WHEN CARING HURTS: THE SIGNIFICANCE OF PERSONAL MEANING FOR WELL-BEING IN THE PRESENCE OF SECONDARY TRAUMATIC STRESS

by

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ABSTRACT

Much of the research literature has focused on the primary victims of trauma and those with Posttraumatic Stress Disorder (PTSD). Only more recently have researchers begun to look at the well-being of those who care for these individuals. Those who have been victimized do not heal in isolation; most often they seek emotional support from family and friends. Further, there are many occupations that include regular exposure to traumatized individuals. Secondary Traumatic Stress (STS) is a risk for everyone who supports primary victims of trauma (Figley, 1995; Stamm, 1999). Since STS affects both the caregiver and indirectly the victim, it is particularly important to understand the various predictive and protective factors involved in the development of STS. Exposure to traumatic events may result in substantial changes to one's worldview. When the assumptive world is shattered, beliefs about self, others and the meanings that life once held no longer make sense (Janoff-Bulman, 1992). Initially, this is very disorienting. Not only are victims at risk for this experience but also their helpers (Arvay, 1999). However, as individuals begin to re-evaluate their losses, a search for a sense of purpose and meaning is evoked as a way of transforming these losses into new and viable worldviews (e.g., Frankl, 1969). Results from a sample of caregivers showed that a sense of meaning in life contributes to higher levels of well-being when exposed to secondary traumatic stress. Results revealed both a mediation and a moderation effect. Personal meaning buffered the effects of STS on well-being, resulting in especially high levels of satisfaction in life for caregivers reporting higher levels of meaning. The moderation analysis showed that individuals reporting lower levels of personal meaning also reported greater decreases in well-being when compared with those with higher levels of personal

meaning. In addition, personal meaning partially mediated the impact of STS on satisfaction with life. Substantial direct (10%) and indirect (13%) relationships were both found. STS shaped satisfaction with life in two ways: indirectly through its challenge to personal meaning and directly with other influences on satisfaction with life.

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CHAPTER ONE: INTRODUCTION AND LITERATURE REVIEW

The subject of trauma became an area of particular interest following a personal experience of Posttraumatic Stress Disorder (PTSD). Later as I began to counsel clients who either had symptoms consistent with PTSD, or shared their personal stories of trauma, I began to wonder what the impact of working with these individuals might have on the caregiver. Initially, my interest was limited to counsellors. However, as I began to expand my research I discovered that many other professionals are regularly exposed to physical and/or emotional trauma through their occupations or volunteer work. For example, the nurses in the Sexual Assault Nurse Examiner (SANE) programs in hospitals provide emotional support and physical assessment to women who have been assaulted and raped. Volunteers in the Royal Canadian Mounted Police (RCMP) Victim Services sector are also exposed to trauma as they support victims of domestic violence, assist with sudden death notifications, and offer on-the-scene crisis intervention. Even the individual who lovingly supports a significant other through cancer or a car accident will feel the effects of the victim's trauma, grief and loss.

Following the Vietnam War, the public became familiar with the risk of developing PTSD. However, it has only been in the last twenty years that caregivers have been identified as being vulnerable to developing a similar form of distress known as Secondary Traumatic Stress Disorder (STSD or STS). The essential difference between PTSD and STS lies in the fact that the primary victim is traumatized by a particular event, or series of events, whereas the caregiver is traumatized by helping or wanting to help the primary victim and in doing so becomes exposed to the original trauma. The helper may begin to experience symptoms consistent with PTSD, except that the

symptoms are associated with the primary victim's trauma (Figley, 1995). For instance, a caregiver may be experiencing STS when she has nightmares or flashbacks about a car accident or a sexual assault that occurred to the individual that she has worked with or supported.

Given the potential for caregivers to experience STS, it is essential that we not only recognize the factors involved in the development of STS, but also delineate the sources that might protect or lessen the probability of helpers becoming significantly distressed. If our caregivers are troubled, they are at risk of not only harming themselves, but also potentially derailing the healing process of the individuals they were trying to care for in the first place. We know that every individual who works with traumatized people does not develop STSD; what then, can we learn about the differences between those with higher levels of STS and those with lower levels of STS?

In addition, what role does meaning in life play in providing some protection to a caregiver who is regularly exposed to another's emotional or physical trauma? Victor Frankl (1984), arguably one the world's best known proponents of meaning in life, asserts, "Once an individual's search for a meaning is successful, it not only renders him happy but also gives him the capability to cope with suffering" (p. 163). Similarly, Nietzsche's (1844-1900; n.d.) famous aphorism "He who has a why to live for can bear with almost any how," suggests that when we derive a sense of meaning and purpose in life we have a greater capacity to tolerate injustice and suffering. There are two questions arising from this line of reasoning. First, what does the impact of secondary traumatic stress have on a caregiver's sense of meaning in life? Second, does personal meaning in

life help to protect a caregiver from developing higher levels of secondary traumatic stress?

Conceptual Issues in Secondary Traumatic Stress (STS)

The primary focus of this research project was to examine whether meaning in life contributes to the overall well-being of an individual who is at risk for developing STS as a result of caring for someone who has been traumatized. This risk could emerge from involvement at work or from caring for a significant other.

The importance of these questions becomes clearer when reviewing literature on Secondary Traumatic Stress. A wide range of literature addresses STS from varying perspectives. For the purposes of the present project, the terms "informal caregiver" and "professional" will be used to include anyone who encounters traumatized people in the course of employment, whether or not they are mental health professionals.

First, I will review the history and development of STS for the reader and then provide information on related notions such as countertransference, vicarious trauma and burnout. A definition of STS as it pertains to this study will be given followed by an exploration of empirical studies done on secondary trauma. Risk factors for developing STS will also be looked at. Finally, personal meaning as a coping resource will be examined in light of how it might serve as a protective factor when caregivers are exposed to traumatized individuals. A list of the hypotheses concludes this chapter.

History and development. The consequences, both positive and negative, of empathically caring for someone who has been traumatized have been studied and labelled in a variety of ways within the literature. While there are a number of names to describe this phenomenon, and certainly some overlap in the symptoms described, there

is no doubt that within the process of helping someone who has suffered a traumatizing experience, there exists the potential to be become similarly traumatized. As Figley (1995) so aptly states, "There is a cost to caring" (p. 1). However, prior to understanding something about Secondary Traumatic Stress, it is important to first consider Post-Traumatic Stress Disorder (PTSD), which is associated with the primary victim.

Although the American Psychiatric Association (APA) officially recognized the notion of PTSD in 1980, the common symptoms consistent with this disorder had been known for over one hundred years (Arvay, 1999; Sexton, 1999). In the past it was known by other terms such as "shell shock, combat neurosis, and combat fatigue" (Sexton, p. 393). Even though 2000 cases of shell shock were diagnosed in 1940 during World War II (Arvay), the disorder was virtually overlooked until the Vietnam War. By then, thousands of veterans were suffering from their wartime experiences. Exerting pressure on the government, the Veteran's Administration was commissioned to conduct a wide-ranging study on the impact of the Vietnam War on these soldiers (Arvay). The outcome of this research produced a five-volume study in which the symptoms of Posttraumatic Stress Disorder are described demonstrating beyond any reasonable doubt the direct relationship to battle exposure (Herman, 1997). For the first time PTSD was listed as an anxiety disorder in the American Psychiatric Association's (1980) third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-III*) and refined in the *DSM-III-R* (1987) (Figley, 1995; Stamm, 1999).

Around this same time, it became apparent that victims of rape and violent crimes also displayed symptoms consistent with PTSD (Cameron, 1994). Arvay (1999), for instance, identifies Burgess and Holstrom's (1983) research, reporting their findings on

the psychological effects of rape. These researchers found that the victim's symptoms, which they labelled 'rape trauma syndrome,' were very similar to the symptoms described by war veterans. A link had been established between individuals who experienced rape, battery and incest, and those who had lived through the trauma of warfare.

Over time the research literature reflected the increased acceptance and understanding of the phenomenon known as PTSD. However, it has only been in the last twenty years that Secondary Traumatic Stress has also been acknowledged as a legitimate area of concern. Knowledge of Secondary Traumatic Stress has its roots in the emergency services literature (Nelson-Gardell & Harris, 2003). During the decade of the 70's, it became apparent that some rescue workers were displaying symptoms similar to PTSD and, as a result, group debriefings were put into practice as the primary prevention strategy (Iliffe, 2000). Other natural disasters such as such as the flood at Buffalo Creek provided evidence that those who had witnessed the event or lost a family member in the torrent experienced trauma symptoms long after the event (Arvay, 1999).

In her book *Trauma and Recovery*, Herman (1997) suggested that, "Trauma is contagious" and the helper experiences "to a lesser degree, the same terror, rage, and despair as the patient" (p. 140). Courtois (1988) also warned that PTSD could be contagious, calling it "contact victimization"; whereas, McCann and Pearlman (1990) labelled this phenomenon 'vicarious traumatization'. Gradually, it was becoming clear that traumatic stress was a not only a concern for primary victims, but also for those who witnessed the event or provided help in some way.

Information from countertransference literature also provided evidence that exposure to traumatized people often resulted in helpers manifesting trauma symptoms (Danieli, 1984; Figley, 1995; Pearlman & Saakvitne, 1995a; Wilson & Lindy, 1994). Countertransference is a notion that originated with psychodynamic therapy and has a variety of definitions, but traditionally refers to the unconscious emotional reactions to a client by the therapist (Figley, 1995). Figley further expanded on this notion by stating that STS includes, but is not limited to, the usual definition of countertransference. It had been assumed that countertransference happened only within the psychotherapeutic relationship. However, Figley argued that STS is the natural consequence of caring that occurs between two people when one has been traumatized and the other is distressed by the first person's trauma. Unlike countertransference, STS is not so much a problem to be eliminated but should be viewed as a "natural by-product of caring for traumatized people" (p. 11). Indeed, all caregivers (whether professional or non-professional) are affected in the process of helping traumatized fellow human beings.

The year 1995 seemed particularly significant in terms of adding to the expanding knowledge of STS. Three major books were published, each making significant contributions to an under-researched area. Pearlman and Saakvitne's book entitled *Trauma and the Therapist,* detailed information on experiences of psychotherapy with incest survivors, focusing on countertransference and vicarious traumatization. Stamm's (1995/1999) book *Secondary Traumatic Stress* and Figley's *Compassion Fatigue* both contained chapters exploring the impact on those who work with the traumatized, including counsellors and other professionals such as emergency workers.

A review of current research reveals that there is a growing body of literature on STS in an attempt to better understand the causes, effects and ways to manage this stress. There are numerous articles with information promoting greater conceptual understanding of STS (Arvay, 2001a; Badger, 2001; Figley, 2002; Heather, 2002; Phipps & Byrne, 2003; Salston & Figley 2003) including literature on counsellors, and experiences of vicarious traumatization (Etherington, 2000; Sexton, 1999). While there are still too few empirical studies available, there are a number of quantitative and qualitative studies that have been published within the past few years. These will be reviewed in a later section of this chapter.

An internet search on STS brings up many websites which list related books, studies, and information. In addition, many organizations such as the RCMP Victim Services provide regular training and annual workshops for volunteers on STS and related self-care strategies. SANE nurses also receive training on STS and provide opportunities for staff members to debrief and obtain emotional support when needed. According to head nurse Sheila Early (personal communication, May, 2005) of the SANE program at Surrey Memorial Hospital, providing STS training and support has dramatically reduced the high turnover of nurses leaving the program. Initially many nurses left after only one year, whereas some have now been active in the program for as long as ten years.

An understanding of STS and the need for training and support has come a long way. Survivors of abuse, violence, and natural disasters will continue to need the assistance of caregivers. It is therefore vital that we persist in our effort to identify the

related predictive and protective factors in order to better support both helpers and victims.

Vicarious traumatization, compassion fatigue, and secondary traumatic stress. There are several terms to describe what happens to individuals who work with those who are traumatized. The definitions of vicarious traumatization, compassion fatigue, and secondary traumatic stress will be outlined, along with similarities and differences between the terms.

Vicarious Traumatization (VT) was first described by McCann & Pearlman (1990), and refers to the cumulative transformative effect upon the trauma therapist as a result of working with survivors of traumatic life events (Pearlman & Saakvitne, 1995a), and is particularly relevant for therapists who work with victims of sexual assault and incest survivors. The underlying assumption of VT is that it causes profound disruptions in the therapist's frame of reference, including his or her basic sense of identity, worldview, and spirituality (Pearlman & Saakvitne, 1995a). Almost every aspect of the therapist's life is impacted, resulting in changes such as affect tolerance, beliefs about self and others, interpersonal relationships, and sense of oneself in the world (Pearlman & Saakvitne; Jenkins & Baird, 2002; Steed & Downing, 1998).

