (2005) conducted research which assessed the prevalence and severity of compassion fatigue among EAP counsellors. This study explored the relationships between individual and work-related characteristics as they predict the EAP counsellor's reactions to working with traumatised individuals. Results indicated that

EAP counsellors on average reported experiencing moderate levels of risk for compassion fatigue. They indicated that significant predictors included whether or not the counsellor's reported a personal trauma history, whether or not the counsellor's reported experiencing work related stress resulting from working with traumatised individuals in the past year and the total number of trauma debriefings offered (Jacobson, 2005).

From the studies cited above, it is apparent that counsellors involved in trauma work may be at risk for compassion fatigue. This may be attributed to factors such as degree of exposure, personal history, and work environment factors. There has been no known research regarding trauma workers within any EAP organisation in South Africa. Due to the large number of counsellors working in such organisations, there is a need for research in this area. The research examples exemplify reasons for this particular study, that is, trauma counsellors are a vulnerable group of professionals, are at risk for compassion fatigue and that certain factors seem to contribute to the development of compassion fatigue. Hence this group of professionals is an important population for further study and requires attention.

2.6. Concluding Comments:

This chapter provided an overview of the genesis of compassion fatigue indicating that the effects of trauma has emerged from the investigation of the long term effects of war, torture, rape, natural disasters, accidents and death of loved ones; and research had largely focused on post-traumatic stress disorder. However, Figley (1999) asserted that individuals can be traumatised indirectly without actually being physically harmed. This chapter went on to further explore the different conceptualisations of compassion fatigue, defined compassion fatigue and viewed the symptomatology to be similar to PTSD, compared compassion fatigue to burnout, and provided a theoretical explanation of compassion fatigue. This chapter also provided general research findings related to

compassion fatigue. What becomes apparent is that although there has been research on compassion fatigue, there have been limited studies on trauma counsellors who work in EAP organisations.

A number of theories attempt to explain why some trauma counsellors develop compassion fatigue while others do not. Some theories point to the notion that empathy, exposure and external factors may play a role in the development of compassion fatigue (Wilson, 1998). In order to accurately illustrate the nature of compassion fatigue within which findings from research studies can be understood, a theoretical framework is required. Therefore, the following chapter will endeavour to provide a theoretical framework for understanding this phenomenon of compassion fatigue.

CHAPTER 3: A Theoretical Framework for Compassion Fatigue:

3.1. Introduction:

Compassion fatigue is regarded as a compilation of symptoms similar to PTSD except that exposure to a traumatic material experienced by one person becomes a traumatising event for the second person (Figley, 1995). Only a few authors have attempted to describe this transmission of trauma from one individual to another (Ortlepp, 1998). Therefore, a theoretical model is required to describe the nature of compassion fatigue. Furthermore, there is a paucity of research into factors which are hypothesised to have an influence in the impact of trauma work, such as exposure, empathy and affect intensity.

3.2. Theoretical Models of Compassion Fatigue:

There have been a few theoretical models proposed to explain the nature of compassion fatigue such as Beaton and Murphy's (1995) theoretical systems model of secondary traumatic stress and Friedman's (1996) twin peaks model (Beaton & Murphy, 1995; Dutton & Rubinstein, 1995). Figley (1995) and Dutton and Rubinstein (1995) also introduced the Trauma Transmission Model and the Ecological Framework of Trauma, respectively. These models will be used for the purposes of this study due to their relevance and applicability to trauma counsellors.

3.2.1. Trauma Transmission Model:

Figley (1995) developed a trauma transmission model consisting of two components (model of compassion stress and model of compassion fatigue) which attempts to explain the process of trauma transmission and provides a plausible reason for some individuals developing compassion fatigue while others do not. This model asserts that counsellors' attempt to understand the trauma victim's experiences by identifying

with the victim and in this process the counsellor also experiences similar difficulties as the victim, example, hyper vigilance (Figley, 1995). The model is represented in the following diagram:

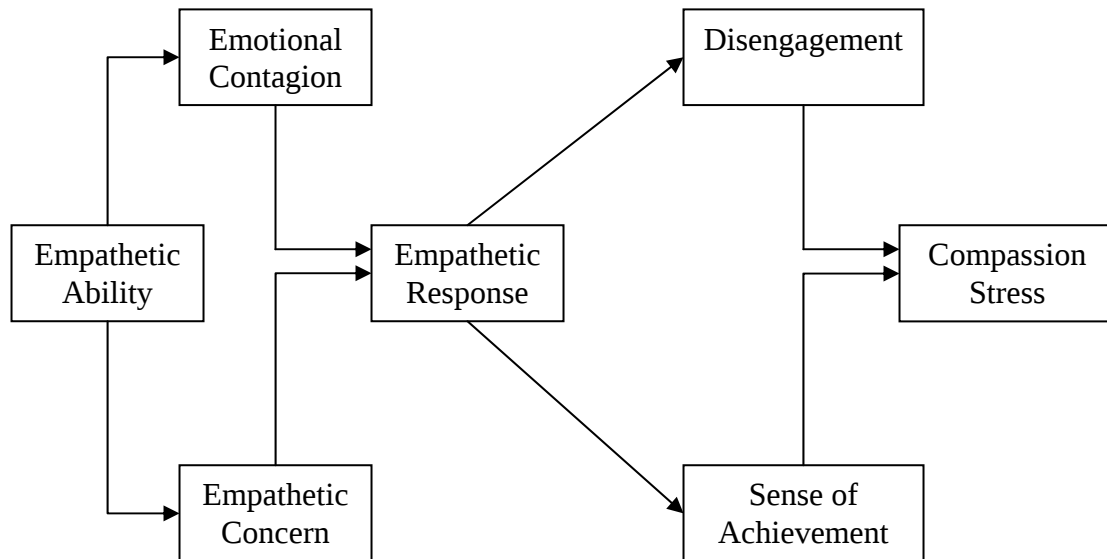


Figure 1: A Model of Compassion Stress (Figley, 1995)

The first component of the model describes the onset of compassion stress as the function of six interacting variables. The key aspect of this model is empathy and Figley (1995) divides empathy into three types: empathetic ability, empathetic concern and empathetic response. Empathetic ability relates to the counsellors' ability to recognise the pain of others, to convey unconditional positive regard and genuineness. Hence, the concept of empathetic ability is linked to empathetic

concern, which constitutes the motivation to respond to the victim. Literature argues that trauma counsellors' empathetic ability is a key quality to them opening their heart and mind to their clients.

Without this quality the trauma counsellor plays no significant role and would be of no assistance to the victim. Empathetic response is the combination of the trauma counsellors' empathetic ability and empathetic concern. It measures the level of effort put forth by the counsellor in assisting the client manage the pain of the trauma (Figley, 1995). Figley (1995) mentions emotional contagion which he describes as "experiencing the feeling of sufferers as a function of exposure to the sufferer" (Figley, 1995, p.252). He connects emotional contagion to the counsellors' empathetic ability, which subsequently gives rise to compassion stress. However, if the trauma counsellor can disengage from the relationship with the client, he/she will experience a sense of satisfaction from the helping relationship (Figley, 1995) rather than experiencing the stressful effects of working with the client's traumatic material.

Part two of Figley's (1995) trauma transmission model reveals that the development of compassion fatigue is a function of four interacting variables: level of compassion stress, prolonged exposure to the victim, traumatic recollections, and degree of life disruption.

Figley (1995) indicates that prolonged exposure to traumatic material occurs due to the trauma counsellor's feeling that they continuously have to take care of and are responsible for their client. The counsellor feels solely responsible for the client, and is unable to minimize their compassion stress. Consequently, recollections cause secondary symptoms and other related responses in the counsellors. Figley (1995) asserts that compassion fatigue becomes a natural phenomenon when these circumstances exist. This belief is very pertinent to the current study, as it is the researcher's belief that the trauma counsellors' at the EAP organization are all exposed to the mentioned variables. Part Two of the model is represented in the following diagram:

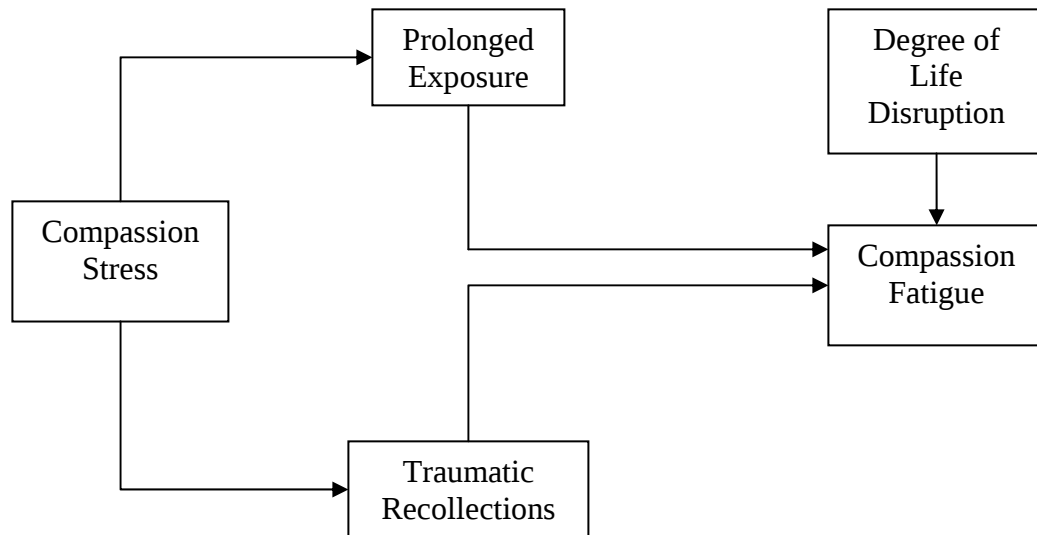


Figure 2: A Model of Compassion Fatigue (Figley, 1995)

The trauma transmission model provides a handy theoretical framework for understanding the etiology of compassion fatigue, however it is criticised for being narrow in its focus and as being too complex (Kleber & Brom, 1992). Research has highlighted the importance of contextual and circumstantial factors in the transmission of traumatic material (Kleber & Brom, 1992), but this model does not take adequate cognisance of such factors.

3.2.2. An Ecological Framework of Trauma:

Dutton and Rubinstein (1995) also attempt to provide a theoretical framework for compassion fatigue. They developed an ecological framework of trauma which integrates aspects of Figley's trauma transmission model. According to Dutton and

Rubinstein (1995) the range of reactions that trauma workers may experience due to their interactions with clients are categorized into three areas. The first category relates to the symptoms of psychological distress, such as avoidance behaviour, intrusive imagery, somatic complaints or physiological numbing.

A second category of reactions refers to shifts in assumptions and beliefs about the world (Janoff-Bulman, 1992). Individuals have assumptions on a preconscious level which allow them to set goals, plan activities and order their behaviour. It is believed that these assumptions are shattered by exposure to trauma (directly or indirectly), which causes psychological stress and symptom formation.

The last category, which is relational disturbances, may occur within the counselling relationship as a consequence of mistrust between the client and the counsellor. Furthermore, due to the secondary exposure, trauma counsellors' relationships (professional and personal) may suffer. Their sensitivity to similar occurrences in their personal lives may cause difficulties in their relationships and they may isolate themselves in the workplace (Dutton & Rubinstein, 1995).

Therefore, Dutton and Rubinstein's (1995) model of secondary traumatic stress proposed four components: the traumatic event to which the trauma worker is exposed; trauma workers coping strategies; the trauma workers post traumatic stress reactions; and personal and environmental factors (Dutton & Rubinstein, 1995).

Dutton and Rubinstein (1995) posit that exposure to traumatic material is unique for every trauma counsellor and they provide five reasons: the traumatic material differs in degree of severity from one client to another; the trauma counsellor is not only exposed to traumatic material but also to the emotions that the client experiences in relation to the event; the counsellor is exposed to the re-victimisation of their client which may occur due to social systems; the counsellor is exposed to the realisation that the type of trauma does exist which may challenge their cognitive beliefs; and lastly the counsellor may have to deal with the client's previous trauma which may

resurface (Dutton & Rubinstein, 1995). As the nature of exposure is unique to each counsellor, this model directs research into the level of exposure to traumatic material to which the counsellor is exposed.

The second component of the model taps into coping strategies whereby Dutton and Rubinstein (1995) espouse that coping strategies affect the development and course of compassion fatigue. Dutton and Rubinstein (1995) assert that there are two types of coping strategies, namely, personal and professional strategies and they indicate that these strategies are linked to a person's social support network.

Dutton and Rubinstein (1995) further believe that individual and environmental factors may be mediators of compassion fatigue. Individual factors encompass the trauma workers inner strengths, their resources, vulnerabilities and their level of satisfaction with both their personal and professional life. Dutton and Rubinstein (1995) consider environmental factors such as social support, an organisations response to the counsellor, the context within which the counsellor works and lives and social and cultural factors to be important in influencing the counsellors' reactions to traumatic material.

The Ecological model of Trauma is represented in the following diagram:

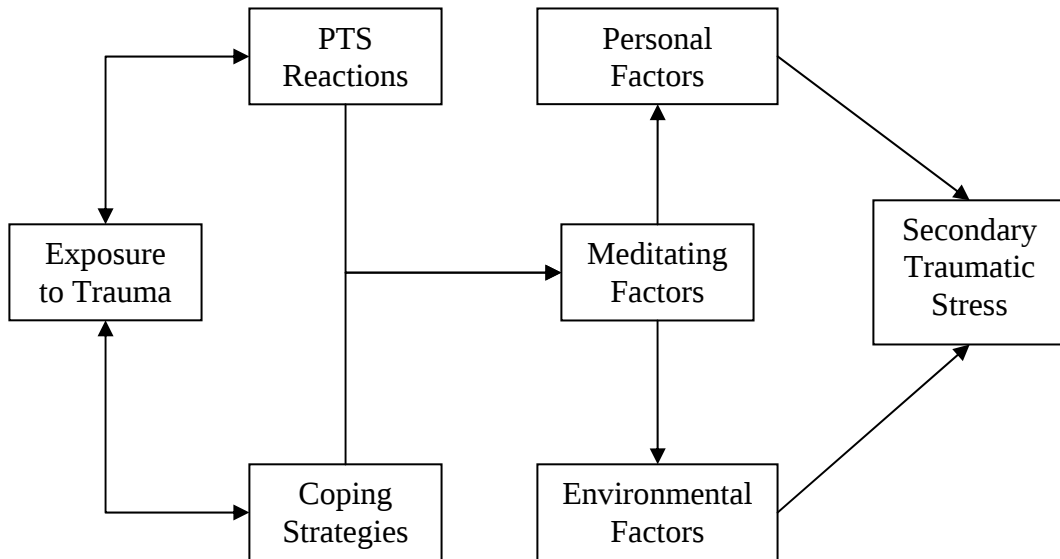


Figure 3: An Ecological Model of Compassion Fatigue (Dutton & Rubinstein, 1995))

Although these models are specific to trauma counsellors and emphasise cognitive elements, they also differ in their focus. Figley's (1995) model stresses elements of the trauma counsellors' personality and Dutton and Rubinstein (1995) focus on environmental factors. These models of compassion fatigue suggest that individual factors and level of exposure influence an individual's reactions to traumatic material, but there is limited empirical evidence to substantiate these hypotheses.

There are key universal variables which are believed to play a role in the transmission of compassion fatigue and it is important to investigate these variables. Therefore, variables which are considered to be of significance in the development of compassion fatigue, namely, empathy, level of exposure, and affect intensity should be considered. A model is therefore required which encompasses these key personal and environmental factors which are important in the etiology of compassion fatigue.

McRitchie's (2006) study proposed a Refined Model for Trauma Workers in South Africa. The current researcher has based the following model on McRitchie's (2006) model. Affect intensity has not been considered within the scope of compassion fatigue previously and the current author will attempt to place this variable within a trauma model. Hence, a Revised Model for Trauma Counsellors is proposed in this study.

3.3. A Revised Model for Trauma Counsellors;

This model is an expansion of Figley's (1995) and Dutton and Rubinstein's (1995) models in an effort to take into account other key variables which the researcher believes is important in the transmission of traumatic material from the client to the counsellor. The model provides a basis for the current study and the variables which will be investigated.

