

Factors Affecting Burnout and Compassion Fatigue in Psychotherapists Treating Torture Survivors: Is the Therapist's Attitude to Working Through Trauma Relevant?

Russell McKenzie Deighton
The Cairnmillar Institute, Melbourne, Australia

Norbert Gurrus
Department of Social Work, Catholic University of Applied Sciences, Berlin, Germany

Harald Traue
Medical Psychology Department, University of Ulm, Ulm, Germany

In this study, a group of trauma therapists (N = 100) working with torture survivors was investigated with respect to the extent to which they advocated and practiced working through traumatic events as well as levels of symptomatology including compassion fatigue, burnout, and distress. Results showed that a combination of high advocacy and low degree of working through traumatic events was related to high symptomatology. Therapists with this combination showed more compassion fatigue, burnout, and distress than therapists who advocated and practiced working through traumatic events, as well as therapists who neither advocated nor practiced it. Results are discussed with respect to the pathogenic role of fear avoidance in therapists.

The prevailing opinion among psychotherapists working with traumatized individuals is that working through (or controlled reactivation of at least some aspect of the memory of) the traumatic events is beneficial to the sufferer (e.g., Briere & Scott, 2006). The most direct form of "working through" is exposure in behavior therapy, in which clients are confronted with stimuli relating to the traumatic events. These stimuli can be experienced in vivo (e.g., returning to a crime scene) or in sensu (e.g., imagining or remembering the events of the crime). Cognitive-behavior therapy (CBT) takes this process a step further by aiming at the integration of the traumatic events into the

client's life story leading to the restructuring of dysfunctional beliefs and attitudes (e.g., Foa & Riggs, 1993; Resick & Schnicke, 1992). Working through is also considered a basic constituent of psychodynamic trauma therapies and is often based on concepts such as denial, abreaction, and catharsis or transference.

Many other interventions or forms of psychotherapy also promote the controlled reactivation of the traumatic memories. Some are therapies specifically developed for trauma, such as the testimony method (e.g., Cienfuegos & Monelli, 1983) or eye movement desensitizing and reprocessing (EMDR; Shapiro, 1989), others are interventions

Correspondence concerning this article should be addressed to: Russell McKenzie Deighton, The Cairnmillar Institute, School of Counseling and Psychotherapy, 993 Burke Road, Camberwell, VIC 3122, Australia. E-mail: russell.deighton@cairnmillar.org.au.

that constitute important parts of other psychotherapies, such as psychodrama or neurolinguistic programming (NLP).

Most of the evidence that working through is beneficial comes from controlled studies testing the effectiveness of behavioral therapies. These studies show that exposure is an effective method in reducing the symptoms of posttraumatic stress disorder (PTSD), whereas at present therapies not based on CBT do not have strong scientific evidence in support of their effectiveness (Foa & Meadows, 1997). However, many forms of working through embedded in nonbehavioral therapies could well be based on similar underlying mechanisms.

Although working through the traumatic events experienced by a sufferer of PTSD seems to be beneficial to the client, psychotherapy work with torture victims is potentially harmful to the therapist. A growing body of literature suggests that being exposed to described traumatic events while treating can lead to a form of traumatization in therapists, manifested in symptoms similar to those of PTSD, including intrusive and avoidant symptoms, physiological arousal, and feelings of helplessness and isolation.

The two most widely used concepts in the literature to explain such symptom development in therapists are compassion fatigue (CF), which is also known as secondary traumatic stress (STS), and vicarious trauma (VT). These are very similar concepts, but differ in their focus: Compassion fatigue is based on the idea of a syndrome resulting specifically from empathizing with people who are experiencing pain and suffering (Figley, 1983, 1995). Vicarious trauma, on the other hand, results from exposure to clients' material, empathic engagement with clients and a sense of responsibility for them and culminates in not only cognitive, but also affective and relational changes (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995a, 1995c; Saakvitne, Gamble, Pearlman, & Lev, 2000).