While some may identify VT only with those who work with survivors of incest and sexual violence, Pearlman & Saakvitne (1995a) state that VT is an occupational hazard for

> All trauma workers, including emergency medical technicians, fire fighters, police, criminal defence lawyers, medical personnel, battered women's shelter staff, sexual assault workers, suicide hotline staff, AIDS volunteers, prison

> personnel, and trauma researchers, as well as journalists, clergy, and others who engage empathically with victims and survivors. (p. 31)

Like VT, the term Compassion Fatigue (CF) is often used when referring to reactions and changes acquired by those who work therapeutically with individuals who have been traumatized (Motta, Newman, Lombardo, & Silverman, 2004). Figley (2002) explains that when a caregiver extends compassion and empathy in an effort to understand the suffering of a client, the helper also suffers. This may lead to CF, which limits the caregiver's ability, or interest, in bearing the suffering of others.

Secondary Traumatic Stress is a term used to describe reactions of individuals who have close contact with trauma survivors, and refers to the same set of symptoms as Compassion Fatigue. In fact, Figley uses these terms interchangeably (Figley, 1999; Salston & Figley, 2003). This writer asserts that this condition, whether you call it Compassion Fatigue, Compassion Stress, or Secondary Traumatic Stress, is the natural outcome of working with traumatized individuals, and is not only predictable but also treatable.

Secondary trauma, although less severe, is a set of symptoms similar to PTSD. Figley (1995) describes Secondary Traumatic Stress Disorder (STSD) as:

> A syndrome of symptoms nearly identical to PTSD, except that exposure to knowledge about a traumatizing event experienced by a significant other is associated with the set of STSD symptoms, and PTSD symptoms are directly connected to the sufferer, the person experiencing primary traumatic stress. (p. 8)

Simply put, PTSD is the reaction that occurs when something very distressing

happens to an individual, and STSD is the reaction that happens to the person who has empathically listened to the distressing events experienced by the primary victim (Figley 1995; Nelson-Gardell & Harris, 2003).

While there is overlap in the symptoms cited for Vicarious Trauma and Secondary Traumatic Stress, the main difference between the two is that VT is a concept based on McCann and Pearlman's (1990) constructivist self development theory that focuses on the whole person, emphasizing integration, meaning, and adaptation (Pearlman & Saakvitne, 1995a; see also Bell, 2003); whereas STS is based on a set of symptoms found within the diagnostic criteria of PTSD in the *DSM IV* (1994; see Arvay, 2001a; Figley, 1995).

In summary, no matter the name or theoretical constructs one uses, I agree with Arvay (2001a) and others (Bell 2003; Figley, 1995; Motta, Newman, Lombardo, & Silverman, 2004; Stamm 1999), that all these terms refer to similar reactions that may occur when professionals, family members, or friends care for someone who is suffering from a traumatic experience.

Burnout. While burnout and STS share some of the same symptoms, they are not the same construct. The essential difference between the two lies in the cause of the symptoms. Burnout has many contributing factors such as an overload of responsibilities, conflicts between individual values and organizational goals, having little control over the quality of services provided, and inequality or lack of respect at work (Nelson-Gardell & Harris, 2003; Salston & Figley, 2003). Burnout occurs because of the ongoing demands of caring for others in either a work setting or family, rather than due to exposure to traumatized individuals such as is the case with STS (Iliffe, 2000; Motta,

Keefer, Hertz, & Hafeez, 1999). In addition, burnout happens slowly as a result of emotional exhaustion; whereas, the onset of STS can begin very quickly and without warning (Figley, 1995). While burnout is a risk for anyone involved in human service work, STS is the direct result of having been exposed to another individual's traumatic experience(s). Therefore, people can experience either burnout or STS and sometimes both, but they must be understood and treated as separate stressors.

Definition of secondary traumatic stress. For the sake of clarity, Figley's (1995) definition of STS will be used throughout this paper:

> We can define STS as the natural consequent behaviours and emotion resulting from knowing about a traumatizing event experienced by a significant other-the stress resulting from helping or wanting to help a traumatized or suffering person. (p. 7)

As noted above, the experience of STSD is less severe than PTSD, however, it is also characterized by symptoms that include: intrusive thoughts, nightmares, avoidance of thoughts/feelings, numbing, exaggerated startle response, changes in worldviews and/or crises in spirituality or trust and intimacy issues. The nightmares and intrusive thoughts are the traumata from the primary victim and there is often anger toward the perpetrator(s), decreased interest in activities, isolation from others, difficulty with concentration, and flattened affect (Figley, 1995; Herman, 1997; McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995a).

Empirical Research on Secondary Traumatic Stress

The conceptual understanding of STS has steadily developed over the last twenty years, yet the number of empirical studies in existence is still fairly limited. Further

empirical investigation is needed in order to substantiate and differentiate factors that contribute to the development of STS as well as the conditions that protect individuals from becoming traumatized (Arvay, 2001a; van Ijzendoorn, Bakermans-Kranenburg & Sagi-Schwartz, 2003; Zimering, Munroe, & Guilliver, 2003). For the purposes of this project, both quantitative and qualitative investigations are important to review. Brief descriptions of relevant STS questionnaires will also be provided.

Quantitative research. Pearlman and Mac Ian (1995) surveyed 188 self-identified trauma therapists in order to measure their perceived psychological well-being following exposure to their clients' traumatic material. These researchers found that therapists with personal histories of trauma showed greater disruptions than those without trauma histories, scoring higher on five of the seven subscales on the Traumatic Stress Institute Belief Scale (Pearlman, 1995). In addition, therapists with trauma histories were more negatively affected by the length of time they had been doing trauma work and by the number of trauma survivors on their caseloads. Results also revealed that the newest therapists with trauma histories were experiencing the most difficulties. However, these new therapists were not receiving supervision and tended to be working in hospitals.

Schauben and Fraser's (1995) study examined vicarious traumatization among female counsellors who worked with survivors of sexual violence. It was found that those with higher caseloads of survivors experienced greater numbers of PTSD symptoms, held more disrupted beliefs (particularly about the goodness of others), and experienced greater degrees of self-reported vicarious traumatisation. In contrast to the previous study, a counsellor's personal trauma history was found not to be related to symptoms of distress. In a qualitative component of the study, participants were asked to specify the

most difficult and positive aspects of their work as well as the coping strategies employed to relieve stress. Of the various coping strategies used by these counsellors, the five most common were active coping, emotional support, planning, instrumental support, and humour. Lower symptom levels were found to be correlated with the use of these five coping strategies.

A study by Follette, Polusny and Milbeck (1994) focused on general and trauma symptoms in mental health and law enforcement professionals. The researchers found significantly more distress among enforcement professionals than among mental health workers. Personal stress, a trauma history, and negative responses to investigating sexual abuse cases were predictive of trauma symptoms among law enforcement officers. Mental health professionals, however, were not found to be negatively impacted by their trauma histories or by percentages of sexual abuse cases on their caseloads. On the other hand, the development of trauma symptoms for mental health workers was found to be related to negative coping responses, clinically ineffective responses to clients, and levels of personal stress. While secondary traumatic stress symptoms were found among both groups, it was suggested that law enforcement professionals would benefit from additional education and support around understanding the risks involved in this type of work. In addition, this group should also be encouraged to engage in positive coping strategies and the use of personal therapy.

Kassam-Adams (1995) studied the relationship between exposure to traumatized clients and STS amongst 100 psychotherapists. Level of work-related STS symptoms was significantly correlated with therapist's exposures to sexually abused or assaulted clients.

Further, personal trauma history (especially childhood trauma) was also found to be a predictor of trauma symptoms.

Ghahramanlou and Brodbeck (2000) conducted a study that examined STS amongst 89 sexual assault trauma counsellors. Results revealed that personal trauma history and younger age were associated with higher levels of secondary trauma intensity. However, contrary to expectations, exposure to trauma survivors and levels of education did not predict psychological distress or STS.

Steed and Bicknell (2001) examined the presence of STS symptoms amongst 67 Australian therapists working with sex offenders. Although not all of their results proved statistically significant, this study clearly suggested that new therapists, and those in the field for longer than nine years, were most at risk of developing trauma symptoms. The researchers recommended further study on this population, as it appears that STS is undoubtedly a risk for therapists who work with perpetrators.

In an effort to understand the similarities and differences between VT and STS, Jenkins and Baird (2002), examined associations among measures of these trauma-related constructs in a sample of sexual assault and domestic violence counsellors. The TSI Belief Scale (TSI-BSL, 1994) was used to measure VT, while Figley's (1995) Compassion Fatigue Self-Test (CFST) was used for STS, with results suggesting that while there were some similarities in how trauma therapists experience both VT and STS, there are also some differences. These authors suggest that using both the TSI-BSL and CFST-CF together would help distinguish differences between therapists who are mainly struggling with the cognitive impact of trauma work, from those experiencing PTSD symptoms and negative experiences with clients.

Ortlepp and Friedman (2002) conducted a study with lay trauma counsellors that had both a quantitative and a qualitative component. Results revealed that while most counsellors experienced some STS symptoms, they were not within the clinical range. Neither prior exposure to work related traumas or personal trauma histories was related to counsellors' levels of STS. Moreover, counsellors' coping styles, as measured by Antonovsky's (1987; cited in Ortlepp & Friedman, 2002) sense of coherence construct found that higher levels of sense of coherence were strongly related to lower levels of STS as well as role satisfaction. It is important to note that in this study it was also found that the perceived effectiveness of the training program played a significant role in counsellor's feelings of self-efficacy and satisfaction as counsellors.

Nelson-Gardell and Harris (2003) studied the link between personal trauma history, childhood abuse or neglect, and increased risk of STS in child welfare workers. The findings revealed that childhood emotional abuse or neglect put the welfare workers most at risk of developing STS.

A meta-analysis on 32 samples involving 4,418 participants (van Ijzendoorn, Bakermans-Kranenburg, & Sagi-Schwartz, 2003), examined secondary traumatization within Holocaust survivor families. Initial results showed significant differences in psychological well-being and adaptation between second generation Holocaust survivors and members of a comparison group. However, when the set of studies was divided between convenience samples (Holocaust survivor groups, meetings) and non-selected samples, only the convenience samples showed any STS symptoms. In addition, second generation Holocaust survivors were only less well-adapted than their comparisons when there was also an additional serious stressor such as combat disorder or breast cancer.

The researchers suggested that one plausible explanation for these results might be that there were often protective factors in the families, children, or the environment that lessened the impact of parent's traumas on their children.

Quantitative research clearly reveals there is a cost to caring for traumatized individuals. A consensus has emerged that many trauma counsellors have experienced at least some degree of disruption, although not necessarily displaying clinical levels of impairment. In addition, while we have gained some valuable information on various factors that contribute to STS, there remains an obvious need for further studies to fully understand the predictive factors in the development of STS. Conflicting results regarding personal trauma histories, size of caseloads, and length of time as a counsellor, all need further investigation. Moreover, counsellors have been the major source of study for STS research and therefore, further quantitative investigation is needed for families and other caregiving networks.

Qualitative research. Qualitative researchers are able to take a deeper look at the impact of STS by exploring the lived experience of trauma work. Caregivers can be asked about positive and negative changes experienced as a result of their caregiving, as well as the coping strategies they employed. For instance, Danieli (1984) conducted in-depth interviews with 61 trauma therapists and looked at the various emotional responses and other problems experienced as by-products of their work with survivors of the Holocaust. It was found that the therapists were using a variety of defences such as numbing, avoidance, and distancing (Sexton, 1999), and had nightmares similar to their survivor clients (Arvay, 2001a).

Steed and Downing (1998) conducted interviews with 12 female therapists. All participants worked as sexual abuse/assault counsellors. The interviews revealed that all of the therapists experienced VT, citing symptoms such as fatigue, disturbed sleeping patterns, flashbacks, dreams, and intrusive thoughts. An interesting note, however, was that many of the therapists had experienced positive changes in their sense of meaning/spirituality and worldview which included increased self-awareness and the addition of new perspectives.

In her dissertation, Arvay (1999; 2001b) investigated the meanings that four trauma counsellors made of their struggles with secondary traumatic stress. Narrative analyses revealed seven areas of particular concern: struggling with changing beliefs, intrapsychic struggles, therapeutic relationship struggles, work-related struggles, struggling with social support, power issues, and physical illness. Arvay's work highlighted how deeply trauma work can impact individuals and documented attempts to reconstruct shattered beliefs and world views.

The purpose of Iliffe's (2000) study was explore the impact and lived experience of trauma work on 18 domestic violence counsellors. VT was reported, and changes were experienced in cognitive schemas: safety, worldview, and gender power issues. The most effective coping strategy identified was debriefing with colleagues after particularly difficult counselling sessions.

In a project completed by Dane (2000), two focus groups were formed, in order to study the impact of STS on child welfare workers. All 10 counsellors reported experiencing sadness as a primary emotion resulting from their work. Moreover, all cited numerous behavioural changes, such as detachment, staying busy, accepting one's

limitations, setting limits, and “cutting off” in an effort to reduce stress. Spiritual and religious beliefs were also cited as a significant coping resource that assisted them in finding meaning in their work.

