

Compassion Fatigue and Psychological Distress among Social Workers: A Validation Study

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Abstract

Few studies have focused on caring professionals and their emotional exhaustion from working with traumatized clients, referred to as Compassion Fatigue (CF). The present study had two goals: 1) to assess the psychometric properties of a CF scale, and 2) to examine the scale's predictive power in a multivariate model. The data come from a survey of social workers living in New York City (NYC) following the September 11 terrorist attacks on the World Trade Center. Factor analyses indicated that the CF scale measured multiple dimensions. After eliminating overlapping items, the scale measured two key underlying dimensions – Secondary Trauma and Job Burnout. In a multivariate model, Secondary Trauma and Burnout were related to psychological distress, even after controlling for other risk factors. We discuss the results in light of increasing the ability of professional caregivers to meet the emotional needs of their clients within a stressful environment without experiencing CF.

Introduction

Although the psychological consequences of providing social support and care to traumatized individuals have been noted for over two decades, relatively few studies have focused on formal caregivers (i.e., therapists, child protection workers, nurses, etc.) and their emotional response to dealing with traumatized clients (Figley 1995). Studies have shown that providing such care can be both highly rewarding and highly stressful (Ohaeri 2003). Individuals working in the caring professions, though, may have occupational environments and caregiving demands that increase the likelihood of adverse psychological outcomes (Figley 2002b; Sabin-Farrell & Turpin 2003).

Theoretically, individuals working in the caring professions often attempt to alter the behaviors and emotions of their clients by providing emotional support (e.g., empathy), strategies for coping with emotions, or by providing better cognitive management skills (Boscarino 1997; Francis 1997, Thoits 1986). Within the context of formal caregiving, providing therapy to clients who have survived a traumatic event can be particularly stressful (Figley 1995). Many have described how therapists who work with traumatized clients often show signs of psychological distress as a result of these interactions (Figley 1995; Nelson-Gardell and Harris 2003; Schauben & Frazier 1995). This adverse impact of working with clients who have a history of psychological trauma (e.g., sexual and physical abuse, military combat, and community disaster) has been described under a variety of terms: vicarious traumatization, secondary traumatic stress, and compassion fatigue (Jenkins & Baird 2002).

Compassion Fatigue (CF)

For the present study, we use the term compassion fatigue (CF), consistent with most current usage, which is defined as the formal caregiver's reduced capacity or interest in being

empathic or “bearing the suffering of clients” and is “the natural consequent behaviors and emotions resulting from knowing about a traumatizing event experienced or suffered by a person” (Figley 1995; p. 7, see also Figley 2002a; 2002b). Thus, compassion fatigue is a hazard associated primarily with the clinical setting or among first responders to traumatic events and is composed of two parts, secondary trauma and job burnout.

With the inclusion of posttraumatic stress disorder (PTSD) in the Diagnostic and Statistical Manual III (DSM-III), common symptoms related to severe psychological trauma were defined as a psychiatric disorder (American Psychiatric Association 1980). Figley (1995) developed the concept of CF when he began to focus on the unique work environment of trauma workers and mental health professionals and how they appeared to experience the effects of trauma vicariously. More specifically, CF appeared to be the consequences of working with traumatized individuals, if the professional was exposed to significant numbers of traumatized persons and had a strong empathic orientation (Figley 1995). Empathic engagement with traumatized clients often requires the professional to discuss details of the traumatic experience, including role play and dramatic reenactment of the events, which are thought vital to the therapeutic process, but can have an adverse emotional impact on the caregiver (Figley 2002a, 2002b). This type of vicarious trauma often is referred to as secondary traumatic stress in the literature (Boscarino, Figley and Adams 2004). Thus, when therapists, doctors, nurses, or child protection workers report symptoms related to re-experiencing the client’s traumatic event, wishing to avoid both the client and reminders of the client’s trauma, and persistent arousal due to intimate knowledge about the client’s traumatic experiences, they are likely suffering from secondary trauma (Figley 1995, 2002a; Jenkins & Baird 2002; Schauben & Frazier 1995).