Different instruments are used to measure these concepts. For VT, the Traumatic Stress Institute Belief Scale Revision L (TSI; Pearlman, 1996; Pearlman & MacJan, 1995) was developed, and later published as the Trauma and Attachment Belief Scale (TABS; Pearlman, 2003). It assesses disruptions in cognitive schemas reflecting psy-

chological needs (safety, trust, esteem, intimacy, and control) considered to be altered by VT. To measure CF (or STS), the Compassion Fatigue Scale (CF; Figley, 1995) was originally developed, which has now been succeeded by a new version called the Professional Quality of Life Scale (ProQOL; Stamm, 2005), of which compassion fatigue is one of three scales. In addition, the Secondary Traumatic Stress Scale has been developed (STSS; Bride, Robinson, Yegidis, & Figley, 2004), which measures intrusions, avoidance, and arousal symptoms associated with secondary exposure to traumatic events. There is a large overlap in the symptoms of CF and VT (Kadambi & Truscot, 2004), such that the above scales may represent different methods for measuring different aspects of the same fundamental phenomenon, as is often assumed (e.g., Boscarino, Figley, & Adams, 2004; Stamm, 1997). In this article, the terms will be used according to the instrument used in each respective study, i.e., CF for the ProQOL, STS for the STSS, and VT for the TSI or the TABS.

Another concept that has been used to describe symptoms related to working with the traumatized is *burnout*, which is less specific than the above two terms, and is often discussed in the literature on work-related symptoms in trauma therapists. It refers to a state of feeling emotionally exhausted and disconnected from other people, and lacking a sense of accomplishment from one's work (Maslach, 1982). It is not specific to work with traumatized people; it is related to the work setting such as workload, overload of responsibility, lack of control over the quality of services provided, and interpersonal problems at the workplace (Maslach & Leiter, 1997). The most common measure for burnout is the Maslach Burnout Inventory (MBI; Maslach & Jackson, 1981), but the ProQOL also has a burnout scale.

Many of the studies that have examined the presence of STS/VT, burnout, or distress in trauma therapists generally show that this group has a high level of work-related symptoms (Moore, 2004; Price, 1998; Steed & Bicknell, 2001; Way, van Deusen, Martin, Applegate, & Jandle, 2004), although some studies have found relatively low symptomatology (Kim, 2000; Kadambi & Truscott, 2004). The level of exposure to trauma clients has often been implicated

as an important factor for the development of work-related symptoms (e.g., Boscarino et al., 2004; Schauben & Frazier, 1995), but there are also studies which have failed to find such a relationship (Ghahramanlou & Brodbeck, 2000; Kim, 2000; Kadambi & Truscott, 2004). Furthermore, differentiating the effects of general workload (which would be a factor for burnout) from the effects of exposure to client trauma (which would be a factor for CF/VT) has sometimes proved difficult (e.g., Price, 1998).

Years of experience working with trauma victims has been found to have a protective effect (on burnout: Boscarino et al., 2004; Price, 1998; on VT: Pearlman & MacJan, 1995), sometimes to have a damaging effect (on emotional exhaustion: Baird & Jenkins, 2004), and to have no effect (on VT: Kim, 2000; on STS: Steed & Bicknell, 2001). Other factors that have been reported to be linked to work-related symptoms in therapists are the lack of a supportive work environment (Boscarino et al., 2004), and having little trauma-specific training and interpersonal resources (Figley, 2002). Having a history of personal trauma as a therapist seems to be quite clearly related to the development of high levels of work-related symptoms such as STS (Price, 1998), CF, and burnout (Moore, 2004) disruption to cognitive schemas (Crabtree, 2002), VT (Dickes, 2001; Pearlman & McJan, 1995), intrusions (Weeks, 2000), and general distress level (Kim, 2000).

Few studies have investigated work-related symptoms in therapists treating torture survivors. Lansen (2001) examined 300 such therapists and concluded that PTSD symptoms and vicarious trauma represent acute dangers to therapists working in this field. He also pointed out the high risk of the systemic spreading of stress throughout the team, possibly being manifested in dysfunctional group dynamics such as mobbing (collective workplace harassment of coworkers); other dysfunctional group processes have also been described (e.g., Pearlman & Saakvitne, 1995b). Therapy with torture survivors involves particularly potent sources of stress, including the type of event the clients are traumatized by and working around the vulnerable refugee status of their clients.

So far, no study known to us has investigated work-related symptoms in trauma therapists in relation to work-

ing through a trauma, and issues such as the extent to which therapists do so with their clients, and their advocacy of it. This variable is very useful, as it includes both the aspect of client exposure and of workplace achievement, which are factors related to CF/VT and burnout, respectively.

STUDY 1

The aim of the first study was to investigate (a) the relationship between therapists' advocacy and achievement of working through traumas, and (b) their work-related symptoms such as burnout, secondary traumatic stress and distress. It was expected that work-related symptoms, including CF, burnout, and distress would be associated with a low degree of working through (being an indicator of avoidance), and that burnout especially would be associated with high discrepancy between advocacy of working through and the extent to which it was actually practiced, as this may be representative of disillusioned work ideals.