Lyons (2001) used a phenomenological approach to study the experience of 10 wives and female partners of Vietnam veterans who suffered from PTSD. Interviews were conducted in order to explore the meaning of living with their partners through three overlapping phases of their relationships (early, middle, and later). The central meaning of living with a veteran (with PTSD) was a gradual process of becoming enmeshed in his pathology, followed by many attempts to minimize the impact on self and family, and finally working intermittently towards resolution/healing. All of the participants were found to be experiencing some degree of secondary traumatic stress. They had chronic stress related symptoms such as panic, agoraphobia, and hypervigilance. Various forms of coping were cited such as over-functioning in their roles, avoiding conflict, denial, repressing their anger, immersing themselves in their work, increasing self-care activities and spirituality.

Bell (2003) applied a ‘strengths’ perspective in exploring secondary trauma with counsellors of battered women. This researcher identified several strategies and resources that seemed to protect many counsellors from developing symptoms of secondary trauma. The counsellors who were the least stressed were those who had creative and resilient ways of approaching challenging situations, both at home and at work. Those in the high stress group tended to report multiple serious stresses, due to work, personal events, or some combination of both.

Research by Wasco and Campbell (2002) involved the emotional reactions of rape victim advocates. Findings revealed that the advocates faced both fear and anger; however, fear was most often associated with those who were newer to the job. On the other hand, anger remained salient even for those who had been advocating for rape survivors for many years. Finally, both emotional reactions were seen as catalysts for better self-care and taking action against some of the terrible events the advocates learned about on a daily basis.

Empirical research continues to lag behind the clinical and conceptual understanding of STS. It is apparent that much more work is needed in order to determine the correlates of STS as well as the protective factors. There are still too few studies, and sometimes contradictory results provide inconclusive evidence. For example, four studies (Ghahramanlou & Brodbeck, 2000; Kassam-Adams, 1995; Nelson-Gardell & Harris, 2003; Pearlman & Mac Ian, 1995), found a link between personal trauma history and the development of secondary traumatic stress, whereas two studies (Ortlepp & Friedman, 2002; Schauben & Frazier, 1995) found they were not related. Follette, Polusny, and Milbeck (1994) also claimed that trauma history was not significantly predictive of trauma symptoms among mental health workers, but seemed to have some influence on the investigative activities of law enforcement officers. However, these researchers found significantly higher levels of trauma-specific symptoms in both mental health workers and law enforcement officers reporting childhood physical or sexual abuse when compared to those in the sample not reporting these forms of childhood trauma.

Given the likelihood that there are a high number of trauma survivors who go on to support or work with traumatized individuals (Salston & Figley, 2003; Wiebe 2001), it

seems especially important to have a sense of how salient personal trauma history is for the development of STS. With this knowledge, caregivers might be more apt to consider the value of general support and self-care while engaging in trauma work.

In addition, there is still ambiguity regarding potential predictive factors for STS such as level of training or education (Ghahramanlou & Brodbeck, 2000; Ortlepp & Friedman, 2002; Steed & Downing 1998), support in the workplace (Ortlepp & Friedman), length of time doing trauma work and size of caseload (Kassam-Adams, 1995; Schauben & Frazier, 1995; Steed & Bicknell, 2001; Wasco & Campbell, 2002). Protective factors also need further study. Various coping strategies were cited such as debriefing (Iliffe, 2000), spiritual and religious beliefs (Dane, 2000; Lyons, 2001), resiliency (Bell, 2003), self-care, and advocacy (Wasco & Campbell; Steed & Downing), however, there is clearly a need for additional studies to identify and confirm the most effective methods for coping with exposure to traumatized individuals.

Professional models are still in tentative forms, and the uncertainty sometimes puts caregivers at greater risk of developing STS. While there has been an increase in the number of studies on STS, there is no consistency in the assessments used or in the factors studied. The value of investigating the various factors involved in the development and treatment of STS cannot be underestimated. The well-being of our caregivers is of utmost importance, because it has a direct impact on the level and quality of care provided (Herman, 1992/1997; Pearlman & Saakvitne, 1995b; Zimmering, Munroe, & Gulliver, 2003).

Finally, having reviewed the above studies, one might wonder if quantitative research tells us anything different about STS than qualitative research. The populations

chosen for the studies in both types of research are fairly similar, with the majority of participants being trauma counsellors. Although there were a small number of studies that investigated the experience of other types of caregivers, such as child welfare workers and the wives of Vietnam veterans, informal caregivers are clearly under-represented highlighting the need for further study in such populations.

Methods used to measure STS were predictably different between the two types of research. A variety of available assessments and questionnaires were used in the quantitative studies, whereas qualitative studies used semi-structured or in-depth interviews to gather all relevant information. This leads us to the question of whether quantitative and qualitative research provides similar (convergent) or different (divergent) information on STS and how individuals cope with exposure to traumatized individuals.

Both types of research reveal similar results: Exposure to traumatized individuals may lead to the development of Secondary Traumatic Stress symptoms. Quantitative research tends to focus on the correlates of STS and allows for greater generalizability due to the larger sample sizes. On the other hand, qualitative researchers explore the impact of trauma work on much broader levels, and often include commonly used coping strategies. Both types of studies are needed. Quantitative researchers reveal that people experience changes in their world views, levels of trust, vigilance, and so on; while qualitative researchers provide understanding regarding those levels of changes that are experienced by caregivers. In Arvay's (1999) qualitative study for example, she offered a particularly close look at lived experiences of trauma work, while Bell (2003) used a 'strength' perspective to identify strategies and resources used to prevent STS symptoms.

Quantitative researchers provide important numerical data to highlight the risks associated with caring for traumatized individuals, while qualitative researchers provide narrative accounts of some of the positive and negative changes that caregivers experience. I believe that results of qualitative studies balance quantitative research findings, reminding us that while the numbers tell us that STS can and does happen, there are also positives changes that occur, such as increases in compassion and gratitude (Bell), and clarifications of values and attitudes (Steed & Downing, 1998).

STS questionnaires. Not only is there a lack of studies on STS, there seems to be difficulty in even assessing the point at which caregivers meet the clinical criteria (or impairment levels) for STS (Zimmering, Monroe, & Gulliver, 2003). Most scales do not have reliable cut-off scores to indicate the presence of clinical levels of STS (see Motta, Chirichella, Maus, & Lombardo, 2004), so there are no consistent means of determining when caregivers have reached clinical impairment levels. In addition, most instruments have been designed for particular populations such as mental health professionals, or those with primary PTSD.

The TSI Belief Scale (The Traumatic Stress Institute, 1994) was developed in order to measure disrupted beliefs in self and others as a result of exposure to traumatic material but the authors do not provide cut off scores. Figley (1995) developed a scale called the “The Compassion Fatigue Self-Test for Psychologists,” but is no longer recommended for use due to psychometric problems. The Secondary Traumatic Stress Scale (STSS) developed by Bride, Robinson, Yegidis, and Figley (2004) measures intrusion, avoidance, and arousal symptoms but also lacks cut-off scores, and is intended primarily for mental health workers.

Building on Figley's (1995) original scale, Stamm (2005) developed a new measure entitled, "The ProQOL: The Professional Quality of Life Scale: Compassion Satisfaction, Burnout & Compassion Fatigue/Secondary Trauma Scale IV." This scale looks promising as it is intended for a wide range of helpers, rather than specifically for mental health workers and includes cut-off scores. However, Stamm does not recommend this scale for assessing family caregivers; instead suggests individuals consider other caregiver scales. While other scales measure overall stress levels, I could not find any scales that measure secondary traumatic stress other than Motta's (1999; 2001) instrument.

Given that STS exists in all segments of the population and professions, a reliable tool to assess secondary traumatic stress among general populations seems particularly important. For this reason the Secondary Trauma Scale by Motta, Hafeez, Sciancalepore, and Diaz (2001) was chosen for this project (see Table 1 for comparisons with other instruments).

The first scale, designed by Motta, et al., (1999), was a paper-and-pencil questionnaire, later modified and renamed "The Secondary Trauma Scale" (Motta et al., 2001). It was designed to test for the presence of STS among all types of caregivers.

The original scale was given to two sets of participants who had been consistently exposed to other traumatized individuals. In the first case, a sample of 157 middle-class students in an introductory psychology class at a private university was asked to complete the survey as part of a course requirement. The second sample consisted of 261 mental health professionals who worked with a large number of HIV/AIDS cases. Results showed the scale was significantly correlated with other standard measures of PTSD such

Table 1

Construct Definitions used for Current Scales Assessing Characteristics of Secondary Traumatic Stress

	Intended Respondent Groups	
Scope of Secondary Stress (in life of respondent)	Both Professionals & Informal Caregivers	Professionals Only
Specific Domains in Life (e.g., a specific relationship; only work-related STS)	STS (Motta, 1999; 2001); ProQOL (Stamm, 2005)	CFST (Figley, 1995); CFST (Figley & Stamm, 1996); STSS (Bride, Robinson, & Figley, 2004); TSI Belief Scale (Traumatic Stress Institute, 1994)
Global Coverage (e.g., both personal relationships & work-related sources of STS may be included)	ProQOL (Stamm, 2005)	

Note. STS = Secondary Trauma Scale; ProQOL = Professional Quality of Life: Compassion Satisfaction and Fatigue Subscales; CFST = Compassion Fatigue Self Test for Psychotherapists; STSS = Secondary Traumatic Stress Scale; TSI Belief Scale = Traumatic Stress Institute Belief Scale.

as the Impact of Event Scale (Horowitz, Wilner & Alvarez, 1979). This also confirmed that secondary trauma and posttraumatic stress share similar symptoms (Motta et al., 1999).

Two follow-up studies were conducted (Motta et al., 2001; Motta et al., 2004) and the scale was reduced from the original 20-item questionnaire to 18-items which measured two factors: intrusion and avoidance. In both studies, undergraduate students from a university volunteered to participate as part of a requirement to obtain course credit. The main purpose of the research project published in 2001 was to establish the discriminant validity of the modified STS. Results showed good internal consistency and discriminant characteristics, and satisfactory correlations with other known measures of trauma (Motta et al., 2001). Researchers have yet to address the epidemiology of STS so evaluating STS measures for sensitivity and specificity, for instance, will await future developments.

The purpose of the study published in 2004 was to establish cut-off scores for the STS. Such cut-off scores indicate the point at which anxiety, depression, intrusive thoughts and avoidance create significant emotional difficulties for the helper. Although cut-off scores were established, researchers cautioned that results were preliminary, and that further study using the scale was needed.

The Secondary Trauma Scale (Motta, et al., 1999; 2001) currently remains under development. Because the original scale was recently reduced to 18 items and subscale development is in preliminary stages, more studies are clearly needed. It is my intention therefore, to gain more information in the present study regarding the usefulness and

validity of Motta et al.'s Secondary Trauma Scale (1999; 2001). The Secondary Trauma Scale was chosen because of the population focus for this particular research project. As noted earlier, other available scales were primarily designed for professional mental health workers. An instrument was needed that was designed to allow the researcher to examine secondary trauma in both non-professional and professional caregivers in the same study. In addition, the focus of the Secondary Trauma Scale is very specific. Participants are asked at the beginning of the questionnaire to think about a particular traumatizing event that has happened to an individual that they are close to, or have helped. By doing so, the results of the test can apply to a specific relationship, or to a particular client at work. Finally, instrument development continues, which will greatly benefit future caregivers.

Risk factors for developing sts. STS is a risk not only for professional helpers such as counsellors, social workers, and emergency response workers (Badger, 2001; Dane 2000; Etherington, 2000; Figley, 1995; Herman, 1992/1997; Iliffe, 2000; Pearlman & Saakvitne, 1995a; Sexton, 1999; Stamm, 1999; Steed & Bicknell, 2001), but also for anyone closely associated with trauma survivors such as spouses living with partners with PTSD, children raised by traumatized parents, and wives of war veterans (Lyons, 2001; Motta, et al., 1999; Nelson & Wright, 1996). In addition, shelter/transition house workers, rape victim advocates, rehabilitation counsellors, lawyers, judges, researchers, journalists, those who work with crime victims, and bank employees may be significantly affected by their exposure to primary victims (Dutton & Rubinstein, 1995; Ochberg, 1996; Ortlepp & Friedman, 2002; Pearlman & Saakvitne, 1995a; Salston & Figley, 2003; Stebnicki, 2000; Wasco & Campbell, 2002).

