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Secondary traumatic stress, burnout and the role of resilience in New Zealand counsellors

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Abstract

One hundred and twenty-nine New Zealand counsellors were surveyed in relation to secondary traumatic stress, burnout, compassion satisfaction, resilience, social support, degree of exposure to trauma, and personal history of trauma. Statistical analyses established the prevalence of secondary traumatic stress, burnout, and compassion satisfaction. The relationships between risk of secondary traumatic stress and exposure to others' trauma, personal trauma history, burnout, compassion satisfaction, resilience, and social support levels were explored. Results established a prevalence of 21.7% for high risk of secondary traumatic stress, 24.8% for high risk of burnout, and 21.7% for high potential for compassion satisfaction in this sample. Statistically significant relationships were found between exposure and secondary traumatic stress, between burnout and secondary traumatic stress, and between resilience and secondary traumatic stress. These results are discussed in relation to counsellors' secondary exposure to trauma when working with clients who have been traumatised.

Keywords: secondary trauma, burnout, compassion satisfaction, resilience, counsellors

There is a growing interest in the deleterious effects for counsellors of working with victims of trauma. Various terms have been used to describe the impact on counsellors after being exposed to the trauma of others. Figley (1995) introduced the term *secondary traumatisation* or *secondary traumatic stress* (STS) to refer to the effects of knowing of the trauma of another and the stress that can be related to helping that person.

While the term secondary trauma encompasses a range of circumstances and people who work in this area, the counselling relationship is unique. Counsellors

typically work with multiple victims and forms of trauma over a significant period of time, frequently spanning the life of their career. McCann and Pearlman (1990) coined the term *vicarious traumatisation* to describe the cumulative effects upon a counsellor from helping clients work through their trauma. Arvay (2001) believed that the primary difference between vicarious traumatisation and secondary traumatic stress was more theoretical and that they both referred to the same phenomenon. According to Salston and Figley (2003), STS "parallels" the symptoms of post-traumatic stress disorder (PTSD) with the exception that, in STS, the traumatic event is the traumatic experience of the client that is shared with the therapist through the process of therapy.

While the terms are often used interchangeably, Figley (1995) preferred the term *compassion fatigue* to secondary traumatic stress, as this expression acknowledges the inherent nature in the cost of caring. According to Figley (2002), the role of the helper requires balancing the need to be objective and analytical with the importance of compassion and empathy. Compassion is the involvement in another's suffering and, as such, carries a cost, which Figley (2002) labelled "compassion fatigue."

Compassion fatigue is experienced as a state of tension and preoccupation with clients who have experienced trauma. This, then, leads to the re-experiencing of the client's traumatic events (for example, through dreams or memory), avoidance of reminders of the client's trauma or numbing, and persistent psychophysical arousal (for example, anxiety), thereby leading to poor concentration and sleep disturbances. Compassion fatigue can further result in a reduced interest in being empathic towards clients' trauma and, as such, has implications for the therapeutic relationship. Although compassion fatigue is closely related to what Pines and Aronson (1988, as cited in Figley, 2002, p. 1436) defined as burnout, which is "a state of physical, emotional and mental exhaustion caused by long-term involvement in emotionally demanding situations," Figley (2002) regarded it as related specifically to exposure to the trauma of others.

As shown in Figure 1, Figley (2002) developed a framework to explain the process of compassion fatigue. His model is based on the assumption that empathy and emotional energy are required for the effective delivery of therapeutic work with people who have experienced trauma, and the same qualities are necessary for establishing and maintaining a therapeutic alliance with such clients. Yet, such emotional investments can result in compassion fatigue for the therapist.