The Revised Model for Trauma Counsellors is represented in the following diagram:

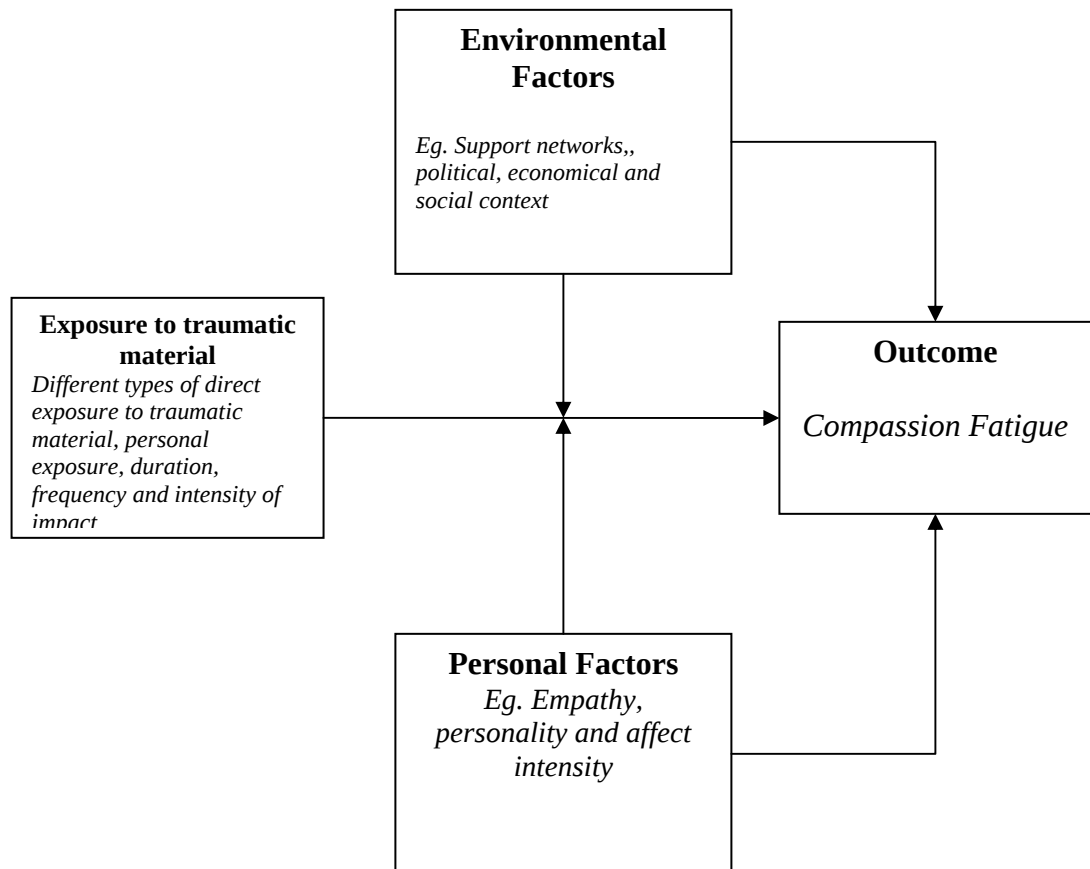


Figure 4: The Revised Model for Trauma Counsellors

This model attempts to provide an understanding of the process by which compassion fatigue develops. The process is seen as a linear one, due to its direct relationship.

The first component of the model is exposure to traumatic material. This includes personal exposure to traumatic material, the type of trauma that the trauma counsellor

has been exposed to, the frequency of the exposure, and the duration of exposure as well as the intensity of the impact of the exposure on the trauma counsellor.

This model is based on the premise that due to the elevated levels of trauma in the South African society, there is a strong possibility that the trauma counsellors would themselves be exposed to trauma, either directly or through other channels such as the media. The nature, severity and frequency of exposure to traumatic material are hypothesised to have a direct impact on the levels of compassion fatigue. The researcher also believes that the length of exposure to traumatic material and the intensity of impact on the trauma counsellor will have a bearing on the levels of compassion fatigue.

The second and third component of the model serves as moderating factors of compassion fatigue and these are environmental and personal factors. Environmental factors encompass the support networks of the trauma counsellor, and take into consideration the political, economical and social contexts of the counsellor. Personal factors include empathy, personality and affect intensity. These variables are believed to influence the relationship between the level of exposure to traumatic material and the trauma counsellors' outcomes.

The last component of the model is the outcome of the relationship between exposure, environmental and personal factors. This component indicates that the outcome is compassion fatigue, which predicts negative consequences for the trauma counsellor unless there is an intervention to assist the counsellor.

Based on this model, the researcher proposes that trauma counsellors exposed to higher levels of traumatic material in a professional capacity together with a history of personal trauma would have higher levels of empathy and therefore be at greater risk for compassion fatigue. Furthermore, counsellors with higher affect intensity, exposed to greater amounts of traumatic material would have elevated levels of empathy and eventually higher levels of compassion fatigue. Thus, there is a need in

determining the role of individual differences in reactions to potentially emotion-provoking events, thereby assisting counsellors in preventing compassion fatigue.

3.4. Concluding Comments

A Revised Model for Trauma Counsellors was proposed to understand the transmission of compassion fatigue, acknowledging universal key variables which are believed to be important in this transmission. Therefore, the key predictors of compassion fatigue: levels of exposure, empathy and affect intensity will be discussed in the following chapter.

CHAPTER 4: COMPASSION FATIGUE, LEVELS OF EXPOSURE, EMPATHY AND AFFECT INTENSITY

4.1. Introduction:

Knowledge of traumatic incidences and how trauma symptoms relate to psychological well being continues to grow (Coursol, Lewis & Garrity, 2001; Keane, Weathers & Kaloupek, 1992). A person's ability to cope with traumatic material is influenced by individual and contextual factors, such as personality variables, cognitive functioning, pre-existing psychological conditions and the duration and intensity of exposure to traumatic material (Keane, 1989).

Previous studies also suggest that key variables such as level of exposure and empathy influence the development of compassion fatigue (Figley, 1995). Furthermore, the observation that individuals differ in the intensity with which they respond to emotional stimuli introduced the concept of affect intensity. To date, there have been no studies to investigate the relationship between affect intensity and compassion fatigue. In addition, little empirical evidence exists in regards to levels of exposure to traumatic material and empathy and the development of compassion fatigue. Therefore, these key variables will be further explored in the current study.

4.2. Level of Exposure:

The concept of exposure to traumatic material was introduced by Figley (1995) as an important aspect of compassion fatigue. This topic has become a key point of discussion in research related to compassion fatigue. However, although level of exposure to traumatic material and its implications gained attention in the literature, the main focus of these studies has been on war and community disasters (Dutton & Rubinstein, 1995; Friedland, 1999). The levels of exposure to other traumatic

material have been neglected. Therefore, this is an important area of investigation in South Africa considering the various forms of trauma in this society.

Dutton and Rubinstein (1995) believed that exposure to traumatic material is different for each trauma counsellor. They asserted that the traumatic material differs in degrees of severity from one victim to another; the trauma counsellor is exposed to emotions of each victim such as anger, pain and helplessness; the counsellor is exposed to the re-victimisations of their clients as a possible consequence of social systems; the counsellor is exposed to the realisation that such trauma can occur which challenges their assumptions and beliefs and the trauma counsellor may also have to cope with previous trauma that the client had suffered. Furthermore, trauma counsellors are faced with prolonged and intense reactions to the trauma, to the pain, fear, rage, hopelessness and further victimisation which the client may experience (Dutton & Rubinstein, 1995).

Previous studies propagate the belief that the level of exposure or severity of exposure to traumatic material is related to the development of compassion fatigue (Durrant, 1999; Dutton & Rubinstein, 1995). Steed and Bicknell (2001) posit that the primary factor influencing an individual's level of exposure to traumatic material is the extent of their caseload, that is, higher caseloads increase exposure to traumatic material. Chrestman (1995) supported this view in his study whereby he reported a relationship between increased professional experiences; the number of clients counselled and increased compassion fatigue symptoms (Steed & Bicknell, 2001). However, Follette, Polusny and Milbeck (1994) examined predictors of PTSD in professionals exposed to traumatic material and found that the percentage of caseload was not significant in predicting secondary traumatic stress. Due to contradictory findings in previous research, level of exposure is an important variable to be investigated in this study.

A review of fifteen studies which investigated the impact of individuals working with clients who had experienced trauma concluded that the severity of symptoms in the affected individuals appeared to be related to the intensity of exposure rather than to the length of exposure (Bride, 2004). It has become evident that there are several limitations in only equating caseload with level of exposure and neglecting the implications of the severity of the traumatic material and the intensity of trauma on the trauma counsellors. Another study which confirmed this belief was conducted by Durrant (1999) who examined whether students allied with medical sciences are at risk of developing symptoms of compassion fatigue. The findings were that exposure to a more traumatised patient contributed to the risk of developing compassion fatigue more so than the number of patients they were exposed to (Durrant, 1999).

Some traumas may be more difficult to manage than others, or some trauma counsellors may be exposed to different levels of severity of traumatic material than other counsellors. The level of unpredictability of traumatic events, the source of traumatic experience, and the level of threat to life involved all will influence the degree to which the trauma counsellor becomes affected (MacLiam, 2003). This is especially true in an Employee Assistance Programme environment, where counsellors are exposed to varying degrees of trauma and may have different caseloads to each other. Furthermore, there is no follow up with cases as clients are referred to other resources or they speak to different counsellors each time they call. Counsellors in an EAP environment are also exposed to other types of psychological problems besides trauma and some counsellors work on a part time basis. The level of exposure and intensity of exposure is not the same for all the counsellors. Therefore, due to the uniqueness involved with this type of work and the subjective perception of a traumatic event which is recognised in the literature as influencing compassion fatigue; there is a need for research into the levels of exposure to traumatic material, including the individual perceptions of the intensity of the nature of exposure by the EAP counsellors (Benatar, 1996). This study aims to make a

relevant contribution to the field of trauma and compassion fatigue by taking this aspect into consideration.

Personal trauma history has been shown to be significantly related to the experience of compassion fatigue symptoms (Kassam-Adams, 1995 & Pearlman & Mac Ian, 1995). Some authors consider it to be more harmful to the counsellor's psychological health than work related trauma, and its effects may lead to PTSD which could add to the severity of compassion fatigue symptoms experienced (Cerney, 1995 & Yassen, 1995). Counsellors may be more likely to experience the client's intrusive imagery or re-experience his or her own imagery which is reawakened by the clients' material (Rosenbloom, Pratt, & Pearlman, 1999). Follette, Polusny and Milbeck (1994) surveyed childhood physical and sexual abuse histories of mental health professionals and found that approximately thirty percent of therapists reported childhood abuse histories. These percentages are similar to those revealed in studies of the general population. If one takes these percentages into consideration, it follows that counsellors with a history of unresolved previous trauma may be more vulnerable to compassion fatigue due to their personal traumatisations. This would be very prevalent in the South African society given its trauma history and current levels of violent crime.

4.3. Empathy:

Empathy is regarded as one of the essential skills enabling health professionals to connect with and work effectively with clients (Pope & Kline, 1999). However, this skill also potentially places them at risk of developing maladaptive responses to the trauma of others. Literature indicates that a key factor in the development of distressing symptoms in trauma workers is that they appear to be related to the health professional's ability to open their heart and mind to the experience of clients, that is, their capacity for empathy. Hence, one of the essential skills enabling health

professionals to connect with and work effectively with clients also potentially places them at risk of developing stressful reactions to the trauma of their clients. Figley (1995) warns that caring for and empathising with traumatised individuals carries a risk as well.

Previous studies on compassion fatigue suggest that empathy is a key factor in the induction of traumatic material from the primary to the secondary “victim”. Cherniss (1980) asserts that the characteristics which attract people to the helping professions and make them initially effective may subsequently become a source of stress. The process of empathising with a traumatised individual helps the counsellor understand the client’s traumatic experiences, but the counsellor may also become traumatised in the process (Figley, 1995). A study conducted by Regehr, Goldberg and Hughes (2002) which investigated the relationship between empathy and trauma in paramedics found that those paramedics who were emotionally empathic provided a higher quality of care, but they also experienced more symptoms of secondary traumatisation.

Researchers have begun to focus on a multi-dimensional definition of empathy that considers both the cognitive and emotional aspects (Atkins & Steitz, 1998). Davis (1983) proposed a multidimensional model of empathy involving a combination of both cognitive and affective components. Davis (1983) described perspective-taking, the spontaneous ability to adopt the viewpoint of others, and fantasy, a tendency to imagine the feelings and actions of fictional characters. He also proposed two distinct emotional components of empathy, empathic concern, involving feelings about others, such as sympathy and concern, and personal distress, feelings of anxiety or tension arising from interpersonal situations. Figley (1995) maintains that an empathic individual has the ability to accurately perceive the problems of others and they are therefore able to help the client deal with their pain. From this cognitive perspective, the counsellor behaves in a manner which communicates to the client that they are concerned and that they care about the client (Atkins & Steitz, 1998).

Empathy is also regarded to be a vicarious emotional process in which the counsellor develops an emotional connection with the client and consequently has an emotional response to the client's suffering. The counsellor would convey genuineness, unconditional positive regard and respect to the client. Therefore, the counsellor experiences a cognitive awareness of the traumatic material and maintains an emotional connection with the client (Regehr, Goldberg & Hughes, 2002). These processes may however lead to compassion fatigue.

McRitchie (2006) explored the relationship between empathy and compassion fatigue, as she named it secondary traumatic stress. Her research found that there was a moderate positive relationship between empathy and compassion fatigue among trauma workers. She proposed that the higher the individual's level of empathy, the more susceptible the individual is at developing compassion fatigue (McRitchie, 2006).

Due to the limited research regarding empathy and compassion fatigue, studies focusing on the relationship between empathy and burnout will be mentioned. Williams (1989) explored the relationship between empathy and burnout in a sample of nurses, social workers and teachers. Emotional empathy and fantasy empathy correlated significantly with the emotional exhaustion scale. His conclusion was that his study added support to the position that empathy in helping professionals can make one susceptible to burnout (William, 1989).

Vachon's (1993) study with nurses indicated that higher levels of the tendency to be personally distressed and high fantasy empathy were associated with higher levels of burnout, while high levels of the cognitive ability to understand the perspective of others and empathic concern were associated with less burnout (Vachon, 1993). It would be interesting to compare these results with the current study. One would assume that individuals with higher empathic concern would be more prone to burnout and/or compassion fatigue.

The importance or relevance of empathy in compassion fatigue has received little theoretical or empirical attention. As there are so few studies in this area, there are many gaps in understanding the relationship between empathy and compassion fatigue. It is the researcher's belief that essentially through the development of empathic relationships with traumatised clients, some counsellors may become traumatised. The impact of this traumatisation is not limited to the therapeutic interaction and may trickle into other aspects of the counsellors' life. Understanding this empathic process is important in order to assess those at risk, promote protective factors, treat those who are already suffering from its impact, and protect clients from enduring further, albeit unintended trauma through the impacted counsellors. Therefore, it is the aim of the current study to explore this relationship between empathy and compassion fatigue.

4.4. Affect Intensity:

According to Larsen and Diener (1987), affect intensity refers to stable individual differences in the intensity of emotions experienced by individuals. It refers to the degree to which an emotion is experienced irrespective of whether it is positive or negative.

Affect intensity is distinguished from emotionality which refers to the tendency to experience negative emotions and the tendency to easily slip from a positive or neutral state into a negative emotional state (Buss & Plomin, 1975). The construct of affect intensity which refers to the regular experience of both strong positive and negative emotions over time appears to closely resemble emotional variability (Wesman & Ricks, 1966). However, emotional variability refers to the frequent and extreme changes in affect while affect intensity refers to the typical strength of the emotional states (Larsen & Diener, 1987). Larsen (1984) argues that affect intensity should be viewed as a temperament as it refers to a general style of emotional

experience and response rather than a personality construct which emphasises the content of the emotional behaviour. He asserts that it appears early in childhood and is fairly stable into adulthood. Larsen (1984) also found that when affect intensity covaries with other temperament dimensions and when it was factor analysed with other temperament dimensions, it did not define a unique temperament dimension. He concluded that affect intensity is a dimension common to all temperament dimensions.

Larsen, Diener and Emmons (1986) found affect intensity to be related to four dimensions of temperament: sociability, activity level, arousability and emotionality. They found that high affect intensity individuals were more active, socially arousable and emotionally reactive than their low affect intensity counterparts. Larsen and Diener (1987) argue that because affect intensity increases the level of all types of emotional responses, then it should be related to any trait or temperament which refers to increased levels of either positive or negative affect in the construct definition. They believe that affect intensity may be tapping into a common underlying mechanism or affect intensity is an energising force which contributes to or drives these temperament dimensions.

Larsen and Diener (1987) confirmed that when individuals are exposed to equal levels of affect-producing stimuli, some individuals consistently respond with high levels of emotional intensity and others respond with only moderate levels. Research indicates that individuals classified as having high affect intensity, when faced with a positive emotion eliciting event reported stronger positive affect than individuals classified as having low affect intensity. Correspondingly, when these high affect intensity individuals are exposed to negative emotion eliciting events, they have reported stronger negative responses than their low affect intensity counterparts (Larsen et al, 1986). It is hypothesised that it may be difficult for such high affect intensity individuals to tolerate the experience of intense negative emotional stimulation (Moore & Harris, 1996). Hence, they dislike exposure to such

stimulation. Geuens and De Pelsmacker, (1999) have observed that high affect intensity individuals develop significantly more cognitive operations than low affect intensity individuals when exposed to emotional advertisements. Haddock, Zanna and Esses (1994) report that when a negative mood is induced in high affect intensity individuals, emotional associations, stereotypes and attitudes become significantly more negative than when a non-emotional mood induction occurs, whereas these stereotypes, associations and attitudes are significantly positively affected after a positive mood induction. These individuals would be expected to have significantly stronger negative attitudes when exposed to negative emotional appeal. Thus, the current study proposes that there is a strong possibility of these individuals displaying higher levels of compassion fatigue when exposed to traumatic material.