More recently, Figley (1995, 2002a, 2002b) and others (e.g. Gentry, Baranowsky, and Dunning 2002; Jenkins and Baird 2002; Nelson-Gardell and Harris 2003; Salston and Figley 2003;

Stamm 2002) observed that secondary trauma and what has been called job burnout overlap, in that both are characterized by the emotionally exhausting nature of working with survivors of trauma. Figley (2002a) has suggested, however, that secondary trauma is not the same as burnout syndrome and that each should be treated as having a unique effect on a professional's well-being (see also, Jenkins and Baird 2002; Sabin-Farrell & Turpin 2003; Salston & Figley 2003). Burnout syndrome is often defined as a response to prolonged exposure to demanding interpersonal situations and is characterized by "emotional exhaustion, depersonalization, and reduced personal accomplishment" (Maslach, Schaufeli, and Leiter 2001). High emotional involvement without adequate social support or feelings of personal work accomplishments (i.e., job satisfaction) may leave the caring professional vulnerable to burnout. Thus, we suggest that both secondary trauma and job burnout are likely central and critical clinical features of CF. In this study, we assess the extent to which secondary trauma and job burnout are related to and independent of one another.

In their review of the literature on compassion fatigue, Sabin-Farrell & Turpin (2003) have suggested several possible psychological or psychoanalytic mechanisms (e.g., countertransference, emotional contagion) by which working with clients may result in CF (see also, Salston & Figley 2003). In this study, we conceptualize CF within a stress process framework (Pearlin 1989; Thoits 1995). This framework contends that challenging environments (stressors) typically require individuals to respond both physiologically through alterations in the neuroendocrine and hormonal systems (Boscarino 1997) and psychologically, usually through alterations in cognitive functioning (Francis 1997; Thoits 1995).

Both stress (Thoits 1995) and CF researchers (Figley 1995; 2002a; Kassam-Adams 1999) also suggest that other aspects of the formal caregiver's life can influence the likelihood of developing CF. For example, a history of trauma, lower social support, and an inability to cope

with the demands of caregiving, are thought to increase the likelihood of developing compassion fatigue. Previous research tends to support the hypothesized relationships between these risk factors, compassion fatigue, and psychological distress (Figley 1995; 2002b; Nelson-Gardell & Harris 2003; Sabin-Farrell & Turpin 2003; Salston & Figley 2003; Schauben and Frazier 1995). Schauben and Frazier (1995), for example, find that female psychologists and violence counselor with a higher percentage of sexual violence victims as clients reported more vicarious trauma and that this was related to greater psychological problems. A history of personal trauma is also related to poor psychological health in child welfare workers (Nelson-Gardell & Harris 2003) and psychotherapists (Kassam-Adams 1999).

Despite these findings, research on CF has several problems. First, there has been a lack of conceptual clarity about what constitutes CF and how it differs from other adverse work outcomes such as job burnout (Jenkins & Baird 2002). There are also a number of CF scales, with many dissimilar items (e.g., Figley 1995; Stamm 2002; Gentry, Baranowsky, & Dunning 2002). Finally, none fully incorporate all aspects of Figley's (1995, 2002a) description of CF or key variables in the stress process model.

In order to address these gaps in previous research, we focused on social workers in clinical practice in a region recently affected by a major traumatic event – the September 11 terrorist attacks in New York City. We were interested in this caregiving profession because the work environment of social workers is often characterized by high case loads and inadequate resources (Duffy, West, Wilk et al. 2003). In addition, the delivery of mental health care services is increasingly being performed by social workers (Mechanic 1999).

Data and Methods

The data for this study are from a survey of social workers living in New York City (NYC). The sampling frame was all social workers with a Masters in Social Work or higher who

were current members of the National Association of Social Workers (NASW). The NASW is the main national social work organization with approximately 50% of all practicing social workers as members. From the membership list, we randomly selected 600 individuals to be sent a mailed questionnaire between May 12 and May 15, 2003. A second questionnaire was mailed two weeks later and a follow-up letter two weeks after the second mailing, reminding the person to return the survey. We accepted returned surveys until August 31, 2003. Since we were mainly concerned with social workers who potentially suffered from CF, we asked those who were not engaged in direct practice to return the survey indicating that they were not involved in clinical practice. These surveys were eliminated from our study. Overall, 236 social workers returned completed surveys and 38 returned surveys indicating that they were not providing services. All of the addresses appeared to be correct, as none of the questionnaires/letters from the three mailings were returned by the Post Office. Thus, the overall survey completion rate (returned surveys [274]/all surveys sent [600]) was 46%. The Institutional Review Board for the New York Academy of Medicine reviewed and approved the study's protocols.

Dependent Variables

This study focused on two conceptual domains: compassion fatigue and psychological distress. Compassion fatigue was measured using the 30 item Compassion Fatigue (CF) scale-Revised (Gentry, Baranowsky, & Dunning 2002). This scale was developed by Figley (1995) based on clinical experience and versions of the scale have been used in several previous studies (Stamm 2002; Jenkins & Baird 2002). The scale was designed to assess both vicarious trauma and job burnout. The present study, however, was the first to assess the basic psychometric properties of this scale. The survey asked respondents to consider each scale item and indicate how closely it currently reflects their experience, using a 10-point, visual analog-type Likert scale (rarely/never=1 to very often=10).