In short, almost anyone is at risk for developing symptoms of STS when two factors are present: exposure and empathy. An effective helper must have the ability to empathize with the victim in order to develop sufficient trust and rapport, to assess the problem and formulate a treatment approach but, ironically, it is that ability to understand an individual's experience of being traumatized that puts the caregiver at risk (Figley, 1995; Pearlman, 1999). That being the case, and the fact that STS is a normal, predictable, and inevitable outcome of trauma work (Salston & Figley, 2003; Pearlman & Saakvitne, 1995a), it is critical that we continue to gain an understanding of all that is involved in the development of STSD and potential protective factors.

Summary: researching sts. As acknowledged above, STS is an important issue identified in the literature. However, empirical studies on STS are limited in scope. In particular, few studies document risk factors, protective factors, or overall patterns of recovery from this disorder. It is imperative that there be understanding about how caregivers become distressed or traumatized following exposure to survivors. With such knowledge it is likely that traumatic stress among helpers can be minimized, and quality of care for victims can be improved as caregivers are supported (Figley, 1995).

Although the literature is replete with differing labels, definitions, and characteristics of STS (Figley, 1995; Herman, 1992/1997; Pearlman & Saakvitne, 1995a; Stamm, 1999), there is a consensus among researchers and clinicians that something happens to people who are in regular contact with traumatized individuals. STS symptoms can, and do, occur under normal circumstances in most therapeutic situations. It becomes a serious predicament, however, when it begins to affect the psychological health of the 'helper,' which in turn affects the primary victim as well. Beaton and

Murphy (1995) suggest that the costs of inattention to the problems associated with STS include a variety of disorders (both emotional and physical), interpersonal struggles, substance abuse, burnout, and abandoned careers.

While additional research on STS among mental health workers is surely warranted, further study on informal caregivers such as volunteers, and family members and other non-mental health professionals, is essential. These groups need further investigation, in order to provide information to assist them in understanding their experiences of caregiving, and related stresses. Such understanding will benefit both caregivers and those they are supporting.

STS and Personal Meaning

Another important variable to consider when exploring how to reduce the risk of developing STS, or aiding in recovery from STSD, is personal meaning. While there are various coping strategies employed by caregivers, personal meaning is a key resource for managing STS, and one that certainly merits a closer look. Results from a number of studies suggest the value of personal meaning in life as an STS resilience factor.

Ortlepp and Friedman (2002) conducted a study in which they examined the relationship between a sense of coherence, and indicators of STS among non-professional trauma counsellors. Antonovsky's (1987) Orientation to Life Questionnaire was used to measure "Sense of Coherence" in lay counsellors in the banking sector in South Africa, and the Compassion Fatigue Self-Test (Figley & Stamm, 1996) was used to determine whether STS was present. The Orientation to Life Questionnaire includes three sub-scales: manageability, meaningfulness, and comprehensibility. Results indicated that a sense of coherence had a strong main effect covarying with indicators of Secondary

Traumatic Stress. In addition, the meaning associated with the act of helping bank employees who had been robbed played a significant role in determining the helper's degree of compassion stress and compassion satisfaction. In this case, meaning could be seen as a protective factor against developing compassion fatigue.

Pearlman (1999), writes about her experience with VT following her return from a trip to Rwanda in which she listened to many stories of helpers who were also traumatized as a result of the 1994 genocide: "I am working to transform my VT by following my passion, strengthening connections, and creating meaning" (p. l). She asserts that while it may be a struggle to find meaning and make sense of what happened, it is a crucial part of working through VT.

A review of grief literature reveals several researchers who provide support of the search for meaning during the process of bereavement (Bowes & Butler, 2002; Davis, 2001; Neimeyer & Keesee; 1998; Neimeyer, 1999, 2000; Walton, 2002). While Neimeyer (2000) believes that grief therapy may or may not assist a client with 'normal' grief, he believes it can be particularly beneficial for clients with traumatic or prolonged grief. He suggests that grief therapy with these clients must "attend to the profound challenges to clients' (inter) personal systems of meaning brought about by tragic loss and facilitate the survivor's own struggle to find significance both in the death and in their ongoing lives" (p. 548). Because Neimeyer considers the search for meaning in traumatic loss an important aspect of healing, I propose that those who support traumatized individuals must also attend to their experiences of personal meaning as they are confronted with stories of violence, abuse and associated losses inherent in changed worldviews.

In her book *Shattered Assumptions*, Janoff-Bulman (1992) suggests that most people have a worldview that consists of three fundamental assumptions: “our world is benevolent, our world is meaningful [and] the self is worthy” (p. 6). When an individual experiences a traumatic experience he or she is confronted with the seeming disparity between those core beliefs that once made sense and a worldview that has radically changed and no longer fits. As the caregiver repeatedly listens to, supports, or works with those whose lives have been significantly altered by traumas, often their fundamental assumptions are also significantly challenged. As the caregiver attends to these challenges and is able to find significance or meaning in both their work and daily lives perhaps, as Pearlman (1999) suggests, the experience of STS would be transformed and serve as a protective factor against STSD.

Rhonda Wiebe (2001) examined the relationship between perceived meaning in life and the experience of vicarious traumatization among therapists. The purpose of Wiebe’s study was to empirically investigate whether a negative correlation exists between the experience of vicarious traumatization and higher levels of personal meaning in life. Her results supported this hypothesis, and indicated that “The more personal meaning therapists experienced in their lives, particularly from relationships, the more able they were to integrate vicarious traumatization into their personal and professional selves” (p. 34).

Aarts and Op den Velde (1996) assert that it is vital to assign meaning and to come to an acceptance of one’s life story in order to enjoy to the last stages of life. Walton (2002) explored how meaning and purpose in life can help the recovery of

patients who have experienced heart traumas. Again, personal meaning was suggested as a positive contributor to enhance recovery of these individuals.

Finding meaning in the midst of suffering is not a new concept. Victor Frankl, founder of logo therapy, and author of the renowned book, *Man's Search for Meaning* (1946/1984) believes that our greatest task is seeking meaning and fulfillment in life. He contends that, "Once an individual's search for a meaning is successful, it not only renders him happy but also gives him the capability to cope with suffering" (p. 169). Perhaps if caregivers are able to find meaning in their work with trauma survivors the benefits would be two-fold. First, as the caregiver experiences a sense of meaning in providing help to the survivor, conceivably this would then increase the caregiver's tolerance for coping with the suffering experienced vicariously, thereby reducing the level of secondary traumatic stress. Secondly, as helpers are able to integrate the injustices and paradoxes of suffering into their worldviews, they are better 'equipped' to do the work of helping the primary victims to do the same. In her book *Meaning in Suffering*, Elisabeth Lukas (1986) speaks about the responsibility one has as a caregiver: "No suffering can defeat us if we are prepared to search for its meaning, no loss is conceivable that does not hold the possibility of at least one meaning-that is the answer we owe to those who seek our counsel" (p. 80).

Wong (1998) also writes about meaning-centered counselling. He offers a model in which individuals are encouraged to consider the meaning of problems with which they are presented, and to develop meaningful life goals. Wong suggests that as an individual develops a clear sense of meaning and purpose, he or she tends to have a greater ability to cope with any difficulties or challenges that life may bring. Existential

coping is a key concept within this model. It involves acceptance of problems as realities of life and discovering of positive meanings in these negative life experiences. With this in mind, Wong (1998) developed the Personal Meaning Profile (PMP), used to identify areas of perceived personal meaning in individuals lives. Wong's instrument is used in this research study and will be reviewed in the Methods section of this thesis.

Folkman and Lazarus (1980) are well known for their research in the field of coping. They propose a model that includes 'problem-focused coping' and 'emotion-focused coping', to describe the processes individuals engage in to cope with stressful situations. 'Problem-focused coping' is seen as creating a plan of action or focusing on the next step. 'Emotion-focused coping', however, involves distracting activities such as the use of alcohol, drugs, or soliciting emotional support. While these two forms of coping certainly capture some of what goes on for individuals under duress, like Wong (1998), researchers have recognized that meaning-focused coping is also a strategy that is employed by those in difficult circumstances (Folkman & Moskowitz, 2004). Farran and Kuhn (1998) cite several studies that examined the role of meaning for caregivers of persons with Alzheimer's disease, and suggest that further study is warranted because it appears that meaning is associated with lower levels of caregiver distress.

Meaning-focused coping involves our values, beliefs, and goals (Folkman & Moskowitz, 2004). As caregivers we are exposed to many situations that clash with our beliefs, values, and goals, which is one reason STS may occur: in essence, our worldview becomes severely challenged or 'shattered' (Janoff-Bulman, 1992; Pearlman & Saakvitne, 1995a). However, if we engage in positive reappraisal that "involves a reinterpretation of the event in terms of benefits to one's values, beliefs and goals"

(Folkman & Moskowitz, p. 766), perhaps both survivor and caregiver can discover meaning(s) that would allow healing (and even growth) despite traumatic events.

As part of the healing process, Janoff-Bulman (1992) explains that it is not at all unusual for survivors over time to completely re-evaluate their traumatic experiences and transform them into recollections that have positive value and meaning. While such traumatic experiences would not have been chosen, they can be seen as a powerful, even worthwhile, life lessons. Survivors re-establish meaning in their life by viewing events as catalysts to reprioritize their lives, establishing new purposes, and perceiving benefits to both themselves and others. For example, many trauma victims report that they are much more compassionate, caring individuals and are far stronger and able to handle life's future difficulties. Just as STS mimics many symptoms of PTSD, caregivers therefore, may engage in the same healing processes as survivors of trauma. Over time, the helper discovers new meanings, strengths, resiliency, and capacity for caring; he or she too transforms negative events into positive life lessons that lessen the risk of STS.

Given the vast number of informal caregivers, volunteers, and others who support victims of trauma, it is critical that we continue to study the factors that lead to the development of STS symptoms. Moreover, the lack of empirical studies and conflicting evidence confirms the need for further research in order to clearly understand the correlates of STS, and factors that might decrease the risk associated with caring for traumatized individuals. In addition, we know that personal meaning is a powerful coping resource that has the potential to protect caregivers from elevated symptoms of distress. Further research is therefore warranted, in order to gain greater understanding of

the ways that meaning is impacted by STS and how it might also serve as a protective factor.

Hypotheses

The main purpose of this study was to determine whether personal meaning changes the way secondary trauma affects our well-being. Motta's Secondary Trauma Scale (STS), Wong's Personal Meaning Profile (PMP), and Deiner's Satisfaction with Life Scale (SWL) were used in the research. It was anticipated that STS scores and SWL scores would be negatively correlated. The following hypotheses were posited:

1. There will be a negative correlation between total STS score and total PMP score.
2. There will be a positive correlation between the total PMP and SWL scores.
3. The relationship between the STS and SWL will be weaker when the total PMP score is taken into account (partialled out).

In other words, it was expected that personal meaning would mediate the impact of STS on the well-being of caregiving individuals. It was hoped that the results of this study would help determine the degree to which personal meaning mediates levels of well-being for individuals, in the presence of secondary traumatic stress. Post hoc analyses were conducted to explore other relationships among these variables.

CHAPTER TWO: METHOD

Participants

This research project was entitled *The Caring Hurts Study* and was advertised in several ways. A recruitment letter (see Appendix A) was the opening page on a web site designed for on-line questionnaires (www.surveymonkey.com). Volunteers and staff of the RCMP (Royal Canadian Mounted Police) Victim Services Program as well as individuals working with the SANE (Sexual Assault Nurses Examiners) program across the province were sent an email with a link to the recruitment letter at the survey site. Secondly, a brief description of the study with the web site address was shown on an overhead at the beginning of several nursing classes at Trinity Western University (Langley, BC). Flyers advertising the study were also made available in the waiting room to patients who were seeing doctors at a naturopathic clinic (South Surrey, BC) as well as to the volunteers and staff at a women's center (White Rock, BC). Lastly, personal contacts of the researcher were encouraged to visit the online survey.

Opportunities were also provided for participants to use a paper and pencil version of the questionnaires to minimize selection due to the use of an online format. Forty packets (containing paper and pencil surveys) were given to the naturopathic clinic, and a dozen, to a child and family counselling agency. Only three packets were returned with the self-addressed, stamped envelope provided. Both the on-line version and the paper and pencil copy of the study met all the criteria for the TWU Review of Ethics Board (REB).

Participants in the study included people who had secondary exposure to trauma via their caregiving roles with individuals, through work or with family members and

friends. The small response rate for the paper and pencil survey was 6%. An estimate of the response pattern from the on-line recruitment format was 40% and can be stated roughly, as 238 from approximately 600 primary email contacts, plus the secondary recruitment from participants who forwarded the email to personal contacts. The total number of completed on-line surveys totalled 200, yielding an overall completion rate of 84%. This pattern of response showed a real interest in participating, especially since the link failed at times and quite a number of people contacted the researcher to ask for assistance. A follow-up email was sent with another link to the survey.

Participants were invited to submit their names and email addresses in a draw for a $50 gift certificate to Chapters Bookstore (See Appendix B). The draw was held, and the winner was contacted after the deadline for the draw. Of those that who filled out (but not necessarily completed) the survey, 205 participants entered the draw. No double entries for the draw were identified.