Affect intensity does not relate directly to indicators of psychological well-being, but does correlate with measures of neurotic and somatic symptoms. Larsen and Diener (1987) report that this may be an indication that while individuals high in affect intensity may not be dissatisfied with their lives; their regular experience of strong negative emotions and strong positive emotions exacts a somatic and psychological price. Individuals with high affect intensity have also been found to rate their daily life events as being more important than low affect intensity individuals do. This is an important finding as counsellors high in affect intensity may tend to exaggerate the emotional states of their clients. In turn, their own emotional and psychological responses may also be intensified.

Larsen, Diener and Emmons (1986) conducted a study to determine whether emotionally intense individuals react more strongly to the same stimuli less emotionally intense individuals encounter. They discovered that relative to events judged objectively by a group of raters, high affect intensity individuals provided more extreme subjective ratings to their daily events than individuals low in affect intensity no matter how objectively good or bad the events were. A study conducted by Moore, Harris and Chen (1994) found that high affect intensity individuals

reported experiencing stronger positive emotions as compared to low affect intensity individuals, when they were exposed to positive emotional stimuli. However, they also experience sadness and anger more strongly (Diener et al, 1985). It is therefore, proposed that a tendency to experience emotions intensely may be a liability to the counsellor. It would be interesting to note the effect that traumatic material would have on those counsellors with high affect intensity.

A study by Larsen, Diener and Cropanzano (1987) found that high affect intensity individuals made more empathic ratings and added more to a scene in terms of fantasy elaboration than low affect intensity subjects. Vachon (1993) attempted to investigate the way in which affect intensity and dispositional empathy may influence the way the frequency of perceived stressors on seven types of medical units is related to burnout among nurses. Affect intensity was found to moderate the relationship between a number of dispositional empathy variables and measures of exhaustion. However, nurses were found to have a significantly lower level of affect intensity than the general population and affect intensity was found to decrease with age and the number of years one has been a nurse (Vachon, 1993). It is therefore proposed by this researcher that counsellors with higher affect intensity, exposed to greater amounts of traumatic material would have higher levels of empathy and ultimately higher levels of compassion fatigue. Thus, there is a need in determining the role of individual differences in reactions to potentially emotion-provoking events, thereby assisting counsellors in preventing symptoms of compassion fatigue. Although previous research has established that individuals' affect intensity levels have a direct impact on their emotional responses (Larsen, Diener & Emmons, 1986), no known research has been conducted on the relationship between affect intensity and compassion fatigue. Taking into consideration the literature relating affect intensity to the perception of emotional stimuli, and the tendency to exaggerate the emotional states of others, it would be important to investigate its role in the relationship between level of exposure to traumatic material, empathy and compassion fatigue.

4.5. Concluding Comments:

Research indicates that individual and contextual factors, pre-existing psychological conditions and the duration and intensity of exposure to traumatic material may impact on the level of compassion fatigue experienced by trauma counsellors. Individuals also differ in the intensity with which they respond to emotional stimuli and the researcher has proposed for the purposes of this study to examine the notion of affect intensity. Levels of exposure, empathy and affect intensity were explored to determine their role in the development of compassion fatigue.

The following chapter presents the methodology of the study which was used to investigate the constructs of exposure, empathy and affect intensity.

CHAPTER 5: METHODOLOGY

5.1. Introduction:

Although the psychological consequences of working with traumatised clients have been noted for some time, the main focus of trauma studies have been on professionals working with victims of natural disasters, wars and sexual abuse. Furthermore, studies have largely focused on the direct victims of trauma and little attention has been dedicated to those professionals, namely trauma counsellors, who work with these victims. Thus, the consequences of working with traumatised clients have been relatively unexplored. Therefore, this study proposes that EAP trauma counsellors are vulnerable within their scope of work and are an important group of health mental professionals to be further investigated.

There has been considerable interest in the contributory factors of compassion fatigue and certain key variables have been highlighted to be significant in the development of compassion fatigue. Research suggests that these variables are exposure to traumatic material and empathy. The researcher proposes in the current study that affect intensity also plays a role in the development of compassion fatigue. However, there is a paucity of research into the relationship between level of exposure to trauma, empathy and affect intensity. Hence, this study seeks to address this gap as well as to contribute to a further refinement of the theoretical understanding of the impact of level of exposure, empathy and affect intensity to the risk of compassion fatigue.

Trauma counsellors who demonstrate symptoms of compassion fatigue would not be offering the best care to their clients, therefore hindering these clients from reaching optimal levels of recovery as quickly as possible. A dearth of data prevents conclusive findings about the impact of traumatic incidences in EAP counsellors and provides the impetus for this study.

This chapter focuses on the research aims, research questions, hypotheses and research design of the study. It also provides a description of the sample, and elaborates on the instruments used, the procedures followed and the statistical techniques that were employed.

5.2. Aims of the Study:

The study will focus on EAP counsellors' reactions to working with trauma victims as assessed by means of a scale measuring Compassion Fatigue. This study aims to empirically assess the presence and extent of Compassion Fatigue in EAP counsellors who are being exposed to trauma material. The primary aim of this study is to explore the relationship between compassion fatigue and level of exposure to traumatic material, compassion fatigue and the level of empathy, and compassion fatigue and affect intensity. The study also aims to explore the interrelationship between these variables in a sample of EAP counsellors.

5.3. Research Design:

The research design for the study was non-experimental ex post facto as a random selection of participants was not possible. Non-experimental designs are used when the researcher has no control over the variables (McBurney, 1994) as was the case in the current study. In this study the variables were compassion fatigue, levels of exposure, empathy and affect intensity, all naturally occurring in the study context. Non experimental ex post facto design is implemented after the event and is believed to be undertaken with the wisdom of hindsight. A cross sectional design was used as it is believed to be useful in research settings where control of the participants is difficult (Kerlinger, 1986). Kazdin (1980) asserted that although data obtained from correlation designs does not necessarily infer a cause-and-effect relationship between

variables, it may be useful in disproving causal relationships. Therefore, a correlation research design was used in this study as it is useful in describing the relationship between two or more variables.

5.4. Research Questions:

The following questions were explored in this study:

1. Is there a relationship between level of exposure to traumatic material and level of compassion fatigue in a sample of trauma counsellors within an EAP organization?
2. Is there a relationship between empathy and levels of compassion fatigue in a sample of trauma counsellors within an EAP organization?
3. Is there a relationship between affect intensity and level of compassion fatigue in a sample of trauma counsellors within an EAP organization?
4. Is there an interrelationship between levels of compassion fatigue, level of exposure, empathy and affect intensity in a sample of trauma counsellors within an EAP organization?

5.5. Research Hypotheses:

Hypothesis One: : An increased level of exposure to traumatic material as measured by the Exposure Checklist is associated with increased levels of compassion fatigue as measured by the Compassion Fatigue Self-Test.

Hypothesis Two: An increased level of empathy as measured by The Interpersonal Reactivity Index is associated with increased levels of compassion fatigue as measured by the Compassion Fatigue Self-Test.

Hypothesis Three: An increased level of affect intensity as measured by the Affect Intensity Measure is associated with increased levels of compassion fatigue as measured by the Compassion Fatigue Self-Test.

Hypothesis Four: There is an interrelationship between levels of compassion fatigue, level of exposure, empathy and affect intensity in a sample of trauma counsellors within an EAP.

5.6. Sample:

The study employed non-probability sampling, that is, purposive sampling (Neuman, 1997). The sample consisted of EAP counsellors who have direct and indirect contact with clients exposed to traumatic material. The sample was selected based on the counsellors' availability and willingness to respond as well as their accessibility to the researcher. The group consisted of both males and females that worked at the EAP organisation either on a full time or part time basis. Preliminary enquiries indicated that there were approximately 87 counsellors who could potentially be requested to participate in the study. In total, the sample for the current study comprised of 60 counsellors.

5.7. Measurement Instruments:

The questionnaires administered to gather information were structured self report scales and were presented to the participants as part of a structured questionnaire.

This allowed the participants to describe their behaviour and state of mind. The questionnaires were administered in the following order: a) Demographic questionnaire; b) Compassion fatigue Self Test; c) the Interpersonal Reactivity Index; d) the Exposure Checklist; e) the Affect Intensity Measure. The instruments will be discussed in greater detail below.

5.7.1. Demographic Questionnaire (Appendix B):

The researcher devised a demographic questionnaire to determine the biographical information of the participants. The questionnaire included questions regarding the participants age, gender, length of service at the organisation, the counsellor's work status, that is whether they were employed on a full time or part time basis, length of service experience as a counsellor, exposure to previous personal trauma, nature of the trauma, number of hours of direct contact with traumatised clients, the number of hours of indirect contact with traumatised clients and the average number of hours spent on general counselling. These variables were specifically chosen in order to determine whether they had a relationship with compassion fatigue. The researcher was also interested in assessing if a greater amount of time spent on general counselling would minimise the impact of compassion fatigue.

5.7.2. Compassion Fatigue Self-Test (Appendix C):

The Compassion Fatigue Self-Test is a self-report scale comprising three subscales, namely, compassion fatigue, burnout and compassion satisfaction. As this study only investigated the risk for compassion fatigue, only those items tapping into compassion fatigue was used. Therefore the current scale consists of 23 items.

The scale was scored according to a 0 (not at all) to 5 (very often) Likert – type scale. The score is summed for the scale. Participants rated each item on how frequently they had experiences characterised by statements such as, “I experience troubling dreams similar to those I help” and “I have gaps in my memory regarding frightening events”.

According to Stamm and Figley (1996), scoring for the Compassion Fatigue subscale should be interpreted as follows:

26 or less	=	extremely low risk
27 – 30	=	low risk
31 – 35	=	moderate risk
36 – 40	=	high risk
41 or more	=	extremely high risk

The higher scores indicate greater risk for compassion fatigue. The cut-off point for compassion fatigue is 31, above which a moderate or severe impact is indicated (Stamm & Figley, 1996).

The psychometric properties of the scales are established (Stamm, 2005) and compassion fatigue alpha is 0.80. The standard errors of the measure are quite small so that the test typically has less error interference, improving the potential measurable effect size (Stamm, 2005). This scale has been successfully used in studies with the South African population (Ortlepp & Friedman, 2001). Wilson (1998) used the scale to measure compassion fatigue in trauma counsellors and the reliability score for the compassion fatigue subscale was 0.80.

5.7.3. The Interpersonal Reactivity Index (IRI) (Appendix D):

The Interpersonal Reactivity Index (IRI) was used to assess empathy as a multidimensional construct. The scale consists of 28 items, measuring four aspects of empathy reflected in the following subscales: Perspective Taking, Fantasy, Empathic Concern and Personal Distress. The subscales consist of two cognitive and two emotional components.

The cognitive component of this scale is fantasy and perspective taking. The Fantasy (Fantasy Scale) is a measure of the ability of the individual to identify with fictitious characters in movies and books (Miville, Carlozzi, Gushue, Schara & Ueda, 2006). Although fantasy as measured by this subscale does not correspond to Figley's view of fantasy, it was still included as it is not legitimate to exclude from the measure.

Perspective Taking (PT) is the tendency of an individual to adopt the point of view of other people (Miville, Carlozzi, Gushue, Schara & Ueda, 2006). An example of a perspective taking item on the scale is "I try to look at everybody's side of a disagreement before I make a decision". This construct relates to Figley's empathetic ability.

The emotional component of this scale comprises empathic concern and personal distress. Empathic concern (EC) is an affective measure of an individual's ability to feel compassion and concern for other individuals who have negative experiences (Miville, Carlozzi, Gushue, Schara & Ueda, 2006). An example of such a construct is "I often have tender, concerned feelings for people less fortunate than me". Empathic concern on this scale corresponds to Figley's empathetic concern.

Personal Distress (PD) is a measure of the extent to which individuals share and experiences the negative emotions of others (Miville, Carlozzi, Gushue, Schara & Ueda, 2006), example, "when I see someone who badly needs help in an emergency,

I go to pieces.” Personal Distress on this scale relates to Figley’s empathetic response.

This questionnaire is scored on a 5 point Likert scale ranging from 0 (does not describe me well) to 4 (describes me very well). A total score for this scale is obtained by summing all the items to obtain an overall level of empathy. The results can be analysed as the higher the score, the higher the level of empathy. The scores will be regarded as any score less than the 50th percentile represents no empathy, scores between 51.56-56.69 represents little empathy, 56.76-59.8 represents moderate empathy and a score higher than 59.8 represents high levels of empathy.

The internal consistencies of the four dimensions of empathy are found to range from 0.68 to 0.79 (Davis, 1980).

The scale has been used by Miville, Carlozzi, Gushue, Schara and Ueda (2006) in a study to assess the relationship between emotional intelligence, universal diverse orientation and empathy. The alpha coefficient for the total IRI was 0.73. Even though the scale has only been used in McRitchie’s (2006) study in South Africa, to the researcher’s knowledge, it is the only multi-dimensional scale used widely to assess levels of empathy (Vachon, 1993).

5.7.4. Level of Exposure Checklist (Appendix E):

The researcher provided participants with a checklist which was self-constructed, based on the study by McRitchie (2006). The development of the checklist which is specific to this study is a result of many previous studies which examined exposure to traumatic material and traumatic stress (Figley, 1993; Munroe, Shay, Fisher, Rappaport, & Zimmering, 1995; Ortlepp & Friedman, 2001). The researcher wanted to determine the nature and the frequency with which the trauma counsellors were exposed to traumatic material, as well as to determine the impact of the intensity of

the trauma on the counsellors. The researcher had developed this checklist after interviewing counsellors at the EAP organisation to verify that the items on the checklist were valid to their work.

Participants were requested to indicate either yes or no to determine which traumatic incident they managed in the past three months in order to give it a time frame. It was felt that the recency of working with a trauma case was important, as the counsellors would be able to recall a recent case (within the past three months) in more detail. Furthermore, for PTSD symptoms to be present the symptoms must be present for more than one month. Therefore, a three month time period was used in order to allow the counsellors to acquire a substantial number of cases within a time frame as well as to examine the ongoing, cumulative impact of traumatic material on these counsellors.

The participants were asked to estimate the average number of times they had managed a specific traumatic incident in the past three months in order to measure the emotional impact of exposure to the traumatic material. Emotional impact in this study will be equated to Bride's (2004) concept of intensity of exposure.

The participants were asked to rate their individual, subjective perception of the emotional impact of the traumatic incident on a scale from 1-5, with 1 being 'no impact' and 5 being 'very high impact'. A total score was obtained by adding the number of 'yes' and 'no' responses and the frequency of cases which the trauma counsellor had dealt with. The participants number of cases and intensity of emotional impact represented the total level of exposure. The following equation was used to calculate the total exposure:

$$\text{Tot Exp} = N_1\text{Ex}_1*\text{In-Ex}_1+N_2\text{Ex}_2*\text{In-Ex}_2\ldots+N_{19}\text{Ex}_{19}*\text{In-Ex}_{19}$$

The number of cases ($N_1\text{Ex}_1$) was multiplied by the intensity of emotional impact (In-Ex_1) for each trauma listed on the checklist.

5.7.5. The Affect Intensity Measure (AIM) (Appendix F):

The Affect Intensity Measure is a 40 item questionnaire that assesses the intensity with which an individual experiences his or her emotions. Items on the scale pertain to strong positive and negative emotional reactions, example, “When I ‘m happy, I feel like I’m bursting with joy”. Respondents indicate the extent to which the statement applies to them using a 6 point scale. All AIM items are summed to produce a total score. The results were analysed as the higher the score, the higher the affect intensity of the individual. The scores will be regarded as any score less than the 50th percentile represents extremely low affect intensity, scores between 51.56-56.69 represents low affect intensity, 56.76-59.8 represents moderate affect intensity and a score higher than 59.8 represents high levels of affect intensity.

Larsen (1984) reported test-retest reliabilities of 0.80, 0.81 and 0.81 for 1, 2, and 3 month intervals respectively. Internal consistency coefficients have ranged from 0.90 to 0.94 in four samples reflecting a highly homogenous item set.

A study conducted by Vachon which looked at the relationship between burnout and affected intensity provided an alpha coefficient of 0.89.

Although the AIM has not been used in South Africa to the researcher’s knowledge, it has been used with professional populations in the helping professions (Vachon, 1993). The AIM has demonstrated good internal consistency and acceptable levels of reliability (Keltner & Ekman, 1996).

5.8. Research Procedure:

Verbal and written permission was obtained from the directors of the EAP organisation in order to distribute questionnaires to the counsellors. Participants were informed about the nature of the study. They were told that participation in the study

was voluntary, confidential and anonymous. They were informed that completion of the questionnaires would take approximately forty minutes of their time they could discontinue at any point if they felt uncomfortable in participating.

Questionnaires were administered to the participants and this included a subject information sheet informing the participants about the study (Appendix A). They were notified that by completing the questionnaire, they will be granting consent to participate in the study.