One of the strengths inherent in this model is its ability not only to explain and predict the occurrence of compassion fatigue, but also to prevent, mitigate, and treat

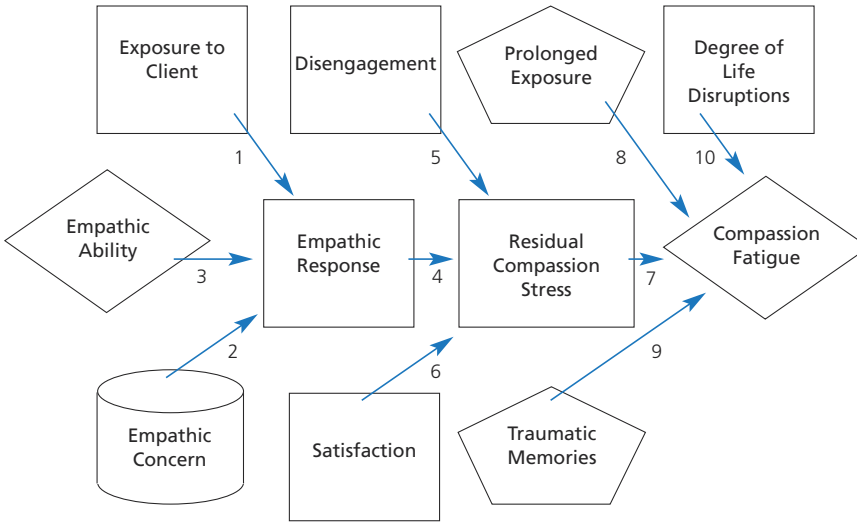

Figure 1: Compassion stress and fatigue model (from Figley, 2002, p. 1432)

it. Figley's (2002) etiological model of compassion fatigue has received some support (see, for example, Craig & Sprang, 2010; Jenkins & Baird, 2002; Killian, 2008; Sprang, Clark, & Whitt-Woosely, 2007). It provides a starting point for understanding compassion fatigue, however further development of this model may be required. It is acknowledged that there are alternative models which also seek to explain the development of compassion fatigue and secondary traumatic stress. For example, Stamm (2010) proposes a model that positions the development of these constructs in the context of a practitioner's work, client, and personal environments.

Prevalence of secondary traumatic stress

The prevalence of secondary traumatic stress has been identified in diverse populations of counsellors and others in the helping professions (see, for example, Benoit, McCarthy Veach, & LeRoy, 2007; Boscarino, Figley, & Adams, 2004; Burns, Morley, Bradshaw, & Domene, 2008; Galek, Flannelly, Greene, & Kudler, 2011; Hendron, Irving, & Taylor, 2012; Holaday, Lackey, Boucher, & Glidewell, 2001; Jacobson, 2006; Moulden & Firestone, 2007; Schauben & Frazier, 1995; Udipi, McCarthy Veach, Kao, & LeRoy, 2008; Vrklevski & Franklin, 2008; Way, VanDeusen, Martin, Applegate, &

Jandle, 2004). In a study employing the Professional Quality of Life (ProQOL: Stamm, 2010) measure to investigate compassion fatigue among employee assistance professionals (EAP), Jacobson (2006) found that 41.2% of her sample presented with low risk, 46.8% with moderate risk, and 12% with high risk of compassion fatigue. In a study of secondary traumatic stress in counsellors involved with victims of bank robberies, Ortlepp and Friedman (2002) found an overall low risk of compassion fatigue, with 79% presenting with low risk, 11% with moderate risk, and 10% with high risk. It is noted that in this study, counsellors' exposure to the trauma of others was periodic and this may have accounted for the lower levels of secondary traumatic stress identified. In their study of compassion fatigue in trauma treatment specialists, Craig and Sprang (2010) reported only 6% of their sample to be at high risk for compassion fatigue, although the researchers acknowledged that the greater experience and age of their participants may have accounted for the lower rates.

Little of the research pertaining to the prevalence of secondary traumatic stress in counsellors specifically considers New Zealand practitioners. Studies that addressed traumatic stress in New Zealand counsellors (Evans & Payne, 2008; Pack, 2004) were qualitative and did not determine the prevalence of counsellors at risk of secondary traumatic stress. Of the one quantitative study found pertaining to secondary traumatic stress in New Zealand (see Hargrave, Scott, & McDowall, 2006), the participants were not trained counsellors, but rather, volunteers, who are not necessarily exposed to the same frequency and severity of clients' trauma as are counsellors. Additionally, the measure used was the Impact of Event Scale (IES; Horowitz, Wilner, & Alvarez, 1979) which measures stress from specific events as opposed to cumulative exposure.