Instruments

A series of demographic questions were included (See Appendix C). Information regarding age, gender, religious affiliation, education, and exposure to trauma via occupation were obtained. In addition, three questionnaires were included: The Secondary Traumatic Scale (Motta et al., 1999; 2001), The Satisfaction with Life Scale (Deiner et al., 1985) and The Personal Meaning Profile (Wong, 1998).

The Secondary Trauma Scale. The Secondary Trauma Scale (STS; Motta et al., 1999; 2001) is being developed to assess secondary traumatic stress in general populations. The STS (see Appendix D) reflects the symptoms listed for PTSD in the *DSM-IV* (1994), and was also derived from the Compassion Fatigue Self-Test for

Psychotherapists (Figley, 1995; Motta, et al., 1999). This scale measures symptoms associated with intrusion and avoidance.

Since their early publications, Motta and his colleagues have been refining the scoring of the STS. The original version consisted of 20 items rated on a scale from 1 to 5 (1 = “rarely/never” to 5 = “very often” (Motta et al., 1999). In a later revision, two items were dropped from the total score based on results of an item-level principle components analysis (Motta et al., 2001). In the present sample, principle components analysis also identified two items that should be dropped from the total score (see Appendix D). The Secondary Traumatic Scale was given to a group of undergraduate university students as well as a sample of mental health professionals (Motta et al., 1999), along with the Modified PTSD Symptom Scale Self-Report (PSS; Resick, Falsetti, Resnick & Kilpatrick, 1991) and the Impact of Event Scale-Revised (IES-R; Horowitz, Wilner, & Alvarez, 1979). The STS was related to both the IES-R and the MPSSS. Internal consistency scores were estimated at .88 for a student sample and .75 for a mental health sample. Responses to the questionnaire in both populations were significantly correlated (*r*’s ranged from .33 to .56, all *p’s* < .01) with standard measures used in the assessment of PTSD (Motta et al., 1999).

The purpose of the study published in 2001 by Motta et al. was to establish the discriminant validity of the modified Secondary Trauma Scale. The findings showed good internal consistency, with a coefficient alpha of .82. Results also showed that it is correlated with other well known measures of trauma, and showed good discriminant characteristics.

The primary purpose of the 2004 study (Motta et al.) was to establish cut-off scores to assist individuals in determining whether secondary stress symptoms are causing significant distress to caregivers. Results showed that STS scores of 38 or higher seemed to indicate mild to severe anxiety and depression and were related to intrusion and avoidance symptoms; whereas scores of 45 or higher are associated with moderate to severe symptomology (Motta et al., 2004). The reliability for the STS in this study was $r = .89$. This result is similar to those reported in prior studies (Motta et al., 1999; 2001) which found coefficient alphas ranging from $r = .8$ to .9 for college students and mental health workers.

Because we know that non-mental health caregivers are clearly underrepresented in STS research, the utility of Motta's (1999; 2001) Secondary Trauma Scale is apparent. Individuals concerned with their STS levels can quickly and easily complete this instrument. Moreover, caregivers are asked to think about single negative experiences impacting someone they supported, making this scale narrow in focus, which provides a specific link between outcomes experienced and the likely sources of distress. This scale is still under development and further refinement will likely occur.

The Satisfaction with Life Scale. The Satisfaction with Life Scale (SWL; Diener, Emmons, Larson, & Griffin, 1985; see Appendix E) is a well-known self-report measure that invites individuals to evaluate their overall experiences with life. Life satisfaction can be described as a global evaluation by an individual of his or her life (Pavot & Deiner, 1993). The scale does not assess satisfaction with specific life domains such as health and finances; instead, it allows respondents to integrate and weight these domains in terms of their own values. The SWL scale shows good convergent validity with other

scales as well as other types of assessments of subjective well-being. It has also shown strong internal reliability (.87) and moderate temporal stability (2 month test-retest .82). This indicates that the scale is stable over time, rather than just reflective of a particular mood, yet sensitive enough to detect changes in life satisfaction due to psychotherapy or major life events such as divorce or changes in employment status. The SWL scale shows good discriminant validity from other emotional well-being measures, confirmed by a number of independent sources. In summary, the SWL scale provides a subjective assessment of a person's life, based on his or her own criteria, and is a valuable assessment tool especially when used as a compliment to other measures of emotional well-being (Pavot & Diener, 1993).

Personal Meaning Profile. The Personal Meaning Profile (PMP; Wong, 1998; see Appendix F) is a 57-item self-report measure, designed to assess level of perceived meaning in an individual's life. Previously used by Wong (1998), Wiebe (2001), and others (Lang, 1994; Giesbrecht, 1997; cited in Wong, 1998), the instrument has been used to increase understanding of the relationship between areas of personal meaning and various psychological constructs (Wiebe; Wong). Finding meaning in life is particularly important in the midst of suffering. Writings by Frankl, (1967; 1969; 1984), May (1979; 1983), Wong, (1998), and others, speak to this desire to make sense of our lives and the world in which we live. The premise is that higher levels of perceived meaning enable us to better cope with suffering and difficulties in our lives. The PMP is useful for measuring participants' levels of personal meaning and correlating them with their levels of distress (Wong). The PMP measures seven factors of personal meaning: Achievement; Relationship; Religion; Self-Transcendence; Self-Acceptance; Intimacy;

and Fair Treatment. The questionnaire uses a 7-point scale from 1 (not at all) to 7 (a great deal). Lower scores indicate lower levels of meaning and higher scores indicate higher levels of perceived meaning.

The PMP (Wong, 1998) has good reliability, and correlates well with other measures of meaning and well-being. Test-retest reliability over three weeks was $r = .85$. Reliability and validity have also been supported by other studies done by Lang (1994; cited in Wong, 1998) and Giesbrecht (1997; cited in Wong, 1998). Lang found that the PMP positively correlated with Ellison's (1981) Spiritual Well-Being Scale ($r = .64$) and Reker and Wong's (1984) Perceived Well-Being Scale ($r = .29$ p <05). Lang also reported an overall alpha coefficient of .93. Giesbrecht found that the PMP was positively related with several Meaning of Work measures, but negatively correlated with Job Stress measures.

For the PMP (Wong, 1998), alpha values of the subscales are as follows: Self-Acceptance (.54); Fair Treatment (.54); Intimacy (.78); Relationship (.81); Self-transcendence (.84); Religion (.89); and Achievement (.91).

Wiebe (2001) also made use of Wong's (1998) PMP and correlated it with the TSI Belief Scale, Revision L (Traumatic Stress Institute, 1994). Her analysis revealed a moderate negative correlation between Total PMP and Total TSI scores, $r(64) = .35$, $r^2 =$ 12%, $p < .01$, demonstrating a significant relationship between the two variables.

Procedure

Participants were assured of confidentiality. It was stated that no identifying information would be needed to complete the survey. Further, for those who chose to

enter the draw, all names and phone numbers were kept separate from the survey responses.

Participants using the web site version of the questionnaires were required to complete the demographic information before moving through the three instruments. The survey took approximately 20 minutes to complete.

An opportunity was provided both within the survey, and at the end, to make comments about the questionnaires and to provide personal anecdotes. A closing page (see Appendix G) which included an email address to caringhurts@telus.net was provided in the event that individuals wanted to contact the researcher for assistance in finding suitable support due to symptoms associated with STS.

Finally, several resources such as links to trauma web sites and books were provided for those who might want additional information on Secondary Traumatic Stress and Meaning in Life (see Appendix H).

CHAPTER THREE: RESULTS

Descriptive Statistics

The final data set consisted of 203 individuals: 200 on-line responses, and three paper and pencil responses. Thirty-five respondents were excluded because of incomplete surveys. Of the total sample, 16 were male, and 187 were female. The sample age distribution ranged from less than 29 years old to older than 60, with approximately 60% of the sample being young adult and the other 40% being in middle-aged groups. Just over half of the respondents (51%), indicated they were married. The remainder were either single (36%), separated/divorced (7%), or other (6%). Religious affiliation was fairly evenly distributed: 8% were Catholic, 59% Protestant, 1% Jewish, 1% Sikh, 1% Buddhist, 12% other, and 17% with no religious affiliation. A good range of educational backgrounds was found within this sample: 22% of the respondents indicated completion of high school, 20% college or tech school, 33% university, and 26% with graduate degrees.

Of those that completed the survey, 86% indicated they *always or frequently* work with people who have experienced trauma within their occupations. The length of time that these people have worked in their occupations ranged from: less than 1 year (19%), 1-5 years (40%), 6-10 years (9%), and 10 years or more (30.9%).

Respondents were asked to think of the person(s) they support while completing the survey. When asked to provide the context of that relationship, 49% of respondents said the person was a family member or friend, 5% a co-worker, 34% someone supported as part of their work, 4% someone helped as a volunteer, and 5% designated as “Other.”

Ninety-two percent said that they are the *main source* of support for this person most or some of the time. When asked for the length of time involved in being a support, 35% said 1 year or less, 20% said 2-3 years, 12% said 4-5 years, 6% stated 6-10 years, and 25% reported 10+ years. Eighty-five percent reported they had an adequate support system in place, whereas 15% said they did not.

Descriptive statistics for the key study variables are presented in Table 2.

Hypotheses

In the first hypothesis, a negative correlation was predicted between total Secondary Trauma Scale (STS) score and Satisfaction with Life (SWL) scale score. As shown in Table 2, this hypothesis was supported, $r(203) = -.48$, $p < .001$, one-tailed. As anticipated, when secondary stress arises, one's satisfaction with life or overall well-being seems to be lower. There was also a strong effect ($r^2 = 23\%$).

In the second hypothesis, a negative correlation was anticipated between total STS score and total Personal Meaning Profile score (PMP). Correlational analyses showed a negative correlation, $r(203) = -.29$, $p < .001$, one-tailed. In this case, when an individual experiences increasing levels of secondary stress, their meaning in life tends to decrease. This was a medium effect size ($r^2 = 8\%$).

In the third hypothesis, it was expected that there would be a positive correlation between total PMP and SWL scores. Again, correlational analyses revealed that $r(203) = .57$, $p < .001$, one-tailed. This result suggests that when one has greater personal meaning in life, their satisfaction with life also increases. This was also a strong effect ($r^2 = 32\%$).

The fourth is a mediation hypothesis in which it was proposed that the relationship between STS and SWL is weaker when the PMP is taken into account. A

Table 2

Correlations, Means and Standard Deviations of Key Study Variables

	1	2	3
1. STS	--		
2. PMP	-.29	--	
3. SWL	-.48	.57	--
Mean	1.62	5.62	5.12
Standard Deviation	0.51	0.62	1.20

Note. STS = Secondary Traumatic Stress. Scores range from 1.0 – 5.0; PMP = Personal Meaning Profile. Scores range from 1 – 7; SWL = Satisfaction with Life. Scores range from 1 –7.

hierarchical regression analysis was conducted to test for the presence of a mediation effect. As shown in Table 3, the effect of STS on SWL decreases from 23% to 10% when the PMP is partialled out (see Figure 1). The direct effect of 10% is still significant, however, showing that the impact of STS on SWL is partially mediated by personal meaning. These results suggest that having a greater degree of personal meaning in one's life may serve as a partial protective factor against secondary traumatic stress, thereby helping to maintain higher levels of satisfactions with life.

Post Hoc Analyses

As shown in Table 4, a 2 X 2 between subjects ANOVA was conducted to test for a moderating effect of personal meaning on the way secondary stress impacts well-being. PMP and STS scores were dichotomized by dividing scores above and below their respective medians. The interaction effect was significant and is graphed in Figure 2. This interaction shows a buffering effect for personal meaning. In other words, some participants indicated that even though they had high levels of secondary stress, their satisfaction with life remained high as did their meaning in life. However, other participants indicated that when their secondary stress was relatively high, their satisfaction with life was lower and their personal meaning was lower. The difference between these two groups suggests that higher levels of personal meaning serves as a buffer against developing lower levels of well-being in the presence of high levels of secondary stress. This finding is in keeping with previous studies documented in the coping literature. Note that this buffering effect is in addition to the mediation effect shown in hypothesis 4, the mediation analysis.

Table 3

Hierarchical Regression Testing Mediation of the STS-SWL Relationship by PMP

Source	R^2 Change	$F(df_1, df_2)$
STS	10%	36.3 (1, 200)
PMP	20%	70.3 (1, 200)
Total	43%	

Note. The strength of the mediation effect is shown by the 13% shared variance in the regression of SWL on STS and PMP. STS = Secondary Traumatic Stress, PMP = Personal Meaning Profile. The effects reported for STS and PMP are unique effects. The simple correlation between STS and SWL yields a shared variance of $r^2 = 23\%$.