A box was provided at the organisation where questionnaires could be returned. In total 87 questionnaires were distributed amongst the counsellors. From this total, 60 questionnaires were returned, yielding an overall response rate of 69%. Once the questionnaires were returned, the data was captured on Microsoft Excel and then analysed using the SAS programme. The results and conclusions were subsequently written up. At the completion of the study, the participants and the organisation were provided with feedback and a copy of the report.

5.9. Statistical Analysis:

The statistical procedures that were used for quantifying and analysing the data are briefly outlined below:

5.9.1. *Internal Reliability: Cronbach's Alpha:*

Cronbach's alpha coefficients were computed for Compassion Fatigue Self-Test, the Interpersonal Reactivity Index and the Affect Intensity Measure, to determine the internal consistency and reliability of the scales. The internal consistency reliabilities provides the researcher with an indication if the variables employed in the study were measured accurately (Rosenthal & Rosnow, 1991).

5.9.2. *Descriptive Statistics:*

Descriptive statistics were used by calculating the means, standard deviations, frequencies, percentages, and minimum and maximum scores on significant variables. This type of analysis is useful in providing a description of various characteristics of the data gathered.

5.9.3. *Correlations:*

Pearsons' Product Moment Correlation Coefficients were used to explore the relationship between the participants' level of exposure and compassion fatigue, empathy and compassion fatigue and affect intensity and compassion fatigue. Correlations aim to describe the degree of relation between two variables and it is important to note that significant correlations do not indicate causation (Rosenthal & Rosnow, 1991).

5.9.4. *Stepwise Regression:*

Hypothesis Four examines the interrelationship between the variables. In order to do this, a stepwise regression was conducted.

5.9.5. *Two Independent Sample T-Tests:*

T-tests are used when one wants to compare the means of two groups (Rosenthal & Rosnow, 1991). A T-test was thus conducted to investigate whether gender had an impact on the variables.

5.9.6. *Analysis of Variance (ANOVA):*

ANOVA is a statistical procedure for testing differences in the means of several groups (Howell, 1995). An ANOVA was conducted on variables such as age, length of service at organisation, and length of service experience as a counsellor.

5.10. Ethical Considerations;

The researcher was employed at the organisation where the study was conducted. Although the researcher does not occupy the same job position as the participants of the study, a number of participants know the researcher on a collegial basis. Therefore, participants were notified at the outset that their participation was totally voluntary. It was communicated to them that they had the right to choose not to participate in the study. They were informed that they were able to withdraw from the study at any time without any negative consequences and that their jobs would not be jeopardised in any way. They were told that they could omit any questions that they did not want to answer.

The participants were provided with a subject information sheet, which provided them with a brief introduction to the study. They were notified that by completing the questionnaire, they would be granting consent to participate in the study.

The researcher ensured absolute confidentiality. Participants were told that no identifying data was requested and only the researcher would be capturing their responses. They could seal their completed questionnaires in an envelope which was provided and they could deposit these questionnaires into a locked box.

Participants were provided with feedback first, once the study had been completed. They were also informed that a copy of the report would be provided to the organisation upon completion of the study. This would be freely available to them for their perusal.

They were informed that if they had any questions or required any form of counselling as a result of their participation in the study, they should contact the researcher and appropriate arrangements would be made for them to get the support they required.

5.11. Concluding Comments:

This chapter aimed to clarify the rationale for the research and provided an outline of the aims of the study. It presented the research design, research questions, and research hypotheses, elaborated on the sample, described the measuring instruments and the procedure and provided an outline of the statistical procedures used in the study. Finally, the ethical considerations of the research were discussed. The results of the statistical analysis are presented in the following chapter.

CHAPTER 6: RESULTS

6.1. Introduction:

This chapter aims to discuss the results of the research study. It includes the internal reliabilities of the scales and descriptive statistics derived from the demographic questionnaire. T-tests, ANOVAs, correlation analyses and regression analyses are presented. A 5% level of significance was used to discuss the findings, therefore the p-value had to be less than 0.05 ($p < 0.05$).

6.2. Reliabilities of the Measuring Instruments:

Cronbach Alpha is a measure of the internal consistency of an instrument. A high internal consistency is indicative of a high degree of generalisability across the items within the instrument (Rosenthal & Rosnow, 1991). Therefore, the Cronbach alpha coefficients for the Compassion Fatigue Self Test, the Interpersonal Reactivity Index, the Level of Exposure Checklist and the Affect Intensity Measure are presented below:

6.2.1. Compassion Fatigue Self Test:

Table 1.1. Cronbach alpha coefficient for Compassion Fatigue:

Cronbach Alpha	
Compassion Fatigue	0.90

Table 1.1. indicates that the reliability of the Compassion Fatigue Self Test is 0.90, which is a high level of reliability.

6.2.2. The Interpersonal Reactivity Index:

Table 1.2. Cronbach alpha coefficient for the Interpersonal Reactivity Index:

Cronbach Coefficient Alpha	
IRI Total	0.59
Fantasy	0.74
Empathic Concern	0.62
Perspective Taking	0.66
Personal Distress	0.48

Table 1.2. indicates that the overall reliability of the IRI is 0.59, which is a low reliability. The internal consistencies of the subscales are Fantasy (0.74), Empathic Concern (0.62), Perspective Taking (0.66) and Personal Distress (0.48), which are all low to adequate levels of reliability (Rosenthal & Rosnow, 1991).

6.2.3. The Level of Exposure Checklist:

Table 1.3. Cronbach alpha coefficient for the Level of Exposure Checklist:

Cronbach Alpha	
Level of Exposure	0.85

Table 1.3. indicates that the reliability of the Level of Exposure Checklist is 0.85, which is a high level of reliability.

6.2.4. The Affect Intensity Measure:

Table 1.4. Cronbach alpha coefficient for the Affect Intensity Measure:

Cronbach Alpha	
Affect Intensity	0.90

Table 1.4. indicates that the reliability of the Affect Intensity Measure is 0.90, which is a high level of reliability.

6.3. Descriptive Statistics:

This section will provide a summary of the descriptive statistics as derived from the demographic questionnaire. The following descriptive statistics are used in this study: frequencies, percentages, means (the average of a set of scores), standard deviations (an indicator of the variability of a set of data around the mean value in a distribution), and minimum and maximum scores (the smallest and largest score that the sample obtained) (Rosenthal & Rosnow, 1991).

6.3.1. The Sample:

Table 2.1. Gender of the Sample:

	Number	Percentage
Males	15	25
Females	45	75

The participants comprised of both males (n=15) and females (n=45). The number of males comprised only one quarter of the sample (25%) and females comprised three quarters of the sample (75%). but this grouping is still representative as there is generally a higher number of females involved in the counselling profession.

Table 2.2. Age of the Sample:

Age group (years)	Frequency	Percent
20-30	19	31.67
31-35	15	25
36-40	9	15
40+	17	28.33

Results indicate that the largest age range is between 20-30 years and older than 40 years. The smallest group of counsellors is in the 36-40 years age range. This is also representative of an EAP setting as many counsellors work as EAP counsellors after completion of their studies and after working for many years as private practitioners.

Table 2.3. Length of service at the organization:

Length of service	Frequency	Percent
0-6 months	11	18.33
7 months-1 year	17	28.33
1.1 years-2 years	15	25
2.1 years +	17	28.33

The results indicate that 53.33 % of the sample has worked at the organization for more than 1 year.

Table 2.4. Work Status:

Work Status	Frequency	Percent
Full Time	48	80
Part Time	12	20

80 % of the sample worked at the organization on a full time basis and 20% of the sample worked at the organization on a part time basis.

Table 2.5. Length of service experience as a counsellor:

Length of service (years)	Frequency	Percent
0-2	7	11.86
2.1-5	23	38.98
6-10	8	13.56
11+	21	35.59

The results indicate that the majority of the sample has worked between 2-5 years as counsellors. However, overall the sample is almost equally divided between those counsellors that had 0-5 years of experience and those that had 6 years and more experience.

Table 2.6. Exposure to previous personal trauma:

	Frequency	Percent
Yes	44	73.33
No	16	26.67

The table indicates that 73.33 % of trauma counsellors at the EAP organization have had previous exposure to personal trauma, whilst 26.67 % of trauma counsellors did not have exposure to previous personal trauma.

Table 2.7. Nature of personal trauma experienced by counsellors:

Type of Trauma	Frequency	Percent
Death	12	27.91
Motor Vehicle Accidents	8	18.60
Hijacking	6	13.95
Robbery	6	13.95
Assault	2	4.65
Relationship Issues	2	4.65
Medical	2	4.65

The table reveals that the counsellors experienced a range of traumatic incidents in their personal lives. There are also a number of other incidents which are not specifically trauma related, but lean more towards stress and adjustment issues (such as death, relationship issues and medical).

Table 2.8. The average number of hours of direct contact with traumatised clients:

Number of hours	Frequency	Percent
0-5	28	56
5.5-10	15	26.79
Above 10	13	23.21

Frequency Missing = 4

56 % of the sample has 0-5 hours of direct contact weekly with traumatised clients, 26.79 % of the sample has 5.5-10 hours of direct contact and only 23.21 % of the sample has more has 10 hours of direct contact.

Table 2.9. The average number of hours of indirect contact with traumatised clients:

Number of hours	Frequency	Percent
0-5	40	71.43
5.5-10	6	10.71
Above 10	10	17.86

Frequency Missing = 4

71.43 % of the sample has between 0-5 hours of indirect contact with traumatic exposure and 17.86 % of the sample has over 10 hours of indirect exposure to traumatic exposure weekly.

Table 2.10. The average number of hours a week on general counselling:

Number of hours	Frequency	Percent
0-10	23	41.07
10-30	21	37.5
Above 30	12	21.43

Frequency Missing = 4

41.07 % of the sample spends 0-10 hours a week on general counselling, 37.5 % of the sample spend 10-30 hours on general counselling and 21.43 % of the sample spends more than 30 hours a week on general counselling. From the table it is apparent that these EAP counsellors invest many hours a week on general counselling issues, other than traumatic experiences.

6.3.2. Means, Standard Deviations and Minimum and Maximum Scores for the Measures used:

Table 3: Means, Standard Deviations and Minimum and Maximum Scores:

Variable	N	Mean	Standard Deviation	Minimum	Maximum
CF	60	24.5	13.21	0	60
IRI	60	55	7.86	39	78.57
AIM	60	54	11.32	32.5	84

Table 3 indicates that the minimum score for the CF scale was 0 and the maximum score was 60. The mean score was 24.5 while the standard deviation was 13.21. The minimum score for the IRI was 39 and the maximum score was 78.57. The mean was 55 with a standard deviation of 7.86. The average score for the AIM was 54 with a standard deviation of 11.32. The minimum score was 32.5 and the maximum score was 84.

6.4. Scoring of the Scales:

6.4.1. Levels of Compassion Fatigue:

In order to obtain a general sense of the level of compassion fatigue experienced by the sample group, table 4.1. reflects the frequency and percentage of the participants' level of compassion fatigue.

Table 4.1. Levels of Compassion Fatigue as measured by the Compassion Fatigue Scale:

Compassion Fatigue		
	Frequency	Percentage
Extremely low risk	35	58.33
Low risk	8	13.33
Moderate risk	6	10.00
High risk	7	11.67
Extremely high risk	4	6.67

Table 4.1. indicates that 28.34 % of the sample met the criteria for compassion fatigue, that is, they had scores between moderate to extremely high risk (Stamm & Figley, 1996). However, the majority of trauma counsellors displayed relatively low scores on the compassion fatigue subscale (71.67 %).

6.4.2. Levels of Empathy:

In order to obtain a general sense of the level of empathy experienced by the sample group, Table 4.2. reflects the participants' level of empathy.

Table 4.2. Levels of Empathy as measured by the Interpersonal Reactivity Index:

Empathy	Frequency	Percent
<=50	16	26.67
Between 51 and 56.69	14	23.33
Between 56.7 and 59.8	12	20.00
Above 59.8	18	30.00

Table 4.2. indicates that the 50 % of the sample has moderate to high levels of empathy.

6.4.3. Levels of Exposure to traumatic material and the intensity of impact:

In order to obtain a general sense of the level of exposure to traumatic material and the intensity of impact experienced by the sample group, Table 4.3. reflects the participants' level of exposure and intensity of impact over a 3 month period.

Table 4.3. Levels of Exposure to traumatic material and the intensity of impact as measured by the Level of Exposure Checklist:

Types of Trauma	Frequency	Percent	Mean Intensity of Emotional Impact
Hijacking/Carjacking	56	93.33	3.13
Common Robbery (taking or attempting to take anything of value from another by force or threat of force)	53	88.33	2.67
Robbery with aggravated circumstances (taking or attempting to take anything of value from another by violence or putting the victim in fear)	49	81.67	3.28
Domestic Violence	49	81.67	3.27
Burglary	44	73.33	2.80
Road accidents	44	73.33	2.76
Smash and Grab	37	61.67	2.64
Mugging	32	53.33	2.50
Rape	32	53.33	3.90
Indecent assault (any unwanted sexual behaviour)	25	41.67	3.30
Child Molestation	21	35.00	3.67
Assault with the intent to inflict grievous bodily harm	20	33.33	3.11
Common Assault (unlawful attack by one person upon another)	20	33.33	2.44
Murder	17	28.33	3.73
Kidnapping/abduction	12	20.00	3.50
Natural disasters	11	18.33	2.17
Road rage	11	18.33	2.44
Attempted Murder	7	11.67	3.40
Mining accidents	4	6.67	2.00

Table 4.3. results indicate that the sample had high exposure to hijackings, common robbery, robbery with aggravated circumstances, domestic violence, burglary and road accidents. The intensity of emotional impact appears to range between low to moderate (2.00 – 3.90).

6.4.4. Levels of Affect Intensity:

Table 4.4. Levels of Affect Intensity as measured by the Affect Intensity Measure:

In order to obtain a general sense of the level of Affect Intensity experienced by the sample group, Table 4.4. reflects the participants' level of affect intensity.

Affect Intensity	Frequency	Percent
<=45.5	16	26.67
Between 45.6 and 53.5	15	25.00
Between 53.6 and 59.74	14	23.33
Above 59.74	15	25.00

Table 4.4. indicates that 51.67 % of the sample experiences low to moderate levels of affect intensity and 48.33 % of participants experience moderate to high levels of affect intensity.

6.5. Statistical Analyses relating to Hypotheses:

6.5.1. Hypothesis One: An increased level of exposure to traumatic material as measured by the Exposure Checklist is associated with increased levels of compassion fatigue as measured by the Compassion Fatigue Self-Test.

In order to investigate the above hypothesis, Pearsons Correlation was conducted, with the participants caseload and intensity of emotional impact representing the total level of exposure (independent variable) and the compassion fatigue score representing the level of compassion fatigue (dependant variable). The following equation was used to calculate the total exposure:

$$\text{Tot Exp} = N_1\text{Ex}_1*\text{In-Ex}_1+N_2\text{Ex}_2*\text{In-Ex}_2\ldots+N_{19}\text{Ex}_{19}*\text{In-Ex}_{19}$$

The number of cases was multiplied by the intensity of emotional impact for each trauma listed on the checklist.

Table 5.1. Correlation between Exposure as measured by the Level of Exposure checklist and Compassion Fatigue as measured by the Compassion Fatigue Self Test.

Pearson Correlation Coefficient	
Prob>/r/ under H0: Rho=0	
	Exposure
Compassion Fatigue	0.2*

*p<0.06

Results from Table 5.1. indicate there is a significant correlation between Level of Exposure to traumatic material and Compassion Fatigue at a 0.06 significance level, that is, p<0.06.

6.5.2. Hypothesis Two: An increased level of empathy as measured by The Interpersonal Reactivity Index is associated with increased levels of compassion fatigue as measured by the Compassion Fatigue Self-Test.

In order to investigate the above hypothesis, Pearsons Correlation was conducted between scores on the IRI (independent variable) and scores on the Compassion Fatigue Self Test.

Table 5.2. Correlation between Empathy as measured by the Interpersonal Reactivity Index and Compassion Fatigue as measured by the Compassion Fatigue Self Test.

Pearson Correlation Coefficient	
Prob>/r/ under H0: Rho=0	
	CF
IRI	0.29*
FS	0.4*
EC	-0.08
PT	-0.36*
PD	0.5*

*p<0.05

Results from Table 5.2. indicate there is there is a weak significant correlation between levels of empathy and Compassion Fatigue, that is, a higher level of empathy was associated with higher levels of compassion fatigue. There is a strong significant relationship between the Fantasy Scale and Compassion Fatigue. There is

no significant relationship between Empathic Concern and Compassion fatigue which is interesting to note. There is a negative correlation between Perspective Taking and Compassion Fatigue. This is a possible indicator that the higher the Perspective Taking ability of the counsellor, then it is less likely for the counsellor to experience compassion fatigue. There is a strong relationship between Personal Distress and Compassion Fatigue which indicates that the higher the Personal Distress of the counsellor, then the greater probability that compassion fatigue exists.

6.5.3. Hypothesis Three: An increased level of affect intensity as measured by the Affect Intensity Measure is associated with increased levels of compassion fatigue as measured by the Compassion Fatigue Self-Test.