METHOD

Participants

The participants were German-speaking therapists in Germany, Austria, and Switzerland working in treatment centers for torture victims. To recruit them, 186 questionnaire booklets were distributed to the therapists at the centers by mail or by e-mail. One hundred three (55.4%) anonymous booklets were returned. Three were falsely or insufficiently filled out and so were not included in the study, leaving a sample of 100—34 men, 65 women, and 1 not specified. The sample consisted of 35 clinical psychologists, 13 other psychologists, 10 psychiatrists, 9 other doctors, 18 social workers, and 13 other professions (6 physiotherapists, 7 art therapists, and 1 child therapist). Sixty-eight of the therapists had completed at least one form of special training in psychotherapy (separate from their professional qualification in psychology, psychiatry, social work, etc.), and 84 had at least started psychotherapy training. Of those who had completed training, 15 had training in psychoanalysis or psychodynamic

therapy, 12 in systemic family therapy, 11 in cognitive-behavior therapy, 9 in client-oriented therapy, 9 in creative therapies (art, movement, dance), 8 in Gestalt therapy, 5 in integrative therapy, 3 in EMDR, 2 in psychodrama, and 8 in an other therapy form. On average, the therapists reported having 5.9 colleagues ($SD = 3.5$), working 24.7 hours per week ($SD = 11.2$), and seeing 10.4 ($SD = 5.4$) clients per week. They had been working on average for 5.3 years ($SD = 4.1$) at their current treatment center, and had been working on average for 7.7 years ($SD = 5.5$) with traumatized clients. Fifty-nine of the therapists reported having had “long stays in other cultures” and 29 had been through serious traumatic experiences in their own lives.

Measures

The questionnaire booklet contained two standardized measures of burnout and professional quality of life, as well as a set of items on general information such as demographics and a set of items on the therapists’ distress.

General information. As well as demographics and information about the occupational situation of the respondent, these items included questions on the therapy methods of the respondent including any ongoing or completed clinical training programs. Respondents were also asked which therapy tools they used in 18 items with 4-point scales (*never, seldom, often, and always*). A measure of tool breadth was calculated as the number of tools that the respondent reported using often or always.

Working through. The questionnaire also included one item on advocacy of working through a trauma and a set of five items on the degree to which the therapist had done so with his or her last five completed or prematurely terminated therapies. The question as to how much a therapist advocated working through referred in parentheses to various possible methods: exposure, narrative methods, EMDR, imaginative techniques, flooding, psychodrama reenactment, and focusing-oriented psychotherapy (Gendlin, 1996). Responses were given on a 4-point scale: *under no circumstances, rarely justified, often justified, and*

in principle always necessary. The items about the degree to which working through was practiced in the therapists’ last five cases were also rated on a 4-point scale: *not at all, to a low degree, to a high degree, completely*. The scores for all five cases were averaged to produce an overall score, called *degree (of working through)*. Cronbach’s α for degree was .72.

As we were also interested in discrepancy between the advocacy and degree of working through, a third scale was formed as a difference between the scales: degree subtracted from advocacy, but for scaling purposes calculated as $(\text{advocacy} - \text{degree} + 5)/2$, so that it was on a scale from 1 to 4. Considering three possible cases, this scale would be high when advocacy was relatively high compared to degree, medium when both scales were at the same level, and low when degree was relatively high compared to advocacy. The first case reflects a subjective lack of working through, the second case a balance in attitude and behavior, and the third case a subjective excess in working through. However, in the present data, the third case practically did not exist: none of those advocating working through *rarely* or *never* had degree scores greater than 2.6 (where a score of 2.5 constitutes the middle of the scale). Therefore, this scale ranges from a roughly balanced ratio of advocacy and degree to a combination of low degree relative to advocacy. For this reason, we called this scale *discrepancy*, indicating a theoretical position that is discrepant with one’s clinical action.

Burnout. The German version of the Maslach Burnout Inventory (MBI-D, Büssig & Perrar, 1992; original MBI by Maslach & Jackson, 1981, 1986) consists of 25 items to be answered on a 6-point scale (from *never* to *very often*) directed at various aspects of burnout. It consists of four scales, corresponding to those of the original American version of the test: personal accomplishment, emotional exhaustion, depersonalization, and involvement. The fourth scale was deemed optional by Maslach and Jackson (1981, 1986), but in the German version it is often included, as was the case in this study. Personal accomplishment, is poled such that high scores correspond to low burnout, contrary to the other scales. Büssig and Perrar (1992) reported varying Cronbach’s α values for these scales based on a sample of 449 nurses: For emotional

exhaustion, α was .88, for personal accomplishment .61, for depersonalization .58, and for involvement .50; although based on the present study's data, none of the values was under .60 (.91, .68, .60, and .63 for the above mentioned scales, respectively).