Risk factors for secondary traumatic stress

Exposure to clients' trauma

One risk factor supported by the literature (Craig & Sprang, 2010; Schauben & Frazier, 1995; Sprang et al., 2007) is the proportion of trauma clients among a counsellor's caseload. In accordance with Figley's (2002) model of compassion fatigue, it would seem logical that the more exposure a counsellor has, the greater the risk of compassion fatigue.

Personal trauma history

The results of research regarding the relationship between personal trauma history and secondary traumatic stress are mixed. While there is some support for the role of personal trauma history in the development of secondary traumatic stress (see, for

example, Adams, Boscarino, & Figley, 2006; Jenkins & Baird, 2002; Killian, 2008), other researchers have failed to find a relationship (Schauben & Frazier, 1995; Way et al., 2004). Recent research also suggests that a practitioner's own trauma history has the potential to facilitate personal growth in counsellors and benefit the counselling relationship, rather than having a deleterious effect (see, for example, Collins & Long, 2003a; Linley & Joseph, 2007).

Protective factors against secondary traumatic stress

Social support

Research investigating the role of social support in protecting one against the development of secondary traumatic stress is sparse and inconclusive. Evidence for the role of social support in protecting against PTSD and secondary traumatic stress has been found by Pietrzak, Johnson, Goldstein, Malley and Southwick (2009) and Ortlepp and Friedman (2002). However, Hyman (2004) found no significant relationship between perceived support and secondary traumatic stress symptoms.

Resilience

Resilience was first investigated by developmental psychopathologists who were interested in children growing up in adverse environmental conditions (Garmezy & Masten, 1986; Werner, 1993). Contrary to expectations, they found that a large number of "vulnerable" children living in these adverse conditions were in fact adaptive and successful, thus changing the focus of the research from risk factors to factors which promoted stress resistance, or resilience.

In their study of potential protective factors against the development of traumatic stress and depressive symptoms in soldiers returning from Operations Enduring Freedom and Iraqi Freedom, Pietrzak et al. (2009) found that increased levels of resilience were negatively associated with levels of traumatic stress and depressive symptoms. Although a considerable amount of research has focused on resilience and its protection against risk of harm to health and mental wellbeing, research concerning the relationship between resilience and secondary traumatic stress in counsellors who work with clients who have experienced trauma is relatively new. However, a 2009 study by Huggard (as cited in Huggard, Stamm & Pearlman, 2013) surveyed resident physicians working in New Zealand hospitals and found a significant negative relationship between compassion fatigue and resilience. This suggests that high scores of resilience may be related to low scores of compassion fatigue.

Compassion satisfaction

Research concerning the wellbeing of therapists has focused almost exclusively on the negative costs of being empathetic, in spite of the fact that therapists may experience satisfaction and growth as a result of working with clients who have experienced trauma (Sprang et al., 2007). Collins and Long (2003a) acknowledged that the motivation to help is shaped at least in part by the satisfaction derived from helping others. They found that trauma workers with high scores on compassion satisfaction were less likely to have high scores for compassion fatigue and burnout (Collins & Long, 2003b). These results suggest that while exposure to clients experiencing trauma has been identified as a potential risk factor for burnout and compassion fatigue, this relationship may be moderated by other factors. Helping clients deal with their trauma can be a great source of satisfaction which can be protective against stress.

Aim of the current study

The aim of this study was to examine the factors that contribute to the relationship between secondary trauma and compassion fatigue. Based on the reviewed literature, it was hypothesised that:

1. Between 10 and 25% of counsellors would self-report high levels of compassion satisfaction, secondary traumatic stress, and burnout.
2. Counsellors with higher levels of exposure to traumatic material, as measured by the proportion of trauma clients on their caseloads, would be at greater risk of secondary traumatic stress.
3. Counsellors who had a history of personal trauma would be at greater risk for secondary traumatic stress than those without.
4. Counsellors who scored high on secondary traumatic stress would be predicted to have high levels of burnout and lower levels of compassion satisfaction, resilience, and social support.
5. Compassion satisfaction would moderate the relationship between burnout and secondary traumatic stress.

Method

Research design

This study used a quantitative, cross-sectional design to investigate secondary traumatic stress, burnout, compassion satisfaction, resilience, and social support among a sample of New Zealand counsellors working with clients who had experienced trauma.