In order to test the above hypothesis, Pearsons Correlation was conducted between scores on the AIM (independent variable) and scores on the Compassion Fatigue Self Test.

Table 5.3. Correlation between Affect Intensity as measured by the Affect Intensity Measure and Compassion Fatigue as measured by the Compassion Fatigue Self Test.

Pearson Correlation Coefficient	
Prob>/r/ under H0: Rho=0	
	AIM
Compassion Fatigue	0.1

*p<0.05

Results from Table 5.3. indicate there is no significant correlation between Affect Intensity and Compassion Fatigue. However, there is a significant correlation between Affect Intensity and Empathy as can be seen below.

Table 5.4. Correlation between Affect Intensity as measured by the Affect Intensity Measure and Empathy as measured by the Interpersonal Reactivity Index

Pearson Correlation Coefficient	
Prob>/r/ under H0: Rho=0	
	AIM
Empathy	0.3*
EC	0.2*

* p<0.05

Table 5.4. indicates that there is a significant correlation between Affect Intensity and Empathy. There is also a correlation between the subscale EC and Affect Intensity.

6.5.4. Hypothesis Four: There is an interrelationship between levels of compassion fatigue, level of exposure, empathy and affect intensity in a sample of trauma counsellors within an EAP.

To determine the interrelationship between the variables a Stepwise Regression was conducted with the subscales of empathy, that is, Fantasy Scale, Perspective Taking and Personal Distress and Levels of Exposure. These variables had significant correlations with compassion fatigue.

Table 5.5. Empathy Moderating the effects for Compassion Fatigue

Parameter Estimates				
Variable	DF	Parameter Estimate	Standard Error	t Value
Intercept	1	10.93	8.38	1.30
FS	1	0.27	0.05	4.62*
PT	1	-0.21	0.09	-2.31*
PD	1	0.36	0.09	3.75*
Exposure	1	0.02	0.009	2.41*

*p<0.05

Table 5.5. shows that the Fantasy Scale, Perspective Taking and Personal Distress subscales of empathy moderate the relationship between exposure and compassion fatigue at a 5% significance level. From the table, it is apparent that the higher the Fantasy empathy of the counsellor, then the possibility of Compassion Fatigue existing is higher. There is a negative correlation between Perspective Taking and Compassion fatigue, which indicates that the lower the Perspective Taking abilities of the counsellor then the higher the possibility of Compassion Fatigue existing and the higher the perspective taking abilities of the counsellor, then the lower the compassion fatigue. The table indicates that the higher the Personal Distress of the counsellor then the higher the possibility of Compassion Fatigue. The results also reveal that the greater exposure the counsellors have to traumatic material, then the higher the likelihood that Compassion Fatigue exists.

Table 5.5.1. Strength of the Regression:

Root MSE	8.43	R-Square	0.56
Dependent Mean	24.49	Adj R-Sq	0.5
Coeff Var	34.44		

The strength of the regression as illustrated by the above table is 56 % which is representative of strong strength.

6.6. Additional Results:

6.6.1. T-Tests:

Table 6.1. T-Tests for Gender:

Variable	Variances Equal/Unequal	DF	t Value	Significance Pr>/0.05/
Compassion	Equal	58	0.43	0.66
	Unequal	16.6	0.32	0.75
Empathy	Equal	58	-2.18	0.03
	Unequal	20.6	-1.97	0.06
Level of Exposure	Equal	52	0.45	0.65
	Unequal	12.5	0.31	0.75
Affect Intensity	Equal	58	-1.64	0.10
	Unequal	25	-1.68	0.10

Table 6.1. indicates that there are no significant differences between males and females on any of the scales.

Table 6.2. T-Tests for Work Status:

Variable	Variances Equal/Unequal	DF	t Value	Significance Pr</0.05/
Compassion	Equal	58	2.15	0.03*
Fatigue	Unequal	19.5	2.38	0.02*
Empathy	Equal	58	0.77	0.4
	Unequal	16.3	0.74	0.4
Level of	Equal	52	0.45	0.65
Exposure	Unequal	12.5	0.31	0.75
Affect	Equal	58	-0.18	0.8
Intensity	Unequal	15.8	-0.18	0.8

*p<0.05

Table 6.2. indicates that there is a significant difference in levels of compassion fatigue between full time and part time participants with full time participants experiencing higher levels of compassion fatigue.

Table 6.3. T-Test for Exposure to Personal Trauma:

Variable	Variances Equal/Unequal	DF	t Value	Significance Pr>/0.05/
Compassion Fatigue	Equal	58	2.20	0.03*
	Unequal	29.9	2.33	0.02*
Empathy	Equal	58	0.29	0.8
	Unequal	27.6	0.30	0.7
Level of Exposure	Equal	52	1.75	0.08
	Unequal	35.2	2.14	0.03
Affect Intensity	Equal	58	-0.71	0.4
	Unequal	25.8	-0.70	0.4

*p<0.05

Table 6.3. indicates that there is a significant difference in levels of compassion fatigue between those participants who had experienced personal trauma and those that had not, with those participants who had experienced personal trauma having higher levels of compassion fatigue.

6.6.2. ANOVA's

Table 7.1. ANOVA for Age:

Variable	Sum of Squares	DF	Mean Square	F Value	Significance
Compassion Fatigue	490	3	163	0.93	0.43
Empathy	157	3	52	0.84	0.4
Level of Exposure	69084	3	23028	1.66	0.18
Affect Intensity	105	3	35.3	0.27	0.8

Table 7.1. shows no significant differences in the effect of age on the variables.

Table 7.2. ANOVA for Length of Service at the Organisation:

Variable	Sum of Squares	DF	Mean Square	F Value	Significance
Compassion Fatigue	1271	3	423	2.63	0.059
Empathy	14	3	4.79	0.07	0.9
FS	1077	3	359	0.96	0.4
EC	665	3	221	1.14	0.34
PT	1566	3	522	3.02	0.03*
PD	599	3	199	1.10	0.3
Level of Exposure	58798	3	19599	1.39	0.2
Affect Intensity	488	3	162	1.29	0.28

*p<0.05

Table 7.2. shows no significant differences in the effect of length of service at the organization on the variables, except for the subscale Perspective Taking. It appears that the shorter the length of service at the organization, then the higher the Perspective Taking.

Table 7.3. ANOVA for Experience as a Counsellor:

Variable	Sum of Squares	DF	Mean Square	F Value	Significance
Compassion	232	3	77.6	0.43	0.73
Fatigue					
Empathy	620	3	206	3.78	0.01*
FS	1564	3	521	1.40	0.25
EC	873	3	291	1.51	0.2
PT	1497	3	499	2.82	0.04*
PD	480	3	160	0.86	0.4
Level and intensity of Exposure	122906	3	40968	3.18	0.03*
Affect Intensity	805	3	268	2.20	0.09

*p<0.05

Table 7.3. indicates that there is a significant difference in the effect of experience as a counsellor on empathy and on the subscale Perspective Taking. It seems as though those counsellors with less experience as counsellors display higher levels of empathy and have higher Perspective Taking abilities. There is also a significant difference in the effect of experience as a counsellor on the intensity of exposure experienced, that is, the more experience the counsellor has, then the less the impact of intensity of exposure on the counsellor.

6.7. Concluding Comments:

The study examined the relationships between the level of exposure and compassion fatigue, the level of empathy and compassion fatigue and affect intensity and compassion fatigue.

The following is a brief summary of the findings:

Hypothesis One: There was a significant correlation between Level of Exposure to traumatic material and Compassion Fatigue at a 6% significance level.

Hypothesis Two: There was a weak significant correlation between levels of empathy and Compassion Fatigue. There was specifically a strong significant relationship between the Fantasy Scale and Compassion Fatigue. There was a negative correlation between Perspective Taking and Compassion Fatigue. This may indicate that the higher the Perspective Taking abilities the counsellor had, then it was less likely for that counsellor to experience compassion fatigue. There was a strong relationship between Personal Distress and Compassion Fatigue which indicates that the higher the Personal Distress, then the greater probability of compassion fatigue being experienced by the counsellor.

Hypothesis Three: There was no significant correlation between Affect Intensity and Compassion Fatigue. However, there was a significant correlation between Affect Intensity and Empathy. There was also a correlation between the subscale Empathic Concern and Affect Intensity.

Hypothesis Four: The Fantasy Scale, Perspective Taking and Personal Distress subscales of empathy moderate the relationship between exposure and compassion fatigue at a 5% significance level.

The results will be discussed in the following chapter.

CHAPTER 7: DISCUSSION:

7.1. Introduction:

Many companies contract with Employee Assistance Programme (EAP) providers to provide counselling to their employees, and the need for trauma counsellors in this environment has become crucial. These professional counsellors of the EAP are often the first mental health professionals to be exposed to a client's traumatic story through initial assessment and short term counselling. Consequently, such professional counsellors may be vulnerable to compassion fatigue and the current study therefore proposed to make this population the focus of the study.

Hence, this study aimed to determine the relationship between level of exposure to traumatic material and level of compassion fatigue, empathy and levels of compassion fatigue, and affect intensity and level of compassion fatigue in a sample of trauma counsellors within an EAP organization. This study also attempted to explore the interrelationships between these variables.

This chapter discusses the analysis of the results in the same order as presented in the Results chapter, describes the limitations of the study, provides recommendations for future research and finally presents the conclusion.

7.2. Reliabilities of the Measuring Instruments:

0.60 is regarded to be an adequate level of reliability (Rosenthal & Rosnow, 1991). The reliability for the Compassion Fatigue Self Test, the Level of Exposure Checklist and the Affect Intensity Measure all have good levels which are above 0.60. These findings are consistent with past research (Ortlepp & Friedman, 2001; Wilson 1998; Keltner & Ekman, 1996). However, the Interpersonal Reactivity Index had an overall score of 0.59. The reliability of the Fantasy Scale, Empathic Concern and

Perspective Taking subscales were of good levels. The Personal Distress subscale had a score of 0.48 which implies that the counsellors answered the items on this subscale very differently to each other. A study conducted by Miville, Carlozzi, Gushue, Schara and Ueda (2006) also obtained low to adequate scores for the subscales of the Interpersonal Reactivity Index. However, other previous studies such as McRitchie (2006) and Vachon (1993) acquired good reliability levels for this scale. Therefore, it can be argued that the participants for the current study understood and answered the questions assessing Personal Distress very differently to one another. A possible explanation is that they did not want to acknowledge being emotionally distressed.

7.3. Descriptive Statistics:

Descriptive statistics were provided to describe, classify and summarize the quantitative data. They were used to indicate the levels of compassion fatigue, empathy, exposure to traumatic material and the intensity of impact and affect intensity.

7.3.1. The Sample:

The participants comprised of males (n=15) and females (n=45), but this grouping is still representative as there is generally a higher number of females involved in the counselling profession. The largest age range was between 20-30 years and older than 40 years. The smallest group of counsellors was in the 36-40 years age range. This is also representative of an EAP setting as many counsellors work as EAP counsellors after completion of their studies and after working for many years as private practitioners. 80 % of the sample worked at the organization on a full time basis and 20% of the sample worked at the organization on a part time basis. Therefore, this 20% of the sample may have either been exposed to traumatic material in other work contexts or may not have been exposed to any other traumatic

material at all. The majority of the sample had between 2-5 years experience as counsellors. However, overall the sample was almost equally divided between those counsellors that had 0-5 years of experience and those that had 6 years and more experience. 73.33 % of trauma counsellors at the EAP organization had previous exposure to personal trauma. Pearlman and MacIan (1993) posited that counsellor's personal history of trauma was a risk factor for PTSD symptoms. 56 % of the sample had 0-5 hours of direct contact weekly with traumatised clients. 41.07 % of the sample spent 0-10 hours a week on general counselling, 37.5 % of the sample spent 10-30 hours on general counselling and 21.43 % of the sample spent more than 30 hours a week on general counselling. It is apparent that these EAP counsellors invest many hours a week on general counselling issues, other than traumatic experiences.

7.3.2. Levels of Compassion Fatigue:

According to Stamm & Figley's (1996) criteria for risk of compassion fatigue, 28.34% of the sample fell within the range for compassion fatigue. Figley (1999) stated that individuals can be traumatised without actually being physically harmed or threatened with harm. He asserted that merely knowing about a traumatic event carries traumatic potential and it is evident even in this sample of EAP counsellors. This was expected as Jacobson (2005) conducted research which assessed the prevalence and severity of compassion fatigue among EAP counsellors and results indicated that EAP counsellors on average reported experiencing moderate levels of risk for compassion fatigue. The majority of trauma counsellors in this study, 71.67%, however, displayed relatively low scores on the compassion fatigue subscale. This may be as a result of a large proportion of the counsellors (46.67 %) working at the organisation for less than one year and that 20% of the counsellors worked on a part time basis. Furthermore, 56% of the counsellors had only 0-5 hours of direct contact with traumatised clients as a large proportion of their time was utilised on general counselling, other than on trauma related material.

7.3.3. Levels of Empathy:

The results indicate that 50 % of the sample had moderate to high levels of empathy. Empathy is a vital characteristic of counsellors, as with empathic understanding, the barriers are reduced between two individuals, allowing them to reveal themselves more fully. The counsellor can see the client as he is to himself and accept the client as having preconceptions and feelings. The same would occur for the client. Therefore, empathic understanding serves to create a safety in the relationship (Rogers, 1961). Many professionals continue to regard empathy as a core component of effective counselling (McLeod, 1999). Pope and Kline (1999) found that counsellors listed empathy among the top five personal characteristics of mental health counsellors. Figley (1995) espouses that empathy is associated with a number of positive qualities which influence individuals to work in the helping professions. Hence, it is only appropriate that the sample had moderate to high levels of empathy given that it is a counsellor population. However, the levels of empathy may have a bearing on variables such as compassion fatigue, whereby higher levels of empathy may lead to higher risk for compassion fatigue.

7.3.4. Levels of Exposure to traumatic material and the intensity of impact:

The results indicated that the sample had high exposure to hijackings (93.33%), common robbery (88.33%), robbery with aggravated circumstances (81.67%), domestic violence (81.67%), burglary (73.33%) and road accidents (73.33%) as counsellors. These figures are consistent with the current levels of violence within the South African society. The intensity of emotional impact appeared to range between low to moderate (2.00 – 3.90). This is understandable as trauma in South Africa is a common phenomenon and many individuals may react with less intensity.

Furthermore, results indicated that 73.33 % of the sample had been exposed to previous personal trauma. The type of trauma that they were exposed to consisted of

death, motor vehicle accidents, hijacking, robbery, assault, relationship issues and medical problems. Figley (1995) asserted that trauma counsellors who are survivors from previous traumatic events may have unresolved traumatic conflicts and their issues may be aroused due to their experiences with their clients. In this study, the traumatic incidents experienced by the counsellors in their personal lives were similar to the traumatic experiences of the clients, thus increasing the probability of compassion fatigue. McRitchie (2006) also found in her study that counsellors who had been victims of previous personal trauma scored higher on the compassion fatigue scales than those who had not been victims. Therefore, it would seem likely that the levels of exposure to personal trauma and the intensity of impact would have an effect on the levels of compassion fatigue.

7.3.5. Levels of Affect Intensity:

The results indicated that 51.67 % of the sample experienced low to moderate levels of affect intensity and 48.33 % of participants experienced moderate to high levels of affect intensity. Larsen, Diener and Emmons (1986) reported that individuals with high affect intensity tend to be more active, they are higher in sociability, are more reactive and physically arousable. There is no known literature of the distribution of high and low affect intensity individuals in the general population. However, it may be possible to assume that there is an even spread. Therefore the sample having an almost even split between high and low affect intensity individuals would be representative of the general population.

According to Moore and Harris (1996), individuals with high affect intensity tend to express dislike or avoidance of intense negative emotional stimuli and would be expected to have significantly stronger negative attitudes when exposed to negative stimuli. Therefore, it would be logical to assume that high affect intensity individuals would have a greater vulnerability to compassion fatigue than low affect intensity individuals.

7.4. Statistical Analyses Relating to Hypotheses:

7.4.1. Hypothesis One: An increased level of exposure to traumatic material as measured by the Exposure Checklist is associated with increased levels of compassion fatigue as measured by the Compassion Fatigue Self-Test.

According to Figley (1995), compassion fatigue is a consequence of prolonged exposure to traumatic material and the ensuing traumatic recollections provoked by this exposure. Schauben and Frazier (1995) also found that the greater the number of trauma cases reported in a counsellor's caseload, then a greater number of PTSD symptoms were reported.

Results from the current study indicated there was a significant correlation between Level of Exposure to traumatic material and intensity of impact (0.2) and Compassion Fatigue at a 0.06 significance level, that is, $p < 0.06$.