Professional quality of life. The Professional Quality of Life Scale (Stamm, 2005) is comprised of 30 items on a 6-point scale (from *never* to *very often*) about thoughts, feelings and behaviors at work, which are related to burnout, job satisfaction, and CF. Hence, it has three scales: compassion satisfaction, referring to pleasure derived from working well; burnout, referring to feelings of hopelessness and difficulties dealing with work; and compassion fatigue. The Cronbach's α values reported by Stamm for these scales were .82 for compassion satisfaction, .71 for burnout, and .78 for compassion fatigue.

Distress. To measure work-related psychological distress, a set of items were included in the questionnaire referring specifically to working with torture survivors and possible signs of distress. These items were composed and selected based on a Delphi study in which supervisors of therapists working with trauma survivors were interviewed about specific problems associated with this work (described in Gurriss, 2005). A set of 50 items were included in the questionnaire to be answered on a 4-point scale (from *never* to *very often*). These items concern conflicts in the treatment team, dysfunctional emotional reactions to the work, and attitudes to the work conditions. The items were grouped together into five content-related groups, on which five scales were based: task burden (3 items; e.g., "Too many tasks not related to therapy have to be done."), PTSD-related symptoms (18 items; e.g., "I have feelings of helplessness due to the work with torture survivors."), team stress (16 items; e.g., "I feel stressed by conflicts in the team."), vulnerability (4 items; e.g., "I'm afraid of being psychologically hurt by the work with torture survivors."), and somatization (5 items; e.g., "Due to the work with torture survivors I have stomach aches."). These scales had Cronbach α values of .72, .92, .95, .71, and .71, respectively (one item was removed from task bur-

den as it reduced the scale's reliability dramatically, so that this scale was comprised of only two items).

Statistical Analysis

To prevent data loss, missing values were replaced with sample means (average number of replaced values per item = 5). Using SPSS version 11.0, t tests were calculated to determine significant differences in means, and Pearson correlations were calculated to determine the strength of linear relations between variables.

RESULTS

Advocacy and Degree of Working Through

None of the 100 therapists advocated that working through should never be practiced, but 22 believed it to be rarely justified, whereas 56 advocated that it is often justified, and 16 that it is in principle always necessary. The lowest degree of working through was 1.0 (eight therapists), and the highest 3.6 (one therapist) with an average of 1.97 ($SD = 0.60$), where 2 corresponded to *a low degree*. In fact, of the 470 cases (5 for each of the 94 therapists for which the variable degree did not contain a replaced missing value), 35.3% had worked through their traumas with their therapist not at all, 35.7% to a low degree, 25.3% to a high degree, and only 3.6% completely.

Symptom Levels

The means of the MBI-D and ProQOL scales generally indicated average to high levels of symptomatology. The means (and SDs) of the MBI-D scores were for emotional exhaustion, 3.43 (0.92); personal accomplishment, 4.55 (0.43); depersonalization, 2.5 (0.76); and involvement 2.82 (0.89). As no normative data for the MBI-D exist, these scores were compared to those of other studies. They were of similar magnitude to the scores in two other studies using the same instrument: Büssing and Perar's (1992) study with nursing staff ($N = 449$), and Glaser's (2005) study with teachers ($N = 359$), except that

the present sample had substantially higher emotional exhaustion, $t(547) = 5.72$, $p < .001$, $d = .63$, and slightly higher personal accomplishment, $t(547) = 2.78$, $p < .01$, $d = .31$, than the nursing staff described by Büssing and Perar (1992). No significant differences were found in the study values of Glaser's (2005) teachers.

The ProQOL scales showed higher symptomatology than the database of its authors (Stamm, 2005; based on the data of various participant groups, mainly including therapists, nurses, teachers, and humanitarian aide workers): lower compassion satisfaction, $t(771) = 4.98$, $p < .001$, $d = .53$; higher burnout, $t(771) = 6.35$, $p < .001$, $d = .68$; and higher compassion fatigue, $t(771) = 4.03$, $p < .005$, $d = .43$. None of the symptomatology scales showed any sex differences, and only one scale showed significant occupational differences: burnout from the ProQOL, $F(1,91) = 3.11$, $p < .05$. In the post hoc tests of this analysis, only the two extreme groups were significantly different, with burnout being lowest in the "others" group and highest in social workers.

Although no comparison data exist for the means of the distress scales, the frequency distributions of some of the individual items revealed a substantial degree of distress among the therapists (Table 1).