**$p < .001$

Table 4

ANOVA for SWL Showing the Interaction Between STS and PMP

Source	df_1, df_2	F	p	η^2
STS	1, 199	15.7	< .001	.068
PMP	1, 199	39.8	< .001	.156
STS X PMP	1, 199	8.1	.007	.036

Note. STS = Secondary Traumatic Stress, PMP = Personal Meaning Profile.
**$p < .001$

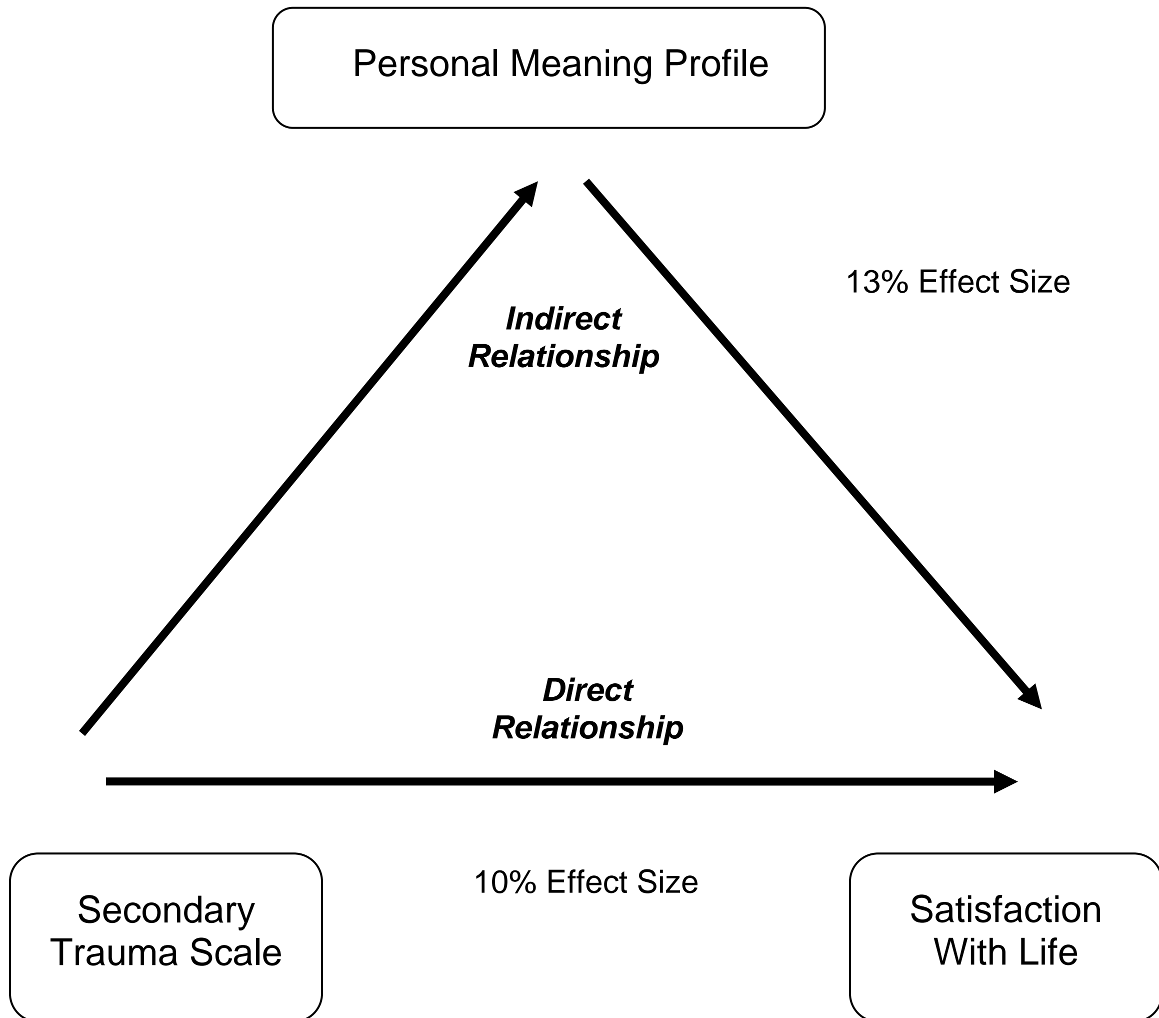

Figure 1. Mediation Relationship. STS = Secondary Trauma Scale, PMP = Personal Meaning Profile, SWL = Satisfaction with Life Scale. The effect of STS on SWL decreases from 23% to 10% when the effect of the PMP is partialled out, yielding a 13% effect size for the indirect relationship. This diagram illustrates a partial mediation relationship.

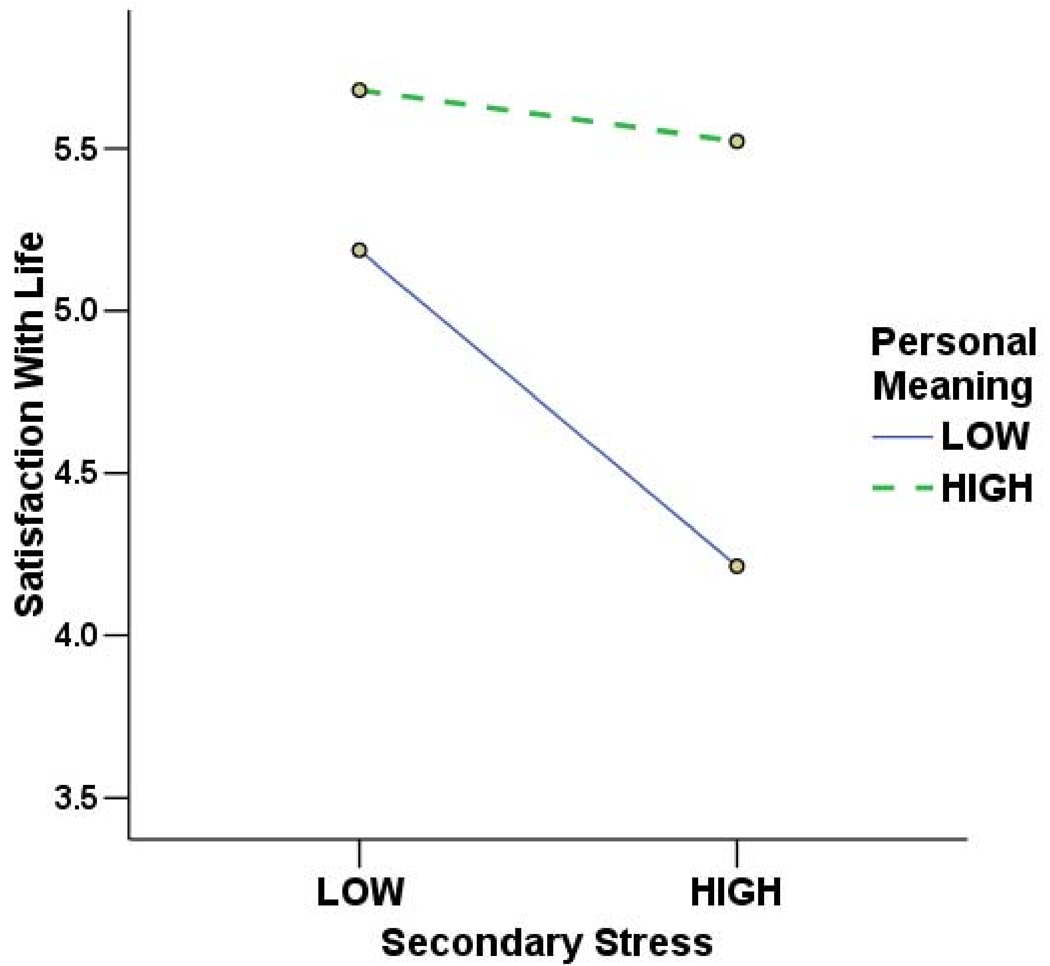

Figure 2. Moderation Relationship. The interaction shows a buffering effect for Personal Meaning (Personal Meaning Profile) on Satisfaction With Life in the presence of Secondary Stress (Secondary Trauma Scale).

CHAPTER FOUR: DISCUSSION

Following the Vietnam War, numerous studies have investigated symptoms present in those who have faced a variety of traumatic experiences. As a result, most people are now familiar with the term Post Traumatic Stress Disorder (PTSD); however, it has only been in the past 20 years that researchers have begun to look at the experience of caregivers following exposure to the traumas of primary victims. Secondary Traumatic Stress (STS) is now a fairly well known term used to describe the symptoms that may occur as a result of a caregiver's empathic involvement with a primary victim. STS symptoms are virtually identical to PTSD, except that caregiver's symptoms (such as flashbacks) contain material from the survivor's trauma. Through a variety of studies within the stress and coping literature, we also know that there is a direct link between higher levels of secondary traumatic stress and lower levels of well-being. The purpose of this study was to explore the impact of personal meaning on an individual's sense of well-being, when exposed to secondary trauma through a caregiver role, either as a helper through one's profession, via a volunteer position or as the main source of support to a family member or friend. After all, if a caregiver begins to experience increasing levels of stress, the health and well-being of both the caregiver and the primary victim are at risk. For these reasons, it seems particularly salient to understand the factors that may protect caregivers from becoming secondarily traumatized.

In this study, the direct relationship between Secondary Traumatic Stress (STS) and Satisfaction with Life (SWL) was examined in addition to the ways in which Personal Meaning (PMP) mediates the relationship between STS and SWL.

Moderation and Mediation of Secondary Stress

The hypotheses in this study were largely supported. In hypothesis one it was predicted that a negative correlation would be found between total Secondary Trauma Scale (STS) score and Satisfaction with Life (SWL) score. This expectation was supported, suggesting that as the level of secondary stress rises, one's satisfaction with life or well-being seems to decrease. In the second hypothesis it was also predicted that a negative correlation would be found between total STS and PMP scores. This result was found; showing that as individuals experience increasing levels of secondary stress, their over-all sense of meaning in life tends to diminish. In the third hypothesis it was predicted that a positive correlation between total Personal Meaning (PMP) and Satisfaction with Life (SWL) scores would be found. This hypothesis was also supported revealing that when one has greater personal meaning in life, one's sense of well-being also seems to increase.

The fourth is a mediation hypothesis, in which it was predicted that a weaker relationship between STS and SWL would exist when PMP was taken into account. It appears that when an individual has higher levels of personal meaning, the impact of secondary traumatic stress is lessened, thereby reducing the negative impact on over all well-being.

In the post hoc analysis, the possibility of a moderating effect of personal meaning on the way secondary stress impacts satisfaction with life was explored. An interaction was found, showing that those with higher levels of personal meaning reported fewer disturbances in their well-being than those with lower levels of personal meaning when exposed to STS. Thus, although most people will experience reductions in

well-being when secondary stress reaches higher levels, such decreases seem to be much less profound for those with higher levels of personal meaning than for those who started out with lower levels of personal meaning.

These results overall confirm what most caregivers know intuitively: There is a cost to caring. Working with an individual (as a professional or volunteer) who has experienced some form of trauma, may result in the caregiver not only experiencing increased levels of stress, but also mild to profound changes in their worldviews leading to questions regarding justice and meaning in life. Shifts of meaning in life can be quite difficult to navigate, and may lead to high rates of change in staffing for both volunteer and professional positions. As Figley (1995) aptly points out, he has often seen “colleagues and friends abandon clinical work or research with traumatized people because of their inability to deal with the pain of others” (p. 6).

Furthermore, individuals may find it increasingly difficult to manage their own feelings of distress when supporting a family member or friend. Our emotional attachment to the one we love leads to an empathic response to their pain, and our world is similarly shaken. A devastating life event not only overwhelms primary victims, but the families and intimate associates of these individuals as well (Janoff-Bulman, 1992).

It is therefore vital that caregivers are made aware that changes in their over all sense of meaning in life are typical, and to be expected. While this process can be very disorienting, it may provide some comfort to know that other caregivers have had similar reactions, thereby normalizing the experience. This knowledge, coupled with a response in the form of meaningful self-care activities, will benefit both caregivers and primary victims.

The findings associated with hypothesis four, as well as the post-hoc analysis, suggest that higher levels of personal meaning serve as protection against developing increased levels of secondary stress. Self-care, then, ought to include participation in activities that increase meaning in life for caregivers. When caring for others, self-care need not be an afterthought, but a deliberate decision to engage in activities such as regular exercise; debriefing with colleagues; and participation in prayer, meditation, or spiritual belief in order to bolster one's sense of meaning in the face of suffering and the inevitable change in one's world view.