These results are supported by previous studies such as Figley (1995) and others (Jenkins & Baird, 2002, & Schauben & Frazier, 1995) who have assumed a causal relationship from exposure to psychologically traumatised clients to compassion fatigue. Boscarino, Figley and Adams (2004) and Chrestman (1995) have proposed that psychologically distressed professionals may also develop compassion fatigue-like symptoms due to personally experienced trauma as well as from the number of interactions and the type of trauma cases that counsellors experience with clients. 73.33 % of the sample had been exposed to previous personal trauma. The results have indicated that there was a correlation between personal exposure to trauma and compassion fatigue. However, the correlation is quite weak (0.03) suggesting the role of other factors. These results will be discussed in further detail later in this chapter.

7.4.2. Hypothesis Two: An increased level of empathy as measured by The Interpersonal Reactivity Index is associated with increased levels of compassion fatigue as measured by the Compassion Fatigue Self-Test.

Empathy is regarded as one of the essential skills enabling health professionals to connect with and work effectively with clients (Pope & Kline, 1999). However, this skill also potentially places them at risk of developing maladaptive responses to the trauma of others. Studies on compassion fatigue propose that empathy is a key factor in the induction of traumatic material from the primary to the secondary “victim” (Figley, 1995). Cherniss (1980) posits that the characteristics which draws individuals to the helping professions and make them initially successful in their careers may subsequently become a source of stress. The process of empathising with a traumatised individual helps the counsellor understand the client’s traumatic experiences, but the counsellor may also become traumatised in the process (Figley, 1995).

The correlation analysis indicated that there was a weak significant correlation between levels of empathy and Compassion Fatigue (0.29), that is, a higher level of empathy may point to higher levels of compassion fatigue. McRitchie (2006) explored the relationship between empathy and compassion fatigue among trauma workers and found that there was also a moderate positive relationship between empathy and compassion fatigue with this population group. She proposed that the higher the individual’s level of empathy, the more susceptible the individual is to developing compassion fatigue (McRitchie, 2006).

In a study which explored the relationship between empathy and burnout in a sample of nurses, social workers and teachers, Williams (1989) found that the Fantasy Scale correlated significantly with emotional exhaustion. His conclusion was that the study added support to the position that empathy in helping professionals can make them vulnerable to burnout.

One of the major findings of Vachon's (1993) study was that individual differences in Fantasy, Perspective Taking, Empathic Concern and the ability to maintain emotional separation from others function as moderator variables influencing the relationship between nursing stress and level of burnout. Perspective taking was found to moderate the amount of depersonalization that nurses felt towards their patients.

In the current study, there was a strong significant relationship between the Fantasy Scale and Compassion Fatigue (0.4). There was also a strong relationship between Personal Distress and Compassion Fatigue (0.5) which indicates that the higher the Personal Distress of the counsellor, then the greater probability of compassion fatigue exists. Vachon (1993) found that higher levels of fantasy empathy and the tendency to be personally distressed were associated with increased emotional, physical and mental exhaustion among nurses. These findings would be relevant to the current study due to the traumatic nature of the workload of the counsellors.

There was a negative correlation between Perspective Taking and Compassion Fatigue (-0.36). This was a possible indicator that the higher the Perspective Taking ability of the counsellor, then it was less likely for the counsellor to experience compassion fatigue. The Perspective Taking subscale has statements such as "I try to look at everybody's side of a disagreement before I make a decision" and "Before criticizing somebody, I try to imagine how I would feel if I were in their place". Counsellors are generally chosen to enter their profession because they are open-minded, non-judgmental and empathic. Their Perspective Taking abilities would therefore be high. The EAP has a high percentage of young counsellors and this may account for the high perspective taking abilities. When these counsellors feel that they are not coping with the traumatic nature of their work, they probably leave the organisation and more counsellors are sourced. The EAP also has a high percentage of older counsellors and these counsellors may have adapted to exposure to traumatic material or personal characteristics may be a key factor in them remaining at the organisation. Vachon (1993) discovered in his study that higher levels of Perspective Taking were related to lower levels of exhaustion among nurses.

There was no significant relationship between Empathic Concern and compassion fatigue (-0.08) which is interesting to note. Items which tap into this subscale make statements such as “I often have tender, concerned feelings for people less fortunate than me” and “I am often quite touched by things that I see happen”. Due to the nature of the training of these professional counsellors, they may hold boundaries that do not allow for these kinds of sentiments and they may not admit their true feelings regarding these statements. Furthermore, general non-specific empathic concern may not be related to compassion fatigue and compassion fatigue may be linked to more specific experiences with clients. Therefore, these statements may not accurately reflect the emotional processes of the counsellors, thus accounting for the lack of a significant relationship between Empathic Concern and Compassion Fatigue. However, Vachon (1993) also noted that although empathic concern was not related to exhaustion among nurses in his study, it was related to less depersonalised attitudes towards patients in a hospital environment.

Vachon (1993) noted that in his study having more of the ability to take the perspective of others was related to less emotional, mental and physical exhaustion. He indicated that it was unclear why empathic concern and perspective taking abilities would be associated with less symptoms of burnout, whereas personal distress and fantasy empathy were related to increased levels of burnout. He hypothesised that in empathic concern and perspective taking, there is a clear sense of the self separate from the client. This would be relevant to the current study as counsellors would maintain professional boundaries and attempt to cognitively separate their issues from those of their clients.

7.4.3. Hypothesis Three: An increased level of affect intensity as measured by the Affect Intensity Measure is associated with increased levels of compassion fatigue as measured by the Compassion Fatigue Self-Test.

The correlational analysis indicates that there is no significant correlation between Affect Intensity and Compassion Fatigue.

Individuals with high affect intensity tend to be regarded as having intense reactivity to emotional stimuli. Previous literature has noted that individuals classified as having high affect intensity, when faced with a positive emotion eliciting event reported stronger positive affect than individuals classified as having low affect intensity. Likewise, when these high affect intensity individuals are exposed to negative emotion eliciting events, they have reported stronger negative responses than their low affect intensity counterparts (Larsen et al, 1986). It is hypothesised that it may be difficult for such high affect intensity individuals to tolerate the experience of intense negative emotional stimulation (Moore & Harris, 1996) and would be expected to have significantly stronger negative attitudes when exposed to negative emotional stimuli. This would have important implications for counsellors as they may exaggerate the emotional states of their clients thereby leading to symptoms of compassion fatigue. However, only 48.33 % of the sample experienced moderate to high levels of affect intensity and this may account for there not being a significant correlation between affect intensity and compassion fatigue.

No other study has been done investigating the role of affect intensity in compassion fatigue. However, in a study conducted by Vachon (1993), affect intensity did not correlate with most measures of burnout, but did influence how other variables were related to burnout. This is seen below.

7.4.4. Additional Correlation: There is a significant correlation between Affect Intensity and Empathy.

A tendency to experience emotions intensely in conjunction with a high degree of empathy may be a liability when working with a client. However, Squier (1990) posits that affective involvement and empathy is necessary as it has been found to help patients recover or cope adaptively in a hospital setting.

A study conducted by Larsen, Diener and Cropanzano (1987) found that high affect intensity subjects made more empathic ratings and added more to a scene in terms of fantasy elaboration than low affect intensity individuals.

Vachon (1993) found in his study that affect intensity appeared to increase the respective positive or negative effects of the empathy variables relationships with the exhaustion component of burnout. Affect intensity was found to correlate positively with the more affective subscales of the IRI and negatively with the more cognitive Perspective Taking subscale. In the present study, there is also a correlation between the subscale EC and Affect Intensity.

As affect intensity is related to the perception of emotional stimuli and is also related to the tendency to exaggerate the emotional states of others (Larsen, Diener & Cropanzano, 1987), it follows that affect intensity would make the empathic experiences of the counsellor's negative feelings more emotionally overwhelming and therefore more likely to lead to symptoms of compassion fatigue. Therefore, although there is no direct relationship to compassion fatigue, affect intensity has an amplifying effect on the empathic abilities of the counsellors which may lead to compassion fatigue.

7.4.5. Hypothesis Four: There is an interrelationship between levels of compassion fatigue, level of exposure, empathy and affect intensity in a sample of trauma counsellors within an EAP.

A Stepwise Regression was conducted with exposure and the subscales of empathy, that is, Fantasy Scale, Perspective Taking and Personal Distress. From the table, it is apparent that the higher the Fantasy empathy of the counsellor, then the possibility of Compassion Fatigue existing is higher. There was a negative correlation between Perspective Taking and Compassion fatigue, which indicated that the lower the Perspective Taking abilities of the counsellor then the higher the possibility of Compassion Fatigue existing and the higher the perspective taking abilities of the

counsellor, then the lower the compassion fatigue. The results indicated that the higher the Personal Distress of the counsellor then the higher the possibility of Compassion Fatigue. The results also revealed that the greater exposure the counsellors have to traumatic material, then the likelihood of Compassion Fatigue existing is also higher.

The level of exposure was correlated with the empathy scales (Fantasy, Perspective Taking and Personal Distress) and 56% of compassion fatigue may be explained by a combination of these four variables. Therefore, it was seen that level of exposure and empathy together had a strong impact on compassion fatigue. Empathy did not holistically influence compassion fatigue, but there were specific aspects of empathy which were important in the development of compassion fatigue. These subscales of empathy offered value to the existence of compassion fatigue independent of each other.

This Fantasy Scale was not equated to Figley's Fantasy scale, but still had a correlation with Compassion Fatigue. . According to Vachon (1993), with personal distress and fantasy empathy there was some loss of oneself into the experience of the client. Perhaps, in the current study, these correlations reflect the extent to which the counsellor was able to maintain boundaries between themselves and the clients' personal experiences. The less they were able to do this (as reflected by higher measures on the Fantasy Scale and Personal Distress and lower levels of Perspective Taking) then the higher the levels of compassion fatigue. Perspective taking is the cognitive component of the empathy scale and the ability of the counsellors to process information and make sound judgments will lead to lower levels of compassion fatigue.

7.5. Discussion of Additional Results:

The results indicate there was a significant difference in levels of compassion fatigue between full time and part time participants. This was not surprising as literature has reflected that higher traumatic caseloads could lead to symptoms of compassion fatigue. Figley (1995) has espoused that compassion fatigue is a consequence from prolonged exposure to traumatic material and Schauben and Frazier (1995) also found that the greater the number of trauma cases reported in a counsellor's caseload, then the higher the number of PTSD symptoms reported.

There was a significant difference in levels of compassion fatigue between those participants who had experienced personal trauma and those that had not. Personal trauma history has been well documented in the literature to be significantly related to the experience of compassion fatigue (Kassam-Adams, 1995; Pearlman & Ma Ian, 1995; Figley, 1995). Personal trauma has been considered by some to be more harmful to the counsellor's psychological well-being than work related trauma, and its effects may lead to compassion fatigue symptoms being experienced (Cerney, 1995 & Yassen, 1995).

There were no significant differences in the effect of length of service at the organization on the variables (CF, Level of Exposure, Empathy, and Affect Intensity) except for the subscale Perspective Taking. It appears that the shorter the length of service at the organization, then the higher the Perspective Taking abilities of the counsellors. Counsellors' views and judgements are not tarnished by continuous exposure to trauma and they are therefore able to adopt the point of view of other people.

There was also a significant difference in the effect of service experience as a counsellor on the intensity of exposure experienced, that is, the more experience the counsellor has, then the less the intensity of exposure on the counsellor. This may be

as a result that counsellors with more experience have been exposed to emotional events over a longer time period and have adapted to exposure to traumatic material.

7.6. Limitations of the Study:

Even though the findings in the study appear to be valid and attention was devoted to the content, methodology and statistical analyses, a number of limitations should be acknowledged. The following section will therefore describe the limitations of the study in respect to the research design, sample, data collection, measuring instruments, data analysis and model used.

7.6.1. Research Design:

The research design was correlational in nature and therefore findings are quite tentative. Cause and effect conclusions cannot be drawn among the variables (Rosenthal & Rosnow, 1991). Even though findings from the research have contributed to some extent to the field of trauma, causality cannot be inferred from the results. A longitudinal study may have produced a deeper, more meaningful level of understanding regarding compassion fatigue and the key variables identified.

The quantitative nature of the study may have had a limiting effect. The use of a multi-method approach, that is, incorporating qualitative measures would have added greater value to the research. Structured interviews would have provided meaning to the data obtained from the participants.

7.6.2. Sample:

The small sample size is acknowledged, but is acceptable given the exploratory nature of the study. However, for future studies, a larger sample size is recommended

to enhance statistical analyses. This sample size was also the result of only one EAP organisation being used for the study, the issue of convenience and the emphasis on voluntary participation. This implies that the findings of the study need to be viewed tentatively, requiring further research and investigation. Furthermore, these results may not be used to represent the larger population and generalisability is reduced.

As the sample consisted of only those participants that voluntarily completed the questionnaires, it could well be that the sample may not be representative of all the counsellors in the organization or any other EAP organization. Sample bias is a possibility as volunteers in the study may have responded differently from how those in the general population may have responded to the questions. The researcher believes that those counsellors who did not respond may have felt threatened by the nature of the questions and did not wish to think about the impact of their work on their functioning.

7.6.3. Data Collection:

Questionnaires were administered as they could be distributed to the sample in a short period of time; they could be completed anonymously, at the respondents' leisure and are generally considered to be less invasive. However, this mode of data collection also lends itself to certain limitations. Participants often tend to answer questions in what they consider to be a socially desirable manner or they tend to answer questions without serious contemplation (Rosenthal & Rosnow, 1991).

Feedback was provided to the researcher that the questionnaires were difficult to comprehend. Questionnaires were only administered in English and second language speakers indicated that they experienced difficulties understanding certain questions. Therefore, many questions may have been misunderstood and incorrectly answered or omitted.

7.6.4. Measuring Instruments:

The questionnaires comprised of self report scales and are therefore subject to problems with accuracy of reporting (Benatar, 1996). Respondents may not have been comfortable with disclosure of confidential information even though questionnaires lend a certain degree of anonymity. Furthermore, if questions are not comprehensible, then the data gathered may be compromised. The reliability score for the empathy scale indicates that the participants may not have responded to the questions with the same consistency. This flaw should be considered and prevented in future studies.

The questionnaires were Likert type scales and this method often brings in central tendency bias. Central tendency bias is the tendency of participants to select the middle response of the rating scale, rather than choosing the most correct answer for them (Howell, 1995). The researcher knew that there was a possibility of this occurring upon administration of the questionnaire, as the counsellors often work in a pressured, crisis oriented centre. However, the questionnaires were still distributed due to practical considerations as well as to provide the counsellors with some degree of freedom of expression. This could be prevented in research where questionnaires are supplemented by interviews.

According to Goldsmith and Walters (1989) research with the AIM has indicated that individuals who answer the questions on the measure are more likely to agree, to be uncritical and enthusiastic and to rate things highly which impress them. Goldsmith and Walters (1989) point out that even though the characteristics of individuals with high affect intensity are similar to these individuals, the tendency to agree all the time may confound the scores of the AIM. Therefore, supplementary interviews may provide additional information.

7.6.5. Data Analysis:

Previous exposure to trauma has been explicated in the literature as having a key role in the development of compassion fatigue. Although the study factored this element into the demographic questionnaire, it failed to pay this variable greater attention in the broader analysis. Its interrelationship with compassion fatigue, empathy and affect intensity was not considered.

The work status of the counsellors should have been considered in greater detail. The study should have examined whether full time or part time counsellors experienced higher levels of compassion fatigue and the interrelationship with empathy and affect intensity.

The main results of the study were gained from correlational designs, which imply that causality cannot be inferred.

7.6.6. The Revised Model for Trauma Counsellors:

A variety of factors have been identified as influencing responses to traumatic incidents (Durrant, 1999; McCann & Pearlman, 1990). This revised model has adopted this view and endorsed that there are indeed a number of personal and environmental variables which may influence the development of compassion fatigue. However, this study only explored the influence of empathy and affect intensity on the levels of compassion fatigue. Hence, the roles of other personal and environmental factors have been minimized. However, no study can be exhaustive in ensuring the inclusion of all variables and the current study examined two variables which the researcher considered to be important in the development of compassion fatigue.

7.7. Recommendations for Future Research:

It is recommended for future research that this study be replicated on larger populations to increase generalisability of the results. This study had selected only one EAP organization due to practical considerations.

There is no known research regarding the construct of affect intensity and its role in the perception of constant emotional stresses in the counselling environment prior to this study. However, given the literature relating affect intensity to the perception of emotional stimuli and the tendency to exaggerate the emotional states of others, it would be important to examine its relationship to compassion fatigue in other counselling environments.

The advantages of implementing a longitudinal design in this area are evident, especially taking variables such as affect intensity into consideration. It would be interesting to note whether changes in affect intensity would initiate changes in empathy and changes in the level of compassion fatigue.

A multi-method data collection should be implemented in future studies to ensure that the researcher obtains the most from the data gathered. This method should include the use of qualitative measures.

Full time versus part time exposure to traumatic material should be considered in future studies, the impact of such exposure on compassion fatigue and interrelationship with empathy and affect intensity.

Previous personal exposure to trauma should be examined in greater detail in relation to its impact on compassion fatigue.