Table 1. Demographics of the study sample

Demographic Variable	***n***	**%**
Gender		
Male	9	15.5
Female	120	84.5
Ethnicity		
NZ Māori	6	4.7
NZ European/Pākehā	105	81.4
Pacific Islander	2	1.6
Other European	4	3.1
American	3	2.3
British	2	1.6
Other	6	4.7
Age		
26–35 years	4	3.1
36–45 years	24	18.6
46–55 years	37	30.3
56–60 years	29	22.5
60 years <	33	25.6
Relationship status		
Single	31	24.0
In a relationship	98	76.0
Highest qualification		
Undergrad cert/diploma	16	12.4
Degree equivalent	12	9.3
Bachelor's degree	29	22.5
Postgraduate	72	55.8
Personal trauma history		
Yes	93	72.1
No	35	27.1
Number of social supports		
0	3	2.3
1–2	61	47.3
3–4	56	43.4
5–8	9	7

Note: Participants were informed of their right not to answer all questions: ethnicity and personal trauma history percentages do not sum to 100.

Participants

The participants were a sample of 129 counsellors in New Zealand who responded to an advertisement emailed by their respective counselling organisations. Of the 129 participants, 84.5% were female and 15.5% were male. The majority of participants reported being older than 50 years of age (65.2%), with 3.1% indicating they were 35 years of age or under. The majority of counsellors identified as New Zealand European/Pākehā (81.4%), followed by New Zealand Māori (4.7%), and Other (4.7%), with most having experienced some personal history of trauma. Further details on the demographics of the participants are contained in Table 1.

Measures

A self-report anonymous survey was used. In addition to basic demographic questions, counsellors were asked about years of experience, professional supervision, and level of support.

Types of trauma experienced by clients

Counsellors were asked to select the types of trauma they had been working with over the past 30 days. Table 2 presents the various types of trauma that counsellors reported working with. The most frequent traumas addressed by counsellors in their therapy work were: childhood sexual abuse, domestic violence, death or injury to a loved one, and sexual assault or rape. In addition, counsellors were asked to indicate whether they had personally experienced any of the traumas identified.

The Professional Quality of Life Scale

The Professional Quality of Life Scale (ProQOL; Stamm, 2010) is a 30-item self-report scale consisting of three subscales that assess secondary traumatic stress, compassion satisfaction, and burnout. Each subscale consists of 10 items. An example item includes, "Because of my helping, I have felt 'on edge' about various things." Items are scored on a 5-point Likert scale from 1 "never" to 5 "very often," with a possible range of 10 to 50 per subscale. The scores are then standardised and converted to t-scores. Low scores are indicative of low risk/potential on the variable, whereas high scores indicate high risk/potential on the variable (i.e., secondary traumatic stress, compassion satisfaction, and burnout). Psychometric properties for the three subscales have been shown to be reliable in the past (Stamm, 2010). In the present study, Cronbach's alpha coefficients for secondary traumatic stress, compassion satisfaction, and burnout were .80, .85, and .72 respectively.

Table 2. Types of trauma worked with over the past 30 days (N=129)

Trauma Type	*n*	%
Childhood sexual abuse	91	70.5
Domestic violence	90	69.8
Death or injury to a loved one	76	58.9
Sexual assault or rape	66	51.2
Suicide of a loved one	37	28.7
Violent crime	29	22.5
Invasive medical procedures	29	22.5
Sexual harassment	27	20.9
Natural disasters	22	17.1
Accidents	20	15.5
Torture	12	9.3
Combat or military experiences	8	6.2
None	4	3.1
Other	27	20.1

The Brief Resilience Scale

The Brief Resilience Scale (BRS: Smith, Dalen, Wiggins, Tooley, Christopher, & Bernard, 2008) was used to measure resilience, which is defined as "the ability to bounce back from stress." This is a six-item scale; an example of an item is "I usually come through difficult times with little trouble." Items are scored on a 5-point Likert scale from 1 "strongly disagree" to 5 "strongly agree." High scores indicate high levels of resilience, while low scores indicate low levels of resilience. Psychometric properties for the BRS have been shown to be reliable (Smith, Tooley, Christopher, & Kay, 2010). For the study, the Cronbach's alpha coefficient was .90.