The only scales related to having a cognitive-behavioral orientation compared with not having one ($n = 11$) were degree of working through a trauma, $t(92) = 3.01$, $p < .01$, and as a trend, tool breadth, $t(98) = 1.80$, $p = .07$. Having a psychodynamic/analytic orientation was related to vulnerability, $t(98) = 2.18$, $p < .05$, and task burden, $t(98) = 2.37$, $p < .05$.

Therapists who themselves reported having experienced severely traumatic events (29 therapists) had more pathological levels on the ProQOL: burnout, $t(98) = 3.56$, $p < .001$, and compassion fatigue, $t(98) = 3.60$, $p < .001$. On the MBI, their levels were higher for emotional exhaustion, $t(98) = 2.09$, $p < .05$, and lower for personal accomplishment, $t(98) = 3.28$, $p < .001$. On the distress scales, their levels were higher for vulnerability, $t(98) = 3.05$, $p < .01$, somatization, $t(98) = 2.22$, $p < .05$, team stress, $t(98) = 2.46$, $p < .05$, and for PTSD-related symptoms, $t(98) = 2.64$, $p < .05$. None of the ProQOL, MBI, or distress scales correlated with years of therapy experience or with years of experience as a trauma therapist. However, several of these scales correlated with the number of clients seen per week, including burnout ($r = .393$, $p < .001$), compassion fatigue ($r = .407$, $p < .05$), emotional exhaustion ($r = .36$, $p < .05$), involvement ($r = .32$, $p < .01$), and all of the distress scales ($.283 \leq r \leq .36$, $p < .01$).

The relationship of symptom levels to working through.

Considering the variables related to working through, advocacy correlated slightly positively with degree, but this was only a trend ($r = .180$, $p = .07$). Therapy tool breadth was related to a high degree of working through ($r = .21$, $p < .05$), but not to its advocacy. Tool breadth, however, was not related to any of the symptomatology scales. The correlations between the symptomatology scales and the working through scales are shown in Table 2. In general, symptomatology was negatively related to degree of working through, but positively related to its advocacy. Furthermore, high advocacy was related to distress and burnout

Table 1. Percentage of Therapists ($n = 100$) Endorsing Selected Items From the Distress Scales

Item	Scale	% Often or very often
"The work cannot be managed."	Task burden	57
"I feel stressed by conflicts in the team."	Team stress	33
"I have feelings of resignation."	PTSD-Related symptoms	32
"Due to the work with torture survivors I have nightmares."	PTSD-Related symptoms	17
"I am afraid of being hurt by the work with clients."	Vulnerability	17
"Due to the work with torture survivors I have back pain."	Somatization	13

Note. PTSD = posttraumatic stress disorder.

Table 2. Correlations Between the Working-Through Scales and Burnout and Distress ($N = 100$)

	Scales related to working through a trauma		
	Degree	Advocacy	Discrepancy
MBI-D			
Emotional exhaustion	-.22*	.31**	.40***
Personal accomplishment	.25*	-.15	-.33***
Depersonalization	-.23*	.12	.26*
Involvement	-.19	.29**	.36***
ProQOL			
Compassion satisfaction	.25*	-.15	-.32**
Burnout	-.21*	.16	.31**
Compassion fatigue	-.19	.24**	.35***
Distress			
Task burden	-.21*	.25*	.32**
PTSD-related symptoms	-.19	.20*	.31**
Team stress	-.18	.33***	.40***
Vulnerability	-.19	.24*	.33***
Somatization	-.05	.24*	.25*

Note. MBI = Maslach Burnout Inventory, ProQOL = Professional Quality of Life Scale.
* $p < .05$. ** $p < .01$. *** $p < .001$.

more strongly than was low degree of working through. Thus, the discrepancy scale, reflecting high advocacy of working through but low degree, was the strongest correlate of high symptoms, correlating significantly with all MBI-D, ProQOL, and distress scales. Interestingly, discrepancy was most highly correlated with team stress and emotional exhaustion.

Hence, both hypotheses were confirmed: low degree of working through was related to CF, burnout, and distress, and high discrepancy between advocacy and degree of working through was associated with not only burnout, but also with other work-related symptoms.

STUDY 2

The aim of the second study was to examine the relationships found in Study 1 with respect to reported hindrances to working through a trauma. In addition, to investigate the interaction of the therapists' advocacy of working through a trauma and the degree to which they did so more thoroughly, the sample was divided into three groups of therapists. These groups formed the basis of comparison in

the study and were based on three modes of functioning: Success, reflecting high advocacy, and high degree, Frustration, reflecting high advocacy, low degree, and Non-Advocacy, including all therapists with low advocacy of working through (cutoffs are described below). It was expected that the Frustration group, having the highest discrepancy, would not only be more susceptible to burnout and distress, but would also report stronger hindrances to working through than the other groups.