7.8. Conclusion:

Trauma is a daily occurrence in South Africa. Therefore, companies have contracted with Employee Assistance Programme Providers (EAP) to provide counselling to their employees. These EAP counsellors can be traumatised by their indirect contact with their clients, but this is a group of professionals who have been largely neglected in the literature. Hence, this gap of empirical research had prompted the motivation for the current research to examine the concept of compassion fatigue among these professionals. Research has argued that both individual and environmental factors play a role in the development of compassion fatigue. Therefore, the study attempted to explore the interplay through identifying possible core variables such as level of exposure, empathy, affect intensity and their link to compassion fatigue.

Compassion fatigue was defined and differentiated from burnout, vicarious traumatisation and compassion stress. The symptoms of compassion fatigue was equated to that of PTSD and described. The Trauma Transmission Model and the Ecological Framework of Trauma was described and a Revised Trauma Model based on McRitchie's (2006) work, was proposed by the current researcher.

The results are as follows:

28.34% of the sample fell within the moderate to extremely high risk range of compassion fatigue. 50% of the sample had moderate to high levels of empathy. 51.67 % of the sample experienced low to moderate levels of affect intensity and 48.33 % of participants experienced moderate to high levels of affect intensity.

The results indicated that the sample had high exposure to hijackings (93.33%), common robbery (88.33%), robbery with aggravated circumstances (81.67%), domestic violence (81.67%), burglary (73.33%) and road accidents (73.33%). Results revealed that 73.33 % of the sample had been exposed to previous personal trauma. In this study, the traumatic incidents experienced by the counsellors in their

personal lives are similar to the traumatic experiences of the clients, thus increasing the probability of compassion fatigue.

There was a significant correlation between Level of Exposure and intensity of impact to traumatic material and Compassion Fatigue.

There was a weak significant correlation between levels of empathy and compassion fatigue, that is, a higher level of empathy may point to higher levels of compassion fatigue. There was a strong significant relationship between the Fantasy Scale and Compassion Fatigue. There was also a strong relationship between Personal Distress and Compassion Fatigue which indicates that the higher the Personal Distress of the counsellor, then the greater probability of compassion fatigue exists. There was a negative correlation between Perspective Taking and Compassion Fatigue. This is a possible indicator that the higher the Perspective Taking ability of the counsellor, then it is less likely for the counsellor to experience compassion fatigue. There was no significant relationship between Empathic Concern and Compassion fatigue which is interesting to note. This may be as a result of many years of emotionally taxing work which has a desensitizing effect, or it may be due to the maintenance of boundaries by the counsellors.

The correlation analysis indicated that there was no significant correlation between Affect Intensity and Compassion Fatigue. However, there was a significant correlation between Affect Intensity and Empathy.

The Stepwise Regression indicated that the higher the Fantasy empathy of the counsellor, then the possibility of Compassion Fatigue existing is higher. There was a negative correlation between Perspective Taking and Compassion fatigue, which indicates that the lower the Perspective Taking abilities of the counsellor then the higher the possibility of Compassion Fatigue existing and the higher the perspective taking abilities of the counsellor, then the lower the compassion fatigue. The results indicated that the higher the Personal Distress of the counsellor then the higher the

possibility of Compassion Fatigue. The results also revealed that the greater exposure the counsellors have to traumatic material, then the likelihood of Compassion Fatigue existing is also higher. The level of exposure was correlated with the empathy scales (Fantasy, Perspective Taking and Personal Distress) and 56% of compassion fatigue may be explained by a combination of these four variables. Therefore, it was seen that level of exposure and empathy together had a strong impact on compassion fatigue.

The results indicated there was a significant difference in levels of compassion fatigue between full time and part time participants. There was a significant difference in levels of compassion fatigue between those participants who had experienced personal trauma and those that had not. There were no significant differences in the effect of length of service at the organization on the variables (CF, Level of Exposure, Empathy, and Affect Intensity) except for the subscale Perspective Taking. There was also a significant difference in the effect of service experience as a counsellor on the intensity of exposure experienced., that is, the more experience the counsellor has, then the less the impact of intensity of exposure on the counsellor.

Theoretically, previous studies have suggested that key variables such as level of exposure and empathy influence the development of compassion fatigue (Figley, 1995). This study revealed a significant correlation between Level of Exposure and intensity of impact to traumatic material and Compassion Fatigue. There was a correlation between levels of empathy and Compassion Fatigue, that is, a higher level of empathy may point to higher levels of compassion fatigue. Therefore, this study has contributed towards confirming the relationship between exposure to traumatic material and empathy that has been discovered in previous research. The observation that individuals differ in the intensity with which they respond to emotional stimuli introduced the concept of affect intensity (Larsen & Diener, 1987). However, there have been no studies to investigate the relationship between affect intensity and compassion fatigue. This study indicated that there was no significant correlation

between Affect Intensity and Compassion Fatigue, which encourages further research in this area.

Practically, 28.34% of the sample fell within the range for compassion fatigue. According to Rudolph and Stamm (1995), counsellors cannot be totally protected from being affected by their work, but certain structures and support is necessary to counteract some of the costs caring. They suggested that lower caseloads will reduce the overall level of exposure to traumatised clients and provide the counsellors with more time between clients to process and complete administrative tasks. Telehealth support is suggested so that access to resources through the internet is possible and allows the counsellors to develop professional supportive relationships. Rudolph and Stamm (1995) also suggest increased staff time and supervision, whereby increased staff time means providing counsellors regular time to discuss the day to day operations of the organization. This would provide the counsellors with time for consultation and debriefing in a supportive collegial environment. Counsellors should also be provided with regular professional clinical support from a senior staff member, which allows for professional development and enables the counsellor to deal practically and emotionally with difficult cases (Hesse, 2002). Leave is regarded as important with counsellors having an adequate amount of vacation, sick and family leave time. Counsellors require a variety in their lives including a life outside of the work environment (Rudolph and Stamm, 1995).

Although the results of the study appears to be valid and contributes to the field of traumatology, it is proposed that further research be conducted in the area of compassion fatigue and related constructs. It is important that risk factors be identified early in the process and prevented so that counsellors can be as productive and effective in their professions as possible.

REFERENCE LIST:

Adams, R.E., Boscarino, J.A. & Figley, C.R. (2004). Compassion Fatigue and Psychological Distress among Social Workers: A Validation Study. New York: The New York Academy of Medicine.

American Psychiatric Association (2000). Diagnostic and Statistical Manual of Mental Disorders. DSM-1V-TR (4th ed.). Washington, D.C.: American Psychiatric Association.

Atkins, M.W., & Steitz, J.A. (1998). The Assessment of Empathy: An evaluation of the Interpersonal Reactivity Index. Retrieved August 31, 2006 from <http://www.trauma-pages.com>.

Barrett-Lennard, G.T. (1962). Dimensions of Therapist Response as Causal factors in therapeutic change. Psychological Monographs, 76, 43, 1-36.

Beaton, R.D., & Murphy, S.A. (1995). Working with People in Crisis: Research Implications. In C.R. Figley (Ed.). Compassion Fatigue: Coping with Secondary Traumatic Stress Disorder in Those who Treat the Traumatized. (pp. 1-20). New York: Brunner/Mazel Publishers.

Benatar, S. (1996). Adult Reactions to Multiple Trauma. Unpublished M.A. Dissertation. University of the Witwatersrand. Johannesburg.

Boscarino, J.A., Figley, C.R. & Adams, R.E. (2004). Compassion Fatigue following the September 11 Terrorist Attacks: A Study of Secondary Trauma among New York City Social Workers. International Journal of Emergency Mental Health, 6, 2, 1-9.

Brody, L.R. (1985). Gender differences in emotional development: A review of theories and research. Journal of Personality, 53, 102-149.

Buss, A.H., & Plomin, R. (1975). A temperament theory of personality. New York: Wiley.

Cerney, M.S. (1995). Treating the “Heroic Treaters”. In C.R. Figley (Ed.). Compassion Fatigue: Coping with Secondary Traumatic Stress Disorder in Those who Treat the Traumatized. (p. 131-149). New York: Brunner/Mazel Publishers.

Cherniss, C. (1980). Staff Burnout: Job Stress in the human services. Beverly Hills, CA: Sage Publications.

Chrestman, K.R. (1995). Secondary Exposure to trauma and self reported distress among therapists. In B.H. Stamm (Ed.). Secondary Traumatic Stress: Self-care Issues for clinicians, researchers and educators. (p.57-77). New York: Brunner/Mazel Publishers.

Coursol, D.H., Lewis, J., & Garrity, L. (2001). Career development of trauma survivors: Expectations about counseling and career maturity. Journal of Employment Counseling, 38, 138-140.

Davis, M.H. (1983). Measuring Individual Differences in Empathy: Evidence for a Multidimensional approach. Journal of Personality and Social Psychology, 44, 1, 113-126.

Diener, E., Sandvik, E. & Larsen, R.J. (1985). Age and sex effects for affect intensity. Developmental Psychology, 21, 542-546.

Diener, E., Larsen, R.J., Levine, S. & Emmons, R.A. (1985). Age and Sex effects for emotional intensity. Developmental Psychology, 2, 542-546.

Dietrich, J. (2003). Secondary Traumatic Stress in Psychotherapists Working with survivors of violence. For completion of diploma in psychology. Konstanz University.

Durrant, P. (1999). Secondary Traumatic Stress (Compassion Fatigue): A study in Allied Medical Science. Unpublished Masters Dissertation. University of the Witwatersrand, Johannesburg.

Dutton, M.A. (1992). Empowering and healing the battered woman: A model for assessment and intervention. New York: Springer Publishing Co.

Dutton, M.A. & Rubinstein, F.L. (1995). Working with people with PTSD: Research Implications. In C.R. Figley (Ed.). Compassion Fatigue: Coping with Secondary Traumatic Stress Disorder in Those who treat the Traumatized. (pp. 82-100). New York: Brunner/Mazel Publishers.

Edelwich, J., & Brodsky, A. (1980). Burnout. Journal of School Psychology, 20, 162-163.

Edworthy, A. (2000). Managing Stress. Buckingham: Open University Press.

Elkins, A.D. & Kearney, M. (1992). Professional Burnout among female veterinarians in the United States. Journal of American Veterinary Medicine Association (JAVMA), 200, 9, 604 -608.

Figley, C.R. (1999). Compassion fatigue: Toward a New Understanding of the Costs of Caring. In B.H. Stamm (Ed.) Secondary Traumatic Stress: Self - Care Issues for Clinicians, Researchers, and Educators. (p. 3- 28). Lutherville, MD: Sidran Press.

Figley, C.R. (1995). Compassion fatigue as secondary stress disorder: An Overview. In C.R. Figley (Ed.) Compassion fatigue: Coping with Secondary Traumatic Stress Disorder in Those Who Treat the Traumatized (p. 1-20). New York: Brunner – Routledge.

Figley, C.R. (1995). Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized. Bruner / Mazel: New York.

Follette, V.M., Polusny, M.M., & Milbeck, K. (1994). Mental Health and law enforcement professionals: Trauma History, psychological symptoms and impact of providing services to child sexual abuse survivors. Professional Psychology: Research and Practice, 25, 3, 275-282.

Free, N.K., Green, B.L., Grace, M.C., Chernus, L.A., & Whitman, K.M. (1985). Empathy and Outcome in brief focal dynamic therapy. American Journal of Psychiatry, 142, 917-921.

Friedland, D.P. (1999). Direct and indirect exposure to criminal violence in South Africa: Post-traumatic stress symptoms and disruptions in cognitive schema. Unpublished M.A. Dissertation. University of the Witwatersrand. Johannesburg.

Freudenberger, H.J. (1974). Staff Burnout. Journal of Social Issues, 30, 1, 159 -165.

Gentry, J.E. (2005). Gift from Within. Camden, Maine. Retrieved from <http://www.giftfromwithin.org/html/compassn.html>.

Geuens, M. & De Pelsmacker, P. (1999). Affect intensity revisited: Individual differences and the communication effects of emotional stimuli. Psychology and Marketing, 16, 3, 195-209.

Haddock, G., Zanna, M.P., & Esses, V.M. (1994). Mood and the expression of intergroup attitudes-the moderating role of affect intensity. European Journal of Social Psychology, 24, 189-205.

Hamber, B. & Lewis, S. (1997). An Overview of the Consequences of Violence and Trauma in South Africa. Report written for the CSV. Retrieved July 26, 2006 from <http://www.csvr.org.za/papers.htm>.

Harris, B. (2002). Xenophobia: A new pathology for a new South Africa. In D. Hook & G. Eagle (Eds.). Psychopathology and Social Prejudice. (pp.169-184). Cape Town: UCT Press.

Hartman, C.R., & Jackson, H. (1994). Rape and the Phenomena of Countertransference. In J.P. Wilson and J.D. Lindy (Eds.). Countertransference in the Treatment of PTSD. (pp. 206-242). New York: The Guilford Press.

Hesse, A.R. (2002). Secondary Trauma: How Working with Trauma Survivors affects Counsellors. Clinical Social Work Journal, 30, 3, 293-311.

Holahan, C.J. & Moos, R.H. (1987). Risk, resistance and psychological distress. A longitudinal analysis with adults and children. Journal of Abnormal Psychology, 96, 3-13.

Hornstein, H. (1976). Cruelty and Kindness. Engelwood ClifFantasy Scale, NJ.: Prentice Hall.

Howell, D.C. (1995). Fundamental Statistics for the Behavioural Sciences. (3rd ed). California: Duxbury Press.

Jacobson, J.M. (2005). Compassion Fatigue, Compassion Satisfaction, and Burnout Among Employee Assistance Counselors. Occupational Stress in Social Work. SSWR Website. Retrieved June 17, 2006 from <http://www.sswr.org.za/art.htm>.

Janoff-Bulman, R. (1992). Shattered Assumptions: Towards a New Psychology of Trauma. New York: The Free Press.

Jenkins, S.R., & Baird, S. (2002). Secondary Traumatic Stress and Vicarious Trauma: A Validation Study. Journal of Traumatic Stress, 15, 5, 423-432.

- Kassam – Adams, N. (1999). The Risks of Treating Sexual Trauma: Stress and Secondary Trauma in Psychocounsellors. In B.H. Stamm (Ed.) Secondary Traumatic Stress: Self - Care Issues for Clinicians, Researchers, and Educators. (p. 37- 48). Lutherville, MD: Sidran Press
- Keane, T.M. (1989). Posttraumatic stress disorder: Current status and future directions. Behavior Therapy, 20, 149-153.
- Keane, T.M., Weathers, F.W., & Laloupek, D.G. (1992). Psychological assessment of posttraumatic stress disorder. PTSD Research Quarterly, 3, 4, 1-7.
- Keltner, D. & Ekman, P. (1996). Affective Intensity and emotional responses. Cognition and Emotion, 10, 323-328.
- Kerlinger, F.N. (1986). Foundations of Behavioural Research. Fort Worth: Harcourt Brace Jovanovich College Publisher.
- Kleber, R.J., & Brom, D. (1992). Coping with Trauma: Theory, Prevention and Treatment. Amsterdam: Swets & Zietlinger B.V.
- Larsen R.J. & Diener, E. (1987). Affect Intensity as an Individual Difference Characteristic: A Review. Journal of Research in Personality, 21, 1-39.
- Larsen R.J., Diener, E. & Emmons, R.A. (1986). Affect intensity and reactions to daily life events. Journal of Personality and Social Psychology, 51, 4, 803-814.
- Larsen R.J., Diener, E., & Cropanzano, R.S. (1987). Cognitive operations associated with individual differences in affect intensity. Journal of Personality and Social Psychology, 53, 767-774.
- Lauterbach, D. & Vrana, S. (2001). The Relationship among Personality Variables, Exposure to traumatic events and Severity of Posttraumatic Stress Symptoms. Journal of Traumatic Stress, 14, 1, 29-44.

Macliam, J.K. (2003). An Exploration of the Experience and Effects of Trauma Counselling on Lay Counsellors: A Constructivist Approach. Unpublished Masters Dissertation, University of South Africa: Pretoria.

Maslach, C. (1978). The client role in staff burn-out. Journal of Social Issues, 34, 4, 111 –124.

Maslach, C. & Jackson, S.E. (1981). The measurement of experienced burnout. Journal of Occupational Behaviour, 2, 99- 113.

Matsakis, A. (1994). Posttraumatic Stress Disorder: A Complete Treatment Guide. California: New Harbinger Publications.

McRitchie, V.J. (2004). An Exploration of PTS Symptomology in Victims of Violent Crimes in South Africa. Unpublished Honours Dissertation. University of the Witwatersrand, Johannesburg.

McRitchie, V.J. (2006). Secondary Traumatic Stress, Level of Exposure, Empathy and Social Support in Trauma Workers. Unpublished M.A. Dissertation. University of the Witwatersrand. Johannesburg.

McBurney, D. (1994). Research Methods. California: Brooks/Cole.

McCammon, S.L. (1999). Painful Pedagogy: Teaching about Trauma in Academic and Training Settings. In B.H. Stamm (Ed.). Secondary Traumatic Stress: Self - Care Issues for Clinicians, Researchers, and Educators. (p. 105- 120). Lutherville, MD: Sidran Press.

McCann, L. & Pearlman, L.A. (1990). Psychological trauma and the adult survivor. New York: Brunner/Mazel.