Procedure

Massey University's Human Ethics approval for the study was obtained. Non-probability, purposive sampling (Goodwin, 2008) was used initially to select the New Zealand Association of Counsellors (NZAC) from the available counselling organisations in New Zealand. In addition to NZAC, the following organisations were subsequently contacted to increase participant numbers: the Addiction Practitioners Association Aotearoa New Zealand (DAPAAZ), the New Zealand Christian Counsellors Association (NZCCA), Relationships Aotearoa, the National

Table 3. Counsellors' scores for potential for compassion satisfaction scale, risk for secondary trauma scale, and risk of burnout scale (N=129)

	Compassion Satisfaction		Secondary Trauma		Burnout	
Level	*n*	%	*n*	%	*n*	%
High	28	21.7	28	21.7	32	24.8
Moderate	69	53.5	67	51.9	70	54.3
Low	32	24.8	34	26.4	27	20.9

Association of Loss and Grief NZ (NALAG), and Te Whariki Tautoko (an organisation for Māori counsellors). The counselling organisations agreed to forward the survey to their members.

The online survey programme Qualtrics (www.qualtrics.com, 2012) was used for the administration of the questionnaire. The Qualtrics survey programme allowed the data to be exported into the Statistical Package for the Social Sciences (SPSS v.19), which was used for statistical analysis.

Parametric and bivariate tests were used for data analysis due to the advantages they have over non-parametric tests in their increased sensitivity to significant differences and the power to detect significant outcomes (Pallant, 2011).

Results

Hypothesis testing

Hypothesis one

As proposed by Stamm (2010), a participant's score was deemed to be high if they were above the cut-off point of 57. A frequency analysis was conducted to determine the percentage of counsellors who scored within high levels on the compassion satisfaction, secondary trauma, and burnout scales.

The potential for compassion satisfaction, risk for secondary traumatic stress, and risk for burnout subscales ranged from 10 to 50. When converted to a *t*-score, the average was 50 (*SD* 10). Stamm (2010) proposed that about 25% of people score over 57 and about 25% of people score below 43. Table 3 presents the proportion of counsellors in the current study who scored in the high, moderate, and low levels on the three subscales based on the cut-off points. Comparably, the current results approximate Stamm's (2010) figures with close to 25% of counsellors scoring in the

Table 4. Proportion of trauma clients on caseload and group means on STS

	n	%	Mean STS
Less than 30%	31	24.0	48.70
Greater than 65%	35	27.1	54.03

high and low levels of compassion satisfaction, secondary trauma, and burnout, and nearly 50% falling in the moderate levels.

Hypothesis two

This hypothesis investigated whether counsellors with higher proportions of trauma clients among their caseloads experienced higher levels of secondary traumatic stress than counsellors with lower proportions of trauma clients among their caseloads. Table 4 presents the results for this hypothesis.

An independent-samples *t*-test was conducted to compare the secondary traumatic stress scores for counsellors with higher versus counsellors with lower proportions of trauma clients in their caseloads. A significant difference was found in scores for counsellors with more than 65% of trauma clients in their caseload ($M = 54.03$, $SD = 10.88$) and counsellors with less than 30% of trauma clients in their caseload ($M = 48.70$, $SD = 8.66$; $t(64) = 2.18$, $p = .03$, two tailed). The magnitude of the differences in the means was moderate (eta squared = .07: mean difference = 5.33, 95% CI: .45 to 10.21).

Hypothesis three

An independent-samples *t*-test was conducted to compare the secondary traumatic stress scores for counsellors with and without a personal history of trauma. There was no significant difference in the scores for counsellors with a personal trauma history ($M = 20.48$, $SD = 4.219$) and counsellors without a personal trauma history ($M = 19.49$, $SD = 3.973$; $t(126) = 1.212$, $p = .228$, two-tailed).

Hypothesis four

Logistic regression was performed to assess the factors that contributed to the self-report of high levels of secondary traumatic stress. The model contained four independent variables (burnout, compassion satisfaction, resilience, and social support) which were selected due to their theoretical basis, and/or to the strength and direction of their correlations with the dependent variable (see Table 5).