METHOD

Procedure

The second study was based on the same data set and participants as the first study, but included additional items. The three groups were formed as follows: For the Non-Advocacy group, all therapists who endorsed working through as being rarely justified were included (as none endorsed that it was never justified). Hence, the Frustration and Success groups contained only therapists who advocated working through as being often justified or in

principle always necessary. These therapists were divided into the groups, Success and Frustration by using the sample's average degree (1.97) as the cutoff. Therapists with higher scores were assigned to the Success group and with lower scores to the Frustration group. Hence, as the cutoff of 1.97 was just below the low mark, the therapists' average level of working through across all clients was between never and low for the Frustration group and from low to completely for the Success group.

The instruments were the same as in the first study except for the addition of a set of items on hindrances to working through.

Hindrances to working through. These items were composed based on the Delphi study described by Gurriss (2005). There were two sets of items concerning possible hindrances to working through: the first relating to the client, and the second relating to the therapist, the team, or the management. Both sets of items were factor-analyzed (principle component analysis with varimax rotation) with factor extraction criteria being the point of flattening out of the scree plot and nonambiguous factor loadings. In the first analysis (16 items relating to the client), three factors were identified: client's reservations (4 items; concerning fears of information leaking to others or political backlash, incompatibility with sociocultural values, and reservations about the presence of the translator), client's symptoms (6 items; concerning symptom worsening, such as pain, fear, between-session symptoms, and dissociation, as well as having no words to describe the events, and bringing up other problems), and therapeutic relationship (6 items about the client missing sessions, dropping out of therapy, mistrusting Western treatment, finding the therapist helpless or unable to help, and not wishing to burden the therapist). The reliability of these scales was satisfactory with Cronbach's α values of .72, .71, and .67, respectively. In the second analysis (18 items relating to the therapist, the team, or the management), again three factors were identified: therapist's insecurity (11 items describing the therapist as unsure or insecure about working through due to problems with the team or the management, feeling weakened, afraid, or angry in relation to the divulged trau-

matic events, or being advised not to work through the trauma), fear of hurting the client (4 items describing worries about overburdening or retraumatizing the client, or the client decompensating or committing suicide), and unfavorable conditions (6 items describing hindrances, such as asylum proceedings, intellectual, financial, or developmental deficits, or the intercultural context). Here the reliability of the scales was satisfactory to good with Cronbach's α values of .89, .73, and .68, respectively.

Statistical Analysis

For the working through scales advocacy and degree, missing values were not replaced, in contrast to the procedure in the first study, to prevent false group allocation. A series of univariate ANOVAs were calculated to investigate group differences (Table 3).

RESULTS

In terms of the setting or demographic data, the three groups showed few differences, with a trend to an age difference, $F(2,91) = 2.61$, $p = .08$; Scheffé tests showing Non-Advocacy > Frustration at $p < .1$, and to a difference in number of clients seen per week, $F(2,91) = 2.99$, $p = .055$; Scheffé tests showing Frustration > Success at $p < 1$. No significant differences were found in terms of therapy schools, or tool breadth, and a χ^2 test showed that there were no group differences in the presence of a personal trauma.

In the therapists' symptomatology, there were substantial differences between the three groups (Table 3). The general pattern was that the Frustration group consistently showed higher symptomatology than at least one of the other two groups. As to the question of what hindrances were reported more in which groups, therapist's insecurity followed the same pattern: The Frustration group was higher than both other groups, with this effect explaining about 20% of the variance. The Frustration group also tended to cite unfavorable conditions more frequently as a hindrance to working through than the other groups. However, for client's symptoms, it was the Success group that distinguished itself from the other two groups, reporting

Table 3. Analyses of Variances (ANOVAs) Showing Groups' Differences in All Scales ($N = 94$)