McCann, L. & Pearlman, L.A. (1999). Vicarious traumatisation: A framework for understanding the psychological effects of working with victims. In M.J. Horowitz

(Ed.). Essential papers on posttraumatic stress disorder (pp. 498-517). New York: New York University Press.

McLeod, J. (1999). A Narrative Social Constructionist approach to therapeutic empathy. Counselling Psychology Quarterly, 12, 4, 377-394.

Mehrabian, A., & Epstein, N. (1972). A Measure of Emotional Empathy. Journal of Personality, 40, 525-543.

Meyer, D. & Ponton, R. (2006). The Healthy Tree: A Metaphorical Perspective of Counselor Well-Being. Journal of Mental Health Counseling, 28, 3, 189-201.

Miville, M.L., Carlozzi, A.F., Gushue, G.V., Schara, S.L. & Ueda, M. (2006). Mental Health Counselor Qualities for a Diverse Clientele: Linking Empathy, Universal-Diverse Orientation, and Emotional Intelligence. Journal of Mental Health Counseling, 28, 2, 151-165.,

Moore, D.J. & Harris, W.D. (1996). Affect Intensity and the Consumer's attitude toward high impact emotional advertising appeals. Journal of Advertising, 25, 2, 37-50.

Munroe, J.F., Shay, J., Fisher, L., Makary, C., Rapperport, K., & Zimmering, R. (1995). Preventing Compassion Fatigue: A Team Treatment Model. In C.R. Figley (Ed.). Compassion Fatigue: Coping with Secondary Traumatic Stress Disorder in Those who Treat the Traumatized. New York: Brunner/Mazel Publishers.

Neuman, W.L. (1997). Social Research Methods (3rd ed.). United States of America: Allyn and Bacon.

Newman, E., Simpson, R., & Handschuh, D. (2003). Trauma exposure and posttraumatic stress disorder among photojournalists. Visual Communication Quarterly, 58, 1, 4-13.

Ortlepp, K. (1998). Non-Professional Trauma Debriefers in the Workplace: Individual and Organisational Antecedents and consequences of their experiences. Unpublished Ph.D, University of the Witwatersrand, Johannesburg.

Ortlepp, K. & Friedman, M. (2001). The Relationship between Sense of Coherence and Indicators of Secondary Traumatic Stress in Non-professional Trauma Counsellors. South African Journal of Psychology, 31, 2, 38-45.

Pearlman, L.A. & Mac Ian, P.S. (1995). Vicarious trauma: An empirical study of the effects of Trauma work on trauma therapists. Professional Psychology: Research and Practice, 26, 6, 558-565.

Pearlman, L.A. & Saakvitne, K.W. (1995). Trauma and the Therapist: Countertransference and vicarious traumatisation in psychotherapy with incest survivors. New York: Norton & Company.

Pines, A.M. & Aronson, E. (1989). Career Burnout: Causes and Cures. New York: Free Press.

Pope, V.T. & Kline, W.B. (1999). The personal characteristics of effective counsellors: What 10 experts think. Psychological Reports, 84, 1339-1344.

Pyevich, C.M., Newman, E., & Daleiden, E. (2003). The relationship among cognitive schemas, job-related traumatic exposure, and posttraumatic stress disorder in journalists. Journal of Traumatic Stress, 16, 4, 325-328.

Regehr, C., Goldberg, G., & Hughes, J. (2002). Exposure to Human Tragedy, Empathy and Trauma in Ambulance Paramedics. American Journal of Orthopsychiatry, 72, 4, 505-513.

Rogers, C.R. (1961). On becoming a person. Boston: Houghton-Mifflin Co.

Rosenbloom, D.J., Pratt, A.C., & Pearlman, L.A. (1999). Helpers' Responses to Trauma Work: Understanding and Intervening in an Organisation. In B.H. Stamm (Ed.). Secondary Traumatic Stress: Self - Care Issues for Clinicians, Researchers, and Educators. (p. 105- 120). Lutherville, MD: Sidran Press.

Rosenthal, R. & Rosnow, R.L. (1991). Essentials of Behavioural Research: Methods & Data Analysis. USA: McGraw-Hill Publications.

Rudolph, J.M., Stamm, B.H., & Stamm, H.E. (1997). Compassion Fatigue: A concern for Mental Health Policy, Providers & Administration. Paper presented at the 13th Annual Meeting of the International Society of Traumatic Stress Studies. Montreal.

Schauben, L.J. & Frazier, P.A. (1995). Secondary traumatic stress effects of working with survivors of criminal victimization. Journal of Traumatic Stress, 16, 167-174.

Simon, C.E., Pryce, J.G., Roff, L.L., & Klemmack, D. (2005). Secondary Traumatic Stress and Oncology Social Work Protecting Compassion from Fatigue and Compromising the Worker's Worldview. Journal of Psychosocial Oncology, 23, 4, 1.

Stamm, B.H. (1997). Work-Related Secondary Traumatic Stress. PTSD Research Quarterly, 8, 2. Retrieved from <http://www.dartmouth.edu/dms/ptsd/>.

Steed, L. & Bicknell, J. (2001). Trauma and the Therapist: The Experience of Counsellors Working with the Perpetrators of Sexual Abuse. The Australian Journal of Disaster and Trauma Studies, 1, 1-14.

Squier, R.W. (1990). A model of empathic understanding and adherence to treatment regimens in practitioner-patient relationships. Social Science and Medicine, 30, 325-339.

Thomas, R. & Wilson, J. (2004). Issues and Controversies in the understanding and diagnosis of compassion fatigue, vicarious traumatisation and secondary traumatic stress disorder. International Journal of Emergency Mental Health, 6, 2, 81-92.

Trippany, R. L., Kress, V. E. W., & Wilcoxon, S.A. (2004). Preventing Vicarious Trauma: What counselors should know when working with trauma survivors. Journal of Counselling & Development, 82, 31-37.

Vachon, D.O. (1993). The influence of affect intensity, dispositional empathy, and emotional separation on the relationship between perceived stress and burnout in a nursing population. PhD Dissertation. Loyola University of Chicago.

Wesman, A.E., & Ricks, D.F. (1966). Mood and Personality. New York: Holt, Rinehart and Winston.

Williams, C.A. (1990). Biopsychosocial elements of empathy: A Multidimensional Model. Issues in Mental Health Nursing, 11, 155-174.

Williams, C.A. (1989). Empathy and Burnout in male and female helping professionals. Research in Nursing and Health, 121, 169-178.

Wilson, K.L. (1998). An Exploratory Study into Secondary Traumatic Stress in Trauma/Crisis Counsellors and the Perceived Effectiveness of Supervision as a Debriefing Process and Coping Mechanism. Unpublished Masters Dissertation. University of the Witwatersrand, Johannesburg.

Yassen, J. (1995). Preventing secondary traumatic stress disorder. In C.R. Figley (Ed.). Compassion fatigue: Secondary traumatic stress disorder among those who treat the traumatised. New York: Brunner/Mazel.

APPENDIX A:

Hi, my name is Eshmin Harinarain and I am a psychology Masters student at the University of Witwatersrand. As part of the requirements for the course I am required to conduct a research project. I therefore wish to invite you to participate in my study, which focuses on the effects of being a trauma counsellor in your organization. Your participation may add great value to the study of trauma and compassion fatigue.

Attached is a set of questionnaires which will take approximately 15 minutes of your time to complete. In completing the questionnaires, you will be granting your consent to participate in the study. However, you are under no obligation to participate. You may also withdraw from the study at any point in time with no negative repercussions and your job will not be compromised in any manner. If you do decide to participate, you are assured of anonymity as no identifying data is required. Your responses will be treated with the utmost confidentiality.

Should you require any feedback; a copy of this report will be given to your organization upon completion of the study. If you have any questions or require any form of counselling as a result of participating in this study, please feel free to contact me and appropriate arrangements will be made for you to get the support you require.

Thank you for taking the time to answer the questionnaire.

Yours sincerely,

E. Harinarain

0824136229

eshminh@yahoo.com

APPENDIX B:

Please complete the following: (Indicate with an X where appropriate).

1. Gender:

MALE	FEMALE
------	--------

2. Age:

20-30 YEARS	31-35 YEARS	36-40YEARS	40YEARS +
-------------	-------------	------------	-----------

3. Length of service at organization:

0-6 MONTHS	7 MONTHS- 1YR	1,1 YEAR-1,5 YEARS	1,6 YEARS- 2,0 YEARS	2,1 YEARS +
------------	------------------	-----------------------	-------------------------	-------------

4. What is your work status?

FULL TIME	PART TIME
-----------	--------------

5. Length of service experience as a counsellor?

0-1YEAR	1,1 YEAR-2 YEARS	2,1 YEARS- 5YEARS	6 YEARS-10 YEARS	11 YEARS +
---------	---------------------	----------------------	---------------------	------------

6. Have you been exposed to previous personal trauma?

YES	NO
-----	----

6a. If the answer is yes, please indicate when this occurred?

6b. What was the nature of the trauma?

7. Estimate the average number of hours a week you have direct contact (telephonic counselling) with traumatized clients. _____

8. Estimate the average number of hours a week you are exposed to trauma by interacting with colleagues who have had direct contact with traumatized clients.

9. Estimate the average number of hours a week you spend on general counselling work (other than trauma cases). _____.

APPENDIX C:

As you probably have experienced, your compassion for those you help has both positive and negative aspects. I would like to ask you questions about your experiences. Consider each of the following questions about you and your current situation. Select the number that honestly reflects how frequently you experienced these characteristics in the last 30 days.

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

1	I feel estranged from others.	
2	I force myself to avoid certain thoughts or feelings that remind me of a frightening experience.	
3	I avoid certain activities or situations because they remind me of frightening experiences of the people I help.	
4	I have gaps in my memory about frightening events.	
5	I have difficulty falling or staying asleep.	
6	I have outburst of anger or irritability with little provocation.	
7	I startle easily.	
8	While working with a victim, I thought about violence against the perpetrator.	
9	I have flashbacks connected to those I help.	
10	I have had first-hand experience with traumatic events in my adult life.	
11	I have had first-hand experience with traumatic events in my childhood.	
12	I think that I need to “work through” a traumatic experience in my life.	
13	I am frightened of things a person I helped has said to me.	
14	I experience troubling dreams similar to those I help.	
15	I have experienced intrusive thoughts of times with especially difficult people I helped.	

16	I have suddenly and involuntarily recalled a frightening experience while working with a person I helped.	
17	I am preoccupied with more than one person I help.	
18	I am losing sleep over a person I help's traumatic experiences.	
19	I think I might have been "infected" by the traumatic stress of those I help.	
20	I remind myself to be less concerned about the wellbeing of those I help.	
21	I feel trapped by my work as a helper.	
22	I have a sense of hopelessness associated with working with those I help	
23	I have been in danger working with people I help.	

APPENDIX D

The following statements enquire about your thoughts and feelings in a variety of situations. For each item, indicate how well it describes you by choosing the appropriate letter on the scale at the top of the page: A, B, C, D, or E. When you have decided on your answer, make an X in the appropriate box next to the item number. Answer as honestly as you can.

A B C D E

DOES NOT

DESCRIBES ME

DESCRIBE ME WELL

VERY WELL

Statements	Statements describes me				
	A Not well	B Some what	C Average	D Well	E Very well
1. I daydream and fantasize, with some regularity, about things that might happen to me.					
2. I often have tender, concerned feelings for people less fortunate than me.					
3. I sometimes find it difficult to see things from the "other guys" point of view.					
4. Sometimes I don't feel very sorry for other people when they are having problems.					
5. I really get involved with the feelings of the characters in a novel.					
6. In emergency situations, I feel apprehensive and ill-at-ease.					
7. I am usually objective when I watch a movie or play, and I don't often get completely caught up in it.					
8. I try to look at everybody's side of a disagreement before I make a decision.					
9. When I see someone being taken advantage of, I feel kind of protective towards them.					

10. I sometimes feel helpless when I am in the middle of a very emotional situation.					
11. I sometimes try to understand my friends better by imagining how things look from their perspective.					
12. Becoming extremely involved in a good book or movie is somewhat rare for me.					
13. When I see someone get hurt, I tend to remain calm.					
14. Other people's misfortunes do not usually disturb me a great deal.					
15. If I'm sure I'm right about something, I don't waste much time listening to other people's arguments.					
16. After seeing a play or movie, I have felt as though I were one of the characters.					
17. Being in a tense emotional situation scares me.					
18. When I see someone being treated unfairly, I sometimes don't feel very much pity for them.					
19. I am usually pretty effective in dealing with emergencies.					
20. I am often quite touched by things that I see happen.					
21. I believe that there are two sides to every question and try to look at them both.					
22. I would describe myself as a pretty soft-hearted person.					
23. When I watch a good movie, I can very easily put myself in the place of a leading character.					
24. I tend to lose control during emergencies.					
25. When I'm upset at someone, I usually try to "put myself in his shoes" for a while.					
26. When I am reading an interesting story or novel, I imagine how I would feel if the events in the story were happening to me.					
27. When I see someone who badly needs help in an emergency, I go to pieces.					
28. Before criticizing somebody, I try to imagine how I would feel if I were in their place.					

APPENDIX E:

Please indicate with a cross (X) in the first column the types of traumatic material you have dealt with as a trauma counsellor in the past 3 months. If you answer yes to any of the following please indicate how often you have dealt with this type of trauma in the second column in the past 3 months. In the third column, please indicate your subjective perception of the intensity of the emotional impact of the cases on a scale of 1-5. You may find that some of the categories may overlap, but please try to locate the type of trauma in the most appropriate category.

1=No impact 2=Some impact 3= Average impact 4= High impact 5= Very high impact

Types of trauma	Yes/No	No of cases	Intensity of Emotional Impact
Hijacking/Carjacking			
Common Robbery (taking or attempting to take anything of value from another by force or threat of force)			
Robbery with aggravated circumstances (taking or attempting to take anything of value from another by violence or putting the victim in fear)			
Mugging			
Rape			
Indecent assault (any unwanted sexual behaviour)			
Child Molestation			
Domestic Violence			
Assault with the intent to inflict grievous bodily harm			
Common Assault (unlawful attack by one person upon another)			
Attempted Murder			
Murder			
Kidnapping/abduction			
Burglary			
Natural disasters			
Mining accidents			
Road accidents			
Smash and Grab			
Road rage			

APPENDIX F:

The following questions refer to your emotional reactions. Please indicate how you react to these events by placing a number from the following scale in the blank space preceding each item. Please base your responses on how you react, not on how you think others react or how you think a person should react.

**1=Never 2=Almost Never 3=Occasionally 4=Usually 5=Almost Always
6=Always**

1. -----When I accomplish something difficult I feel delighted or elated.
2. -----When I feel happy it is a strong type of exuberance.
3. -----I enjoy being with other people very much.
4. -----I feel pretty bad when I tell a lie.
5. -----When I solve a small personal problem, I feel euphoric.
6. -----My emotions tend to be more intense than those of most people.
7. -----My happy moods are so strong that I feel like I'm "in heaven".
8. -----I get overly enthusiastic.
9. -----If I complete a task I thought was impossible, I am ecstatic.
10. -----My heart races at the anticipation of some exciting event.
11. -----Sad movies deeply touch me.
12. -----When I'm happy it's a feeling of being untroubled and content rather than being
zestful and aroused.
13. -----When I talk in front of a group for the first time my voice gets shaky and my heart
races.
14. -----When something good happens, I am usually much more jubilant than others.
15. -----My friends might say I'm emotional.
16. -----The memories I like the most are those of times when I felt content and peaceful rather
than zestful and enthusiastic.
17. -----The sight of someone who is hurt badly affects me strongly.
18. -----When I'm feeling well it's easy for me to go from being in a good mood to being
really joyful.
19. -----"Calm and cool" could easily describe me.

20. -----When I'm happy I feel like I'm bursting with joy.
21. -----Seeing a picture of some violent car accident in a newspaper makes me feel sick to my stomach.
22. -----When I'm happy I feel very energetic.
23. -----When I receive an award I become overjoyed.
24. -----When I succeed at something, my reaction is calm contentment.
25. -----When I do something wrong I have strong feelings of shame and guilt.
26. -----I can remain calm even on the most trying days.
27. -----When things are going good I feel "on top of the world".
28. -----When I get angry it's easy for me to still be rational and not overreact.
29. -----When I know I have done something very well, I feel relaxed and content rather than excited and elated.
30. -----When I do feel anxiety it is normally very strong.
31. -----My negative moods are mild in intensity.
32. -----When I am excited over something I want to share my feelings with everyone.
33. -----When I feel happiness, it is a quiet type of contentment.
34. -----My friends would probably say I'm a tense or "high-strung" person.
35. -----When I'm happy I bubble over with energy.
36. -----When I feel guilty, this emotion is quite strong.
37. -----I would characterize my happy moods as closer to contentment than to joy.
38. -----When someone compliments me, I get so happy I could "burst".
39. -----When I am nervous I get shaky all over.
40. -----When I am happy the feeling is more like contentment and inner calm than one of exhilaration and excitement.