Table 5. Pearson Correlation Coefficients between secondary traumatic stress and variables in logistic regression

Measure	Secondary Traumatic Stress
Burnout	.57**
Compassion satisfaction	–.34**
Resilience	–.53**
Social support	.20*

Note: *.05 (2-tailed); ** $p < .01$ (2-tailed).

Table 6. Logistic regression predicting likelihood of reporting high secondary traumatic stress

	B	S.E.	Wald	*df*	*p*	Odds Ratio	95% C.I. Lower	95% C.I. Upper
Burnout	.69	.30	5.3	1	.021*	2.0	1.11	3.6
Compassion satisfaction	–.20	.15	1.8	1	.178	.82	.61	1.1
Resilience	–.47	.18	6.9	1	.009**	.63	.44	.89
Social support	.22	.47	.21	1	.648	1.24	.49	3.14
Constant	4.46	10.56	.18	1	.673	86.71		

Note: * $p < .05$ (2-tailed); ** $p < .01$ (2-tailed).

The full model containing all predictors was statistically significant, $\chi^2(4, N = 62) = 56.45$, $p < .0005$. The model as a whole explained between 59.8% (Cox and Snell R squared) and 79.9% (Nagelkerke R squared) of the variance in secondary traumatic stress status, and correctly classified 90.3% of cases. As shown in Table 6, only two of the independent variables made a unique statistically significant contribution to the model (burnout and resilience). The strongest significant predictor of high secondary traumatic stress was burnout, with an odds ratio of 2.0. This indicated that respondents with high levels of burnout were twice as likely to report high levels of secondary traumatic stress than were those with lower levels of burnout when other factors were controlled for in the model.

Table 7. Pearson Product-Moment Correlation for primary measure scales

Measure	1	2	3
1. Secondary trauma	–		
2. Burnout	.57**	–	
3. Compassion satisfaction	–.34**	–.57**	–
4. BRS	–.53**	–.44**	.30**

Note: N=129. BRS = Brief Resilience Scale. ** $p < .01$ (2-tailed).

Hypothesis five

It was hypothesised that higher levels of compassion satisfaction would reduce the strength of the relationship between burnout and secondary traumatic stress, where the same level of burnout would be associated with decreasing secondary traumatic stress symptoms as the level of compassion satisfaction increased. Compassion satisfaction was used as the moderating variable since it had a strong relationship with burnout, as evidenced by the correlations presented in Table 7.

Results of the analysis revealed that the interaction term did not explain any significant increase in the variance of secondary traumatic stress (R^2 change = .004, F change (1, 125) = .76, p = .39).

Discussion

Investigating the prevalence of compassion satisfaction, secondary traumatic stress, and burnout in a New Zealand sample of counsellors was a key objective of this study. Previous studies had found that significant levels of secondary traumatic stress affected between 6% and 26% of counsellors, high levels of burnout were reported for 5% to 14% of counsellors, and high levels of compassion satisfaction were reported by 17% to 47% of counsellors (Craig & Sprang, 2010; Eastwood & Ecklund, 2008; Jacobson, 2006; Ortlepp & Friedman, 2002). However, these studies were conducted prior to the more robust measure developed by Stamm's (2010) Concise Professional Quality of Life. It was expected that the prevalence rates in the current study would approximate the findings of Stamm (2010) rather than previously reported prevalence rates.

Hypothesis one was confirmed, in that 21.7% of the sample reported compassion satisfaction in high levels, 21.7% of the sample reported secondary traumatic stress in high levels, and 24.8% of the sample reported burnout in high levels. The prevalence

of burnout and secondary traumatic stress was considerably higher than that previously reported (Craig & Sprang, 2010; Jacobson, 2006; Ortlepp & Friedman, 2002), although Eastwood and Ecklund (2008) reported that 26.3% of their sample scored high levels of compassion fatigue.