	<i>F</i>	<i>df</i>	η^2	Scheffé
MBI-D				
Emotional exhaustion	7.08***	(2,91)	.134	A < B**, B > C*
Personal accomplishment	3.41*	(2,91)	–	–
Depersonalization	2.31	(2,91)	–	–
Involvement	5.46**	(2,91)	.107	A < B**
ProQOL				
Compassion satisfaction	7.11***	(2,91)	.135	B < C**
Burnout	3.69*	(2,91)	–	–
Compassion fatigue	4.84**	(2,91)	.096	A < B*
Distress				
Task burden	4.73*	(2,91)	.097	A < B*
PTSD-related symptoms	3.65*	(2,91)	.074	A < B*
Team stress	6.57**	(2,91)	.126	A < B**, B > C*
Vulnerability	4.68*	(2,91)	.093	A < B*
Somatization	1.75	(2,91)	–	–
Hindrances				
Client's reservations	1.26	(2,91)	–	–
Client's symptoms	6.26**	(2,91)	.121	A > C*, B > C*
Therapeutic relationship	0.33	(2,91)	–	–
Therapist's insecurity	11.26***	(2,91)	.198	A < B**, B > C***
Fear of hurting the client	2.43	(2,91)	–	–
Unfavorable conditions	8.20***	(2,91)	.153	B > C***

Note. MBI = Maslach Burnout Inventory, ProQOL = Professional Quality of Life Scale, Groups: A = Non-advocacy ($N = 22$), B = frustration ($N = 32$), C = success ($N = 40$).

* $p < .05$. ** $p < .01$. *** $p < .001$.

this kind of hindrance significantly less than both of them. In sum, the hypothesis was confirmed that the Frustration group showed higher levels of work-related symptoms, and generally more hindrances to working through.

DISCUSSION

This study shows that considering the degree to which a therapist works through traumatic events with a client and advocates this are important variables in investigating therapists' risk of work-related symptoms. Advocating, but not achieving working through, not only seems to put a therapist at more risk than those who neither advocate working through nor practice it, but also at more risk than those who are successful at working through. This casts an interesting light on the mechanisms behind work-related symptoms in trauma therapists. Secondary or vicarious trauma is thought to be related to exposure to clients' descriptions

of traumatic events (Kadambi & Ennis, 2004), but in the present study the exposure itself did not appear to be decisive, as therapists who preferred not to work through traumatic events had symptom levels indistinguishable from those who advocated and practiced working through. In fact, the degree of working through was generally negatively related to burnout and CF. Only the Frustrated group of therapists who advocated, but did not succeed in working through, had particularly high symptom levels. This group might be considered especially at risk for developing burnout as burnout is related to not being able to realize one's work-related ideals (Maslach & Leiter, 1997). However, this group scored higher than the others not just on scales related to burnout, but also on scales related to secondary or vicarious trauma, such as compassion fatigue, PTSD-related symptoms, and somatization.

These findings indicate that it is not the exposure itself so much as what the therapist does in the face of the

exposure, which represents a risk factor for work-related symptoms. The Frustrated group achieved only a low level of working through the trauma with each client, but witnessing the client's behavior in the sessions and knowing the general history of traumatic events may be enough to cause secondary or vicarious trauma. In fact, the failure of this group to work through the traumatic events with the client could well reflect a form of fear avoidance. Fear avoidance in both the patient and the therapist can reinforce and maintain anxiety symptoms, inducing a cooperative avoidance between therapist and client. The hindrances to working through the traumatic events cited frequently by the frustrated therapists (unfavorable conditions and therapist's insecurity) may well be manifestations of this fear avoidance. Client exposure without high levels of avoidance, as achieved in the Success group, appears to be a symptom-reducing factor.

This explanation leaves open the question as to why the Non-Advocacy group should also show low levels of symptoms. Low burnout symptoms would seem plausible because goals were achieved, but this group should have had the same amount of client exposure as the Frustration group. Again, the level of fear avoidance may be the difference. The Non-Advocacy group (as well as the Success group) may be less fear avoidant than the Frustration group. Their low degree of working through is more likely to be due to theoretical considerations or personal beliefs rather than to evasion of exposure to details of traumatic events. Hence, the Frustration group scored highest on the hindrance item: "You observe stress symptoms in yourself during the phase of working through or between sessions and so you avoid working through" (scale: therapist's insecurity; Kruskal Wallis test: $= 8.52$, $p < .05$, with post hoc Mann-Whitney U-tests showing this group to be higher than both other groups (Frustration: Non-Advocacy = $U = 204$, $p < .01$, Frustration: Success = $U = 474$, $p < .05$). This could mean that the Non-Advocacy group prevents symptom development by decisively forgoing high levels of working through, whereas the Success group prevents symptom development through confrontation with the traumatic material together with the patient. Possibly the Frustration group's

ambivalence has a symptom-enhancing effect beyond that of its fear avoidance. Perhaps living in a state similar to that described by Festinger's (1957) concept of cognitive dissonance, the Frustration group experiences discomfort because their behavior is at odds with their beliefs. Being unwilling or unable to adjust one's behavior to be in accord with one's beliefs is likely to be a source of stress.