In short, there are three facets of this study that are of particular importance. The mediation analysis revealed that personal meaning partially protects individuals from higher levels of STS; therefore, caregivers ought to consider their personal sources of meaning, and take steps to ensure they are regularly incorporated into their daily lives. Secondly, these mediation results also highlighted a general sense in which caregivers may experience disturbances in their levels of personal meaning as a result of their engagements with primary victims. These processes need to be more widely and generally acknowledged and normalized, as important aspects of self care. As noted by Figley (1995), empathy means that individuals are able to identify with and understand the feelings or difficulties of others. As caregivers empathize with victims, they also experience some of the same shock, disbelief, and loss of a sense of order and justice in the world, leading to parallel decreases in meaning in life. This may be the single most challenging aspect of trauma work, and therefore education on this topic must be an essential part of all professional and non-professional training programs, as well as caregiver support groups.

Furthermore, the general importance of personal meaning is just part of the story. Those with lower levels of meaning reported greater vulnerability to STS than those with higher levels of meaning. It should be noted that the results of this study cannot distinguish between people who experienced lower levels of personal meaning before or after (as a result of) the impact of trauma work. In fact, it is possible that both situations may be reflected in these results. Nevertheless, those who are able maintain or find new sources of meaning while being exposed to secondary trauma report higher levels of well-being.

Contributions to the Practice and Theory of Counselling Psychology

Results of this study contribute to the body of research on secondary traumatic stress, personal meaning, and caregiving. While numerous studies can be found in the stress and coping literature, few studies specifically examine connections between these sets of variables. Given the clarity of these results, it is apparent that personal meaning and secondary stress are researchable for family caregivers, informal caregivers, and for professionals. In addition, results of this research extend beyond the familiar notion of burnout. While burnout may also occur along with STS, these are separate stressors, as noted in the introduction (Chapter One).

Funding cuts to many social and medical programs, and the high costs of procuring professional assistance, has led to increased societal reliance on informal caregivers. The volunteer sector is a vast army of individuals, providing an array of services both locally and internationally. However, the majority of research in which STS is explored has more often been focused on professional helpers such as therapists. More research attention is needed to better understand the associated risks, protective factors

and self-care practices that can assist caregivers. Anything we can do to effectively support paraprofessionals, volunteers, and family caregivers will also benefit trauma survivors.

Results of this study also provide clarification of personal meaning, which also helps to extend Figley's (1995) acknowledgement of achievement by professionals in his Compassion Fatigue model. He writes, "The extent to which the helper is satisfied with his or her efforts (sense of achievement), and the extent to which the helper can distance himself or herself from the ongoing misery of the victims(s), accounts for how much the helper experiences compassion stress" (p. 253). One healthy means of creating psychological distance is when people "gain perspective" on suffering and personal experience through existential coping. There are two aspects to existential coping: an acceptance of uncontrollable problems as a reality of life, and finding positive meanings in negative life experiences (Wong, 1998). The findings of this study are not only in agreement with Figley's concept of achievement, but elaborate on this notion by examining other sources of meaning. Perhaps the act of distancing or separating oneself from the sufferer involves finding alternate sources of meaning beyond the satisfaction derived from the act of helping.

Further, it is important that both mediation and moderation analyses are conducted to fully understand the role of personal meaning. The buffering effect of personal meaning was perhaps the most significant piece of information gathered as it points to the potential risks for caregivers who do not have adequate meaning in their lives. Because we know that caregivers are likely to encounter changes in their

worldviews and losses of meaning as a result of secondary exposure to trauma(s), it is essential that personal meaning is addressed.

Another contribution to the study of STS was the use of Motta's (1999; 2001) Secondary Trauma Scale. This new instrument was designed for use with informal and family caregivers, emergency workers, and other helping professionals. Results of this project further support the use and development of scales like the Secondary Trauma Scale to assess the experiences of a wide variety of caregivers and helpers.

Limitations and Future Research

Since this is a correlational study, causal statements regarding the effects of personal meaning on an individual's well-being in the presence of Secondary Traumatic Stress cannot be made. As further research permits causal examination of the place of personal meaning in STS and coping, longitudinal studies and continued improvements in scale developments will be necessary in order to clarify the significance of meaning as a protective factor against developing STS.

Another limitation of this study is the lack of qualitative information. A narrative component, for instance, would enhance our understanding of living with STS and various methods of coping and incorporating traumas into one's world-view. The lived experience would certainly add a deeper understanding of STS beyond what a quantitative study can provide. A viable option might be to use a mixed methods design. This would address the need for generalizability, yet also provide an in-depth look at the impact of STS on the daily lives of people who work or live with traumatized individuals.

A third limitation is the use of self-report measures in this study. Self-report measures can be influenced by social desirability bias and the limitations of recall of past events. Neither of these factors was directly assess in this study.

This project, like other research in this field, provides limited quantitative information about global trauma exposure, in primary or secondary form. This neglect makes it difficult to statistically sort out the impact of a specific caregiving experience from the rest of life stress faced by participants. To partially address this issue, future studies should incorporate questions regarding caregiver's personal trauma histories. Currently, there remains conflicting results as to whether or not individuals with trauma histories are more likely to experience Secondary Traumatic Stress symptoms (Follette et al., 1994; Ghahramanlou & Brodbeck, 2000; Nelson-Garell & Harris, 2003; Ortlepp & Friedman, 2002; Pearlman & Mac Ian 1995; Schauben & Frazier, 1995) and this issue needs to be resolved. After reviewing each of the articles, I cannot say for certain why there are conflicting results regarding the correlation between trauma history and the development of STS. The conflict does not seem related to level of education or professional verses non-profession samples. Part of the difficulty in comparing the results, is that the researchers used different measures to obtain information on trauma history as well as trauma symptoms. In addition, some researchers examined coping resources, while others did not.

However, it is interesting to note the findings by Pearlman and Mac Ian (1995), who reported that individuals with a trauma history, who experienced the greatest disruptions to their schemas, had been working for a shorter time and without supervision. Follette et al., who claimed there was no link between trauma history and

STS, found 58% of the mental health workers received supervision, whereas only 18.2% of law enforcement officers (who were found to be significantly more distressed than the mental health professionals) received supervision. Personal therapy, another correlate, was cited in this study as being particularly helpful to those in mental health and was recommended to those in law enforcement. In any case, Follette et al., found that both mental health and law enforcement professionals indicating a history of childhood physical or sexual abuse had significantly higher levels of trauma-specific symptoms than did professionals not reporting these forms of childhood trauma.

Clearly, there is a need for further studies to determine whether or not a personal trauma history is a correlate of STS. However, based on the information gathered in the available research, I believe that trauma history is most likely a factor in the development of STS, especially when other supports such as supervision or positive coping resources are limited, or not present. It would certainly benefit caregivers with personal trauma histories, to have this information available, in order to better support and protect themselves. The more we know about the factors involved in developing STS, the more that we can do to make informed decisions about self-care and limitations of the amount and duration of trauma work we engage in.

A second area for further study might involve looking at the most effective means for coping with STS and the activities, practices and attitude shifts that protect and maintain caregiver meaning in life, and therefore emotional well-being.

Conclusion

In their chapter in *The Human Quest for Meaning* (Wong & Fry, 1998), Emmons, Colby and Kaiser emphasize that,

> Traumatic events precipitate meaning crisis, raising questions pertaining to the purpose and meaning of life and the nature of suffering and justice in the world, as people struggle to answer both why the event occurred and what the implications will be for the future. (p. 164)

As noted throughout this study, living or working with traumatized individuals may also seriously challenge one's sense of trust, meaning and justice in the world. Clearly it is not only the primary victims that suffer from the collapse of a fair and just worldview; it also infects the helpers. Our lives are full of such examples: a spouse looks after his wife with Alzheimer's; a young dad cares for his wife with breast cancer; individuals who support those who have experienced random violence, incest, and rape; rescue workers in places like New Orleans (the 2005 Hurricane Katrina) and Thailand (the 2004 tsunami), women's shelter employees and volunteers. All of these people are impacted by the traumas and will wrestle with integrating these experiences into their psyches and worldviews.

One of the costs of caring for people who are hurting is that it raises tough questions for us. It is important to deal with those questions in ways that work for us, whether we are caring for family members or just doing our jobs. This is no easy task. People exposed to either primary or secondary traumas cross invisible lines where they embark on personal journeys through jarring landscapes scattered with broken lives and many unanswered questions. Once across this line, there is no way back, and we are forever changed in the process. We will be faced with making sense out of the experience(s) by creating new meanings and purposes for our lives.

Janoff-Bulman (1992) believes that there are three significant factors involved in the recovery process for trauma survivors: (1) the victim's ability to tolerate arousal and distressing emotions; (2) the victim's ability to creatively rework and reappraise the powerful new 'data'; and (3) the support of close, caring others (p. 172). Most certainly, these factors are integral part of the recovery process for caregivers as well. The results of this study help professionals understand a key aspect of the reappraisal process, as caregivers address personal meaning and purpose in life, in the midst of suffering. There are no short cuts through the recovery process, and the experience can be quite disorienting for a time. Yet it is clear that those who are able to creatively rework their worldviews in ways that allow for injustice and suffering, and find meaning and purpose in life, have higher levels of well-being.

Perhaps one of the benefits of reworking one's worldview is that one develops a wiser, more complete understanding of the world around oneself. The inevitable changes that occur while helping others may instil a sense of sadness; however, we are also inspired and strengthened by walking with those who have known darkness, yet step-by-step emerged into the light of hope again. As we bear witness to the courage and resiliency of the human spirit, we are challenged to also find strength, purpose, and new meanings in life. Trauma and Secondary Traumatic Stress will always exist, as will unanswered questions about the nature of suffering and justice in the world. We are not able to change the past, nor alter the experiences of trauma survivors or their helpers, but we can utilize the strengths gained in suffering by extending compassion and knowledge to others who are hurting.

Finding a measure of acceptance that life isn't fair, that injustice and suffering will occur, doesn't mean that we turn a blind eye to the atrocities committed worldwide or to those who suffer. It is an attitude of realism that allows us to move toward creating positive meanings within our suffering and beyond. In fact, our modern world is filled with examples where so many are exposed to traumas through war, natural disasters, abuse and violence. Those who are involved in helping others heal and rebuild their lives will be deeply touched by all they have witnessed. However, caregivers who are able to create positive meanings will not only be protected from higher levels of Secondary Traumatic Stress but will also be of greater assistance to those they help.

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APPENDIX A: RECRUITMENT LETTER
Caring Hurts Study

This survey is a study, which explores the effects on individuals who live, or work with the traumatized or significantly distressed. You will be asked a variety of questions that will help you to explore your current level of stress related to caring for those who hurt as well as how you make sense of life. The questions will take approximately 15-20 minutes.

There will be a draw for a $50 gift certificate to Chapters bookstore. To enter this draw please fill out your name and phone # or email address. The names will be kept separate from the survey results to assure confidentiality. The draw will be on February 15th, 2005.

After the study has been completed, a summary of the research findings will be provided upon request. Please email this request to: caringhurts@telus.net

Confidentiality of all answers will be maintained for everyone who participates. You will not be asked to report your name or identifying information. The responses of people to this survey will be recorded in anonymous form and may be kept for further analysis after this study as been complete.

This exercise provides an opportunity for you to think about your current level of stress and your sense of well-being in life. This process may increase your awareness about the effects of caring for those who hurt or it may validate some of the complex feelings associated with caring for those who are experiencing trauma or significant distress. You may find some of the questions confusing or uncomfortable. Everyone is encouraged to contact the research team if they have any questions or concerns about the study.

When Caring Hurts Research Team:
Nadine Hope (graduate student researcher) at caringhurts@telus.net or Dr. Marvin McDonald (project supervisor) at mcdonald@twu.ca or 604 513-2034, ext. 3223.

If you have any questions about ethical issues involved in this project you may contact Sue Funk at sue.funk@twu.ca or 604 513-2142 in the office of research at Trinity Western University.

By completing this survey you are agreeing that you have read and understood the description of the study and that you willingly consent to participate.

APPENDIX B: THE DRAW

Please enter me into the draw!

If you would like to have your name entered in a draw for a $50. Canadian gift certificate at Chapters bookstore, please submit a current email address or name and phone# in this space. The draw will be held on February 15th, 2005 and the winner will be contacted through email or by phone. (This address/ phone # will be kept separate from survey responses.)

NAME____________________________ PHONE # ____________________________

E-MAIL ADDRESS____

APPENDIX C: DEMOGRAPHICS

Please provide some background information. The questions below that are marked with an asterisk (*) are required. Please feel free to clarify any of your answers on the back of this page.