A possible explanation for the higher rates of secondary traumatic stress and burnout in the current study could be the higher levels of exposure to clients experiencing trauma by counsellors in New Zealand compared with the participants in other studies. Counsellors reported that a high proportion of their caseloads consisted of clients experiencing trauma. Childhood sexual abuse, domestic violence, death of or injury to a loved one, and sexual assault and rape were reported as traumas recently seen by between 51.2% and 70.5% of counsellors. These traumas require long-term ongoing therapeutic relationships, as opposed to problems that require briefer interventions. In addition, New Zealand's high prevalence of traumas such as child abuse (Fanslow, Robinson, Crengle, & Perese, 2007; Pereda, Guilera, Forns, & Gomez-Benito, 2009) may contribute to these cases being seen by counsellors. Figley's (2002) etiological model of compassion fatigue suggests that exposure to a client's trauma contributes to the development of compassion fatigue and secondary traumatic stress in counsellors. This study may be the first to demonstrate that New Zealand counsellors self-report higher levels of secondary trauma than have been previously found in the literature.

Increased proportions of trauma clients within their caseloads appear to increase counsellors' exposure to secondary trauma. Exposure to client suffering and prolonged exposure are both contributory variables in Figley's (2002) etiological model of compassion fatigue. In the current study, nearly a quarter of counsellors reported caseloads of less than 30% trauma clients, and close to a quarter reported caseloads that consisted of more than 65% trauma clients. Hypothesis two was supported in that counsellors with high proportions of trauma clients in their caseloads scored significantly higher on secondary traumatic stress than did counsellors working with low proportions of trauma clients.

The research regarding personal trauma history has elicited mixed results. According to Figley's (2002) etiological model of compassion fatigue, a personal history of trauma was a factor contributing to compassion fatigue. No support for this was found in the current study as counsellors with a personal trauma history were no different in terms of self-reported stress than those without a personal history of trauma. Several explanations may account for this lack of relationship.

First, it is noted that a high percentage of counsellors reported experiencing a personal history of trauma. It may be that the definition of personal trauma history was too broad to be meaningful. For example, counsellors were able to select "natural disasters," yet within this category a range of experiences from meaningless (I experienced an earthquake but I barely noticed it) to highly traumatic (I was trapped during an earthquake and thought I might die) could be described. Second, there could be an assumption that counsellors with a personal history of trauma might be more susceptible to the experience of secondary trauma incurred through the counselling relationship. What may be of greater importance could be whether or not counsellors had worked through their personal experiences of trauma. By choosing to work with this vulnerable group, counsellors may have resolved their own personal trauma to such an extent that they could then assist others. Such practitioners may have significantly different experiences of secondary traumatic stress than other counsellors.

The finding that burnout was the greatest predictor of a high risk of secondary traumatic stress has theoretical and practical importance. Salston and Figley (2003, p. 167) stated that burnout and compassion fatigue "are or nearly are synonymous" with secondary traumatic stress. Yet, the current study identified burnout as a separate construct from secondary traumatic stress, and provides support for the inclusion of burnout as a predictor variable in Figley's (2002) etiological model of compassion fatigue. It is proposed that counsellors who are burned out have less energy to manage compassion stress and are consequently more vulnerable to secondary traumatic stress.

These findings support those of Udipi et al. (2008), who likewise found burnout to be the strongest predictor of compassion fatigue in their study of compassion fatigue in genetic counsellors. Eastwood and Ecklund (2008) also found burnout risk to be the greatest predictor of compassion fatigue in counsellors who worked at a residential childcare centre. The findings of the current study suggest that Figley's (2002) etiological model of compassion fatigue would benefit from the inclusion of burnout as a variable in explaining compassion fatigue.

The findings in regard to compassion satisfaction in the current study were unexpected. Contrary to the hypothesis, it was not found that compassion satisfaction would moderate the relationship between burnout and secondary traumatic stress. Previous research has suggested the potentially moderating effect of compassion satisfaction between burnout and secondary traumatic stress (Eastwood & Ecklund,

2008), yet no known studies to date have tested this proposed relationship. While the current study did not find support for the hypothesis, the results need to be investigated by further research.