Another important result was the particularly high scores on the team stress scale in the Frustration group. This scale is the best predictor of Frustration group membership as revealed by a stepwise logistic regression in which only team stress remained in the equation after one step, $R^2 = .16$; for team stress: $B = 1.26$, $SE = .383$, $OR = 3.52$, $p < .01$. Hence, shifting one unit on the team stress scale (e.g., from seldom to often) represents about 3.5 times more likelihood of being a Frustration group member. The causality of this relationship could of course flow in either direction, or in both. In other words, team stress and conflicting opinions in the team concerning how much working through is appropriate could cause ambivalence in therapists, or a team with ambivalent and stressed therapists may be more prone to dysfunctional group relations. In any case, interventions at the level of group relations in the team probably represent a valuable protective measure against work-related symptoms. The subsequent sensitivity of group relations in teams of trauma therapists and the need for group interventions is a well acknowledged issue in the literature on trauma therapists (e.g., Lansen, 2001). The interpersonal contagiousness of traumatic stress may even go beyond the team and affect friends and family of therapists (Cerney, 1995).

In this sample, CF/VT and burnout symptoms were highly correlated. For example, the ProQOL scales burnout and compassion fatigue correlated at $r = .819$ ($p < .001$), whereas compassion fatigue correlated with emotional exhaustion at $r = .72$ ($p < .001$). The task burden scale was not just related to burnout scales (e.g., burnout, $r = .51$, $p < .001$; emotional exhaustion, $r = .66$, $p < .001$; depersonalization, $r = .394$, $p < .001$), as one might have expected, but also to scales related to secondary/vicarious traumatization such as compassion fatigue ($r = .42$, $p < .001$, somatization, $r = .38$, $p < .001$),

and PTSD-related symptoms ($r = .48, p < .001$). These correlations are possibly a sign that in this group of therapists at least there was really only one work-related syndrome manifested in a cluster of both burnout and secondary/vicarious trauma symptoms, rather than separate syndromes. It is conceivable that in therapists working in this field, burnout and secondary/vicarious trauma become one and the same thing due to the apparent interconnectedness of job disillusionment, avoidant behavior, and dysfunctional team relations. Alternately, this high intercorrelation may reflect limitations in the instruments used. No instrument was used to measure changes in cognitive schemas assumed central to the idea of vicarious traumatization, such as the TSI (Pearlman, 1996; Pearlman & MacLan, 1995), which might have enabled some untangling of syndromes. However, this concept probably also has its limitations, as it has been questioned as being unique to people exposed to accounts of other people's trauma in a recent review of the literature on vicarious trauma (Kadambi & Ennis, 2004). Future studies could well profit from newer, perhaps more sensitive measures of symptomatology, perhaps including standardized interviews.

A limitation of the present study is the fact that a very heterogeneous group of therapists formed the sample. Although this is representative of the actual population of therapists involved in work with torture survivors in German-speaking countries, some of the various methods included may not have been equivalent in terms of exposing the therapist to traumatic material. The exact amount of exposure was not measured in this study, as measures relied on subjective accounts. Studies in which the hours of exposure to traumatic material, perhaps using only one form of therapy such as CBT, could make important contributions to the question as to the circumstances under which exposure produces burnout and secondary trauma. Other sample characteristics that may have affected the results include varying kinds and levels of training, which may also have influenced some therapists' advocacy of working through, and torture survivors as the client group. Exposure to other client groups (such as survivors of natural disasters) may not have produced the same effects.

Other methodological limitations include the response rate of 54%, which is equivalent to that of most mail surveys, and may have obscured an effect specific to non-responders. Furthermore, the working through variables were limited: No information was gathered on the number of prematurely terminated therapies, which may have affected the results. In addition, the advocacy variable was based on a single item. Additional items would allow a more differentiated understanding of this attitude and would increase the measure's reliability. It should also be kept in mind when interpreting the results that the 4-point scale of the working through items did not allow for a middling response. This was done to reduce a central tendency response set, but means that the scales did not necessarily reflect the full range of possible responses.

Overall, this study has implications for therapists as well as individual and group supervisors working in this field. It underlines the importance of monitoring group processes in the team and avoidant tendencies in therapists for preventing work-related symptoms. Diagnostically, it may not always be possible to differentiate between the syndromes of burnout and secondary trauma, at least in therapists working with torture survivors, as both these pathological processes probably reciprocate each other. One telling sign of such symptom development may well be an ambivalence manifested in the discrepancy between the degree to which working through is practiced and advocated.

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