*1. What is your gender? Male ____ Female ____

*2. How old are you? 29 yrs or less____ 30-39 yrs____
40-49 yrs____ 50-59 yrs____ 60-69 yrs____ Over 70____

3. Are you currently married or in a permanent relationship?
Married or Cohabiting ____ Single____ Separated or Divorced___
Other _____(*Optional*: Please clarify your response below at question #11)

4. Which continent do you reside in?
North America ____ South America____ Europe____
Australia, New Zealand or Pacific Islands____ Africa____

5. What is your religious affiliation, if any?
Catholic___ Protestant____ Jewish____ Hindu____ Muslim____
Sikh____ Buddhist____ Other____ No religious affiliation____

6. What is your ethnic background?
European descent____ African descent____ Hispanic____ Asian____
Aboriginal____ Multiple ethnic backgrounds____ Other____

*7. What is your highest level of education you have completed?
Grade 6____ Grade 9____ High School____ College or Technical school____
University____ Professional school or graduate degree____

8. What is your first language?
English____ French____ Spanish____ Other____

*9. In your occupation, do you usually work with people who have experienced trauma (either physical or mental/emotional)?
Yes, always____ Frequently____ Only rarely____ Never____

10. If you frequently encounter trauma in your job, how long have you worked in this occupation?
Less than 1 year____ 1-5 years____ 6-10 years____
10 years or more____

11. Please make any comments you would like about your level of stress, support system, or what is particularly helpful to you in coping with your situation. Also, feel free to comment on these background questions to clarify your responses.

APPENDIX D: SECONDARY TRAUMA SCALE

Now we want to ask you about a distressing or traumatic experience that happened to someone close to you. That person could be a family member, a close friend, or anyone else with whom you have had a close relationship.

- For emergency or support workers like POLICE, NURSES, FIREFIGHTERS, OR VOLUNTEERS IN CRISIS CENTERS OR SHELTERS, please answer the following questions by thinking of "the person who has had a distressing or traumatic experience" as all of those people you help or work with in your job.

Please check the appropriate blanks for each question.

1. Has someone close to you (family member, friend, etc.) or someone you have helped or supported, encountered a negative experience?
   Yes____ No____

2. If you said "yes" to question 1, what relationship was that person to you?

   No one I know has experienced a negative event____
   Family member, or friend_____
   Co-worker____
   Someone you supported as part of your work____
   Someone you have helped as a volunteer worker____
   Other____

3. Describe other________________________________

4. Think of the person close to you who had the negative experience. Are you one of the main sources of support for that person? (Emergency workers: Please think of the time you are with the people you help.)
   Yes, most of the time____ Sometimes____ No_____

5. Think of the person close to you who has had a negative experience. How long if at all, have you been a support to that person?
   Never____ 1 yr or less____ 2-3 yrs____ 4-5 yrs____ 6-10 yrs____ 10+ yrs____

6. Do you have an adequate support system in place to help you cope with the stress of caring for the traumatized?
   Yes____ No____

7. Please describe any other important information about the negative experiences of the person close to you.

SECONDARY TRAUMA SCALE-CONTINUED

QUESTIONS ABOUT THE STRESSES FACED BY SOMEONE CLOSE TO YOU

For the items below, check the space that best describes how you think about the negative experiences that happened to those you care for.

Answers:
Rarely/Never___ At times ___ Not sure ___ Often ___ Very Often ___

1. I force myself to avoid certain thoughts or feelings that remind me of (the person's) difficulties.
2. I find myself avoiding certain activities or situations because they remind of their problems.
3. I have difficulty falling or staying asleep.
4. I startle easily.
5. I have flashbacks (vivid unwanted images or memories) related to their problems.
6. I am frightened by things that he or she said or did to me.
7. I experience troubling dreams similar to their problems.
8. I experience intrusive unwanted thoughts about their experiences.
9. I am losing sleep over thoughts of their experiences.
10. I have thought that I might have been negatively affected by their experience.
11. I have felt "on edge" and distressed and this may be related to thoughts about their problem.
12. I have wished that I could avoid dealing with the person or persons named above.
13. I have difficulty recalling specific aspects and details of their difficulties.
14. I find myself losing interest in activities that used to bring me pleasure.
15. I find it increasingly difficult to have warm and positive feelings for others.

16. I find that I am less clear and optimistic about my future life than I once was.

17. I have had some difficulty with concentrating.

18. I would feel threatened and vulnerable if I went through what the person (I care for) went through.

19. I would have experienced horror or intense fear if I had their problems.

20. I have disturbing recollections and intruding thoughts of their experiences.

Scoring Key:

No items are reverse scored. For the purposes of this project, items 18 & 19 were not included in the total score. (Note: Items #19 & 20 were dropped from the total score in Motta et al., 2001 study).

© By Motta et al., 1999, 2001

APPENDIX E: SATISFACTION WITH LIFE SCALE

Please indicate to what extent you agree with these statements.

Strongly Disagree____ Disagree____ Slightly Disagree____
Neither Agree nor Disagree____ Slightly Agree____ Agree____Strongly Agree____

1. In most ways my life is close to ideal.
2. The conditions of my life are excellent.
3. I am satisfied with my life.
4. So far I have gotten the important things I want in life.
5. If I could live my life over, I would change almost nothing.

Scoring Key

Compute the mean value of all five items (ratings cored from 1 to 7 for each item).

© By Diener, Emmons, Larsen, & Griffin, 1985.

APPENDIX F: PERSONAL MEANING PROFILE

This questionnaire measures people's perception of personal meaning in their lives. Generally, a meaningful life involves a sense of purpose and personal significance. However, people often differ in what they value most, and they have different ideas as to what would make life worth living. The following statements describe potential sources of meaningful life. It is important that you answer honestly on the basis of your own experience and beliefs. For example, a few questions use the term "God". Please feel free to interpret "God" as your Higher Power or in any way that is personally meaningful to you.

Please read each statement carefully and indicate to what extent each item characterizes your own life. You may respond by circling the appropriate number according to the following scale:

1	2	3	4	5	6	7
Not at all			Moderately			A great deal

For example, if going to parties does not contribute to your sense of personal meaning, you may circle 1 or 2. If taking part in volunteer work contributes quite a bit to the meaning in your life, you may circle 5 or 6. It is important that you answer honestly on the basis of your own experience and beliefs.

1. I have a good family life 1 2 3 4 5 6 7
2. I believe I can make a difference in the world. 1 2 3 4 5 6 7
3. I am at peace with God. 1 2 3 4 5 6 7
4. I have learned that setbacks and disappointments are an inevitable part of life. 1 2 3 4 5 6 7
5. I believe that life has an ultimate purpose and meaning. 1 2 3 4 5 6 7
6. I engage in creative work. 1 2 3 4 5 6 7
7. I am successful in achieving my aspirations. 1 2 3 4 5 6 7
8. I pursue worthwhile objectives. 1 2 3 4 5 6 7
9. I strive to achieve my goals. 1 2 3 4 5 6 7
10. I care about other people. 1 2 3 4 5 6 7
11. I have someone to share intimate feelings with. 1 2 3 4 5 6 7
12. I believe in the value of my pursuits. 1 2 3 4 5 6 7

1	2	3	4	5	6	7
Not at all			Moderately			A great deal

13. I seek to actualize my potentials. 1 2 3 4 5 6 7

14. I have found that there is rough justice in this world. 1 2 3 4 5 6 7

15. I strive to make this world a better place. 1 2 3 4 5 6 7

16. I am at peace with myself. 1 2 3 4 5 6 7

17. I have confidants to give me emotional support. 1 2 3 4 5 6 7

18. I relate well to others. 1 2 3 4 5 6 7

19. I have a sense of mission or calling. 1 2 3 4 5 6 7

20. I seek to do God's will. 1 2 3 4 5 6 7

21. I like challenge. 1 2 3 4 5 6 7

22. I believe that human life is governed by moral laws. 1 2 3 4 5 6 7

23. It is important to dedicate my life to a cause. 1 2 3 4 5 6 7

24. I take initiative. 1 2 3 4 5 6 7

25. I am able to make full use of my abilities. 1 2 3 4 5 6 7

26. I strive to do my best in whatever I am doing. 1 2 3 4 5 6 7

27. I have a number of good friends. 1 2 3 4 5 6 7

28. I am trusted by others. 1 2 3 4 5 6 7

29. I am committed to my work. 1 2 3 4 5 6 7

30. I have a purpose and direction in life. 1 2 3 4 5 6 7

31. I seek higher values-values that transcend self-interest. 1 2 3 4 5 6 7

32. I am highly regarded by others. 1 2 3 4 5 6 7

33. I seek to glorify God. 1 2 3 4 5 6 7

1	2	3	4	5	6	7
Not at all			Moderately		A great deal	

Item	Rating
34. I am enthusiastic about what I do.	1 2 3 4 5 6 7
35. Life has treated me fairly.	1 2 3 4 5 6 7
36. I accept my limitations.	1 2 3 4 5 6 7
37. I have a mutually satisfying loving relationship.	1 2 3 4 5 6 7
38. I am at peace with my past.	1 2 3 4 5 6 7
39. I believe that there is coherence and continuity in my life.	1 2 3 4 5 6 7
40. I do not give up when I encounter setbacks or obstacles.	1 2 3 4 5 6 7
41. I am altruistic and helpful.	1 2 3 4 5 6 7
42. I am liked by others.	1 2 3 4 5 6 7
43. I have found someone I love deeply.	1 2 3 4 5 6 7
44. I strive toward personal growth.	1 2 3 4 5 6 7
45. I bring happiness to others.	1 2 3 4 5 6 7
46. I accept what cannot be changed.	1 2 3 4 5 6 7
47. I am persistent and resourceful in attaining my goals.	1 2 3 4 5 6 7
48. I value my work.	1 2 3 4 5 6 7
49. I make a significant contribution to society.	1 2 3 4 5 6 7
50. I contribute to the well-being of others.	1 2 3 4 5 6 7
51. I believe in afterlife.	1 2 3 4 5 6 7
52. I believe that one can have a personal relationship with God.	1 2 3 4 5 6 7
53. I attempt to leave behind a good and lasting legacy.	1 2 3 4 5 6 7
54. I believe that there is order and purpose in the universe.	1 2 3 4 5 6 7

1	2	3	4	5	6	7
Not at all			Moderately		A great deal	

55. I am treated fairly by others. 1 2 3 4 5 6 7

56. I have received my fair share of opportunities and rewards. 1 2 3 4 5 6 7

57. I have learned to live with suffering and make the best of it. 1 2 3 4 5 6 7

58. Feel free to add any comments or explanations of your answers below:

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Scoring Key:

1. Achievement (16 items): 6, 7, 8, 9, 12, 13, 21, 24, 25, 26, 29, 34, 40, 44, 47, 48.
2. Relationship (9 items): 10, 18, 27, 28, 32, 41, 45, 50.
3. Religion (9 items): 3, 5, 19, 20, 22, 33, 51, 52, 54.
4. Self-Transcendence (8 items): 2, 15, 23, 30, 31, 39, 49, 53.
5. Self-Acceptance (6 items): 4, 16, 36, 37, 46, 57.
6. Intimacy (5 items): 1, 11, 17, 38, 43.
7. Fair Treatment (4 items): 14, 35, 55, 56.

APPENDIX G: CLOSING

YOU ARE DONE!

Thank you for participating in this research project! We are part of a growing professional community wanting to encourage us all as we face the pain in the lives of people we love and work with. The time you have taken to share your experience will help us to understand a bit more about the process of people helping people.

Many people find that reflecting on these kinds of questions personally rewarding because they have taken the time to think about important events in their lives. If you have any comments or suggestions for us to consider, please feel free to write them in the Suggestion box below. Sometimes it's also the case that individuals find that answering these questions brings up uncomfortable feelings or they realize that someone else's trauma is causing them significant difficulty. If this is the case for you, you may want to talk to a professional, a friend, or someone else who can provide you with some support. Local phone books often have numbers for phone lines that people can call for support for finding out about local resources. Experiencing stress when people we care about are hurting is a very natural response. We would also be happy to offer further suggestions on ways to find help. You can email us at caringhurts@telus.net .

Helping us all understand more about the process of people caring for people is why we are doing this research.

Suggestions:

APPENDIX H: REFERENCES FOR PARTICIPANTS
YOU MAY KEEP THIS PAGE FOR YOUR REFERENCE

Online Resources for Your Exploration

Many people are interested in promoting growth following traumatic events. For online questionnaires exploring these issues, you may want to explore the following sites.

David Baldwin's trauma site, http://www.trauma-pages.com

Post Traumatic Growth Inventory: http://helping.apa.org/resilience/

Meaning in Life: http://www.meaning.ca

If you would like to read about Secondary Stress you can check the following resources:

Compassion Fatigue: Coping with Secondary Traumatic Stress in those Who Treat the Traumatized / edited by Charles R. Figley, 1995.

Trauma and the Therapist: Countertransference and Vicarious Traumatization in Psychotherapy with Incest Survivors / Laurie Anne Pearlman and Karen W. Saakvitne, 1995.

Too Scared to Cry: How Trauma Affects Children and Ultimately Us All / Lenore Terr, 1990.

Trauma and Recovery: The aftermath of violence – from domestic abuse to political terror / Judith Herman, 1992, 1997.

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© Wong (1998), http://www.meaning.ca
© Deiner, Emmons, Larson & Griffin (1985).

For further information on these questionnaires, please contact us at:
caringhurts@telus.net