It was expected that low scores for compassion satisfaction would predict high scores for secondary traumatic stress based on the negative correlation between compassion satisfaction and secondary traumatic stress. This expectation was borne out by the moderately negative correlation between compassion satisfaction and secondary traumatic stress. This finding replicates that of Udipi et al. (2008), whose results showed that compassion satisfaction did not significantly predict compassion fatigue in genetic counsellors. It may be that compassion satisfaction has its effect on secondary traumatic stress through another variable or it may be that a construct with similarities in content to compassion satisfaction is more suited as a predictor of secondary traumatic stress. Cohn, Brown, Conway, Fredrickson, and Mikels (2009) found that positive emotions but not life satisfaction predicted positive outcomes in a group of university students and that resilience mediated the relationship between positive emotions and life satisfaction. Positive emotionality as opposed to compassion satisfaction may have yielded different results in the current study.

In conclusion, the current study did not provide support for the inclusion of compassion satisfaction in Figley's (2002) etiological model of compassion fatigue nor for the potentially moderating effect of compassion satisfaction between burnout and secondary traumatic stress. However, the high levels of compassion satisfaction indicate that counsellors working with vulnerable clients *are* experiencing satisfaction in their work.

Another important objective of the study was to identify whether low resilience in counsellors predicted high scores on secondary traumatic stress. The study showed that low resilience was a significant predictor of secondary traumatic stress compared to counsellors with high levels of resilience. Future studies should examine what factors contribute to resilience in counsellors as this would assist in the prevention of secondary traumatic stress and burnout. Figley's (2002) etiological model of compassion fatigue would benefit from the inclusion of resilience in ameliorating the deleterious effects of working with clients with trauma, and assist in explaining why some counsellors are better able to cope with compassion stress than others.

Although Figley (2002) acknowledged that social support is a potential protective factor against the development of compassion fatigue, this research did not support such a connection. One of the limitations of the current study was its failure to use a

validated social support scale. It could be that the measure used did not effectively measure social support for counsellors who work with trauma clients. Fenlason and Beehr (1994) also raised concerns that there was potential for support to reinforce stress—for example, where a support person may lead the stressed individual to believe that their situation was worse than they had thought.

Practical implications

One objective of this study was to raise awareness around issues of secondary traumatic stress and burnout among counsellors in New Zealand. The practical implications of the study are now discussed.

First, this study suggests that New Zealand counsellors may have greater exposure to secondary trauma as indicated by the high prevalence of secondary traumatic stress and of trauma clients within their caseloads. Counsellors may benefit from being provided with information about the potential for developing secondary traumatic stress when working with significant numbers of trauma clients. For example, counsellors who are at risk may exercise their discretion as to whether or not to accept additional trauma clients. Consideration should be given to the existing proportion of trauma clients within their caseloads and to the counsellors' wellbeing and stress levels.

Disengagement was one of the coping methods described in Figley's (2002) etiological model of compassion fatigue. The importance of counsellors being able to "disengage" from their clients' traumatic material is crucial in protecting against the development of secondary traumatic stress. One way in which counsellors can disengage may be through supervision, regular breaks, and support. However, it should not be left up to the discretion of individual counsellors to make this decision, but rather through standard workplace practices that actively protect counsellors from the effect of secondary trauma.

Second, while there was no difference in risk of secondary traumatic stress between counsellors with and without a personal trauma history, the current study did identify that a high proportion of counsellors had experienced personal trauma. This would suggest that experiencing personal trauma per se is not as important as having worked through the trauma's negative impact. Personal counselling and professional supervision may both play important roles here.

Third, the relationship between burnout and secondary traumatic stress highlights the importance of protecting counsellors against burnout. It is therefore recommended that the use of a screening procedure (such as the ProQOL by Stamm, 2010) be

implemented regularly. Counsellors scoring at high risk of burnout or secondary traumatic stress can then be supported as they address these issues.

Fourth, the relationship between resilience and secondary traumatic stress highlights the need to identify counsellors with low resilience, and for interventions and training that enhance resilience to be implemented for these counsellors.

Directions for future research are recommended. It is proposed that the prevalence of secondary traumatic stress among New Zealand counsellors be compared with that of counsellors from other countries. It is suggested that a social support measure specific to secondary traumatic stress is necessary to determine whether social support is protective against such stress. Such a measure should be developed and validated among a sample of professionals who work with clients who have experienced trauma. It would also be worthwhile to investigate the relationship between resolved personal trauma histories and secondary traumatic stress. Finally, it is clear that there is a need to develop and evaluate interventions designed to reduce burnout and enhance resilience.

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