General psychological distress was assessed using the 12-item version of the General Health Questionnaire (GHQ-12; Goldberg & Huxley 1992; McDowell & Newell 1996). This scale, based on a 4-point Likert scale, was designed to be a general screening instrument for psychological problems in a general population and has excellent validity and reliability (McDowell & Newell 1996). In our study, the GHQ-12 scale (Cronbach's $\alpha = .80$) was scored so that higher scores reflected poorer psychological status (mean = 24.2; sd = 3.5, range=15-38).

Independent Variables

Based on Figley's (2002) conceptual of compassion fatigue and psychosocial stress theory (Pearlin 1989; Thoits 1995), we included demographic, stressor exposures, and psychological resources as independent variables. The five *demographic variables* were gender, race/ethnicity, age, marital status, and years working in professional counseling. Age and years in professional counseling were coded to the nearest year (mean = 55.9; sd = 8.0 and 23.4; 7.9, respectively). Gender, marital status, and race/ethnicity were coded as binary variables, with male, not married/not living together, and person of color coded as 0.

We included four variables measuring *exposure to stressful events*. First, the survey inquired about eight negative life events (e.g., getting divorced, having problems at work, etc.) which could have occurred to the respondent in the past 24 months (Freedly, Kilpatrick, & Resnick 1993). These events were summed to produce a negative life events scale (mean = 1.1; sd = 1.2). Second, we asked about 8 lifetime traumatic events (e.g., attacked with a gun, a situation where being killed was possible, etc.) which could have happened during the respondent's lifetime (Freedly, Kilpatrick, & Resnick 1993). As with negative life events, these events were summed to produce a lifetime traumatic events scale (mean = 1.9; sd = 1.4). Third, there were seven questions about whether or not the respondent counseled people exposed to the September 11 World Trade Center disaster (WTCD), such as counseling those who directly witnessed the

events, lost a spouse, etc. We summed these questions into a 9/11 counseling experience scale (mean = 3.2; sd = 1.6). As a measure of exposure to other traumatized clients, we asked participants what percentage of their clients were survivors of physical or sexual violence. Responses were coded into a binary variable, indicating “low” exposure if less than 20% of clients were survivors of violence and “high” exposure if 20% or more were survivors. The negative life events, traumatic events, and the counseling individuals exposed to the WTCD measures discussed were used and validated in other WTCD studies in NYC (Boscarino et al. 2002; Boscarino et al. 2004; Galea et al. 2003).

Finally, we assess three measures of *psychological resources*: having information to work effectively with clients, social support, and sense of mastery. Work information was the sum of two items (Information needed to enhance the delivery of my services to my clients or patients has been readily available to me; and I have adequate information about how to control my emotional fatigue through such strategies as deep breathing, positive self-talk, and the appropriate use of humor) and related to how organizations can help formal caregivers cope with the stressful events associated with their work (Figley 1995, 2002a). The response options for these 2 questions were based on 5-point Likert scales, ranging from strongly disagree (coded 1) to strongly agree (coded 5). Higher scores indicated greater agreement that information to be an effective social worker was available (mean = 8.3; sd = 1.2). The social support scale (Sherbourne & Stewart 1991) consisted of 4 items (e.g., someone was available to confide in), summed so that higher scores reflected higher social support, based on a 4-point Likert scale, from “none of the time” to “all of the time” (mean = 12.8; sd = 3.2) (Cronbach’s alpha=.89). Finally, sense of mastery (Cronbach’s alpha=.76) was measured using 6 items from Pearlin’s mastery scale (Pearlin et al. 1981). The response categories were based on a 5-point Likert scale (strongly disagree to strongly agree, coded 1 to 5). These items were summed, with higher scores on this scale

indicating a greater sense of mastery (mean = 23.4; sd = 3.8). Both social support and mastery scale were validated in many studies and showed good reliability (Boscarino et al. 2002; Boscarino et al. 2004; Pearlin et al. 1981).

Statistical Analysis

Our analytical goals were to develop a measure of CF that was parsimonious, measured core dimensions, were valid and reliable, and was a good predictor of psychological distress. To achieve these, we used principal component analysis with a varimax rotation to identify the number of underlying factors in the CF scale (Pett, Lackey, & Sullivan 2003). Once the factor analyses specified items to be included, reliability analyses, using Cronbach's alpha, assessed item consistency within each scale. After establishing that the scales measured only one factor and had acceptable internal reliability, we assessed the validity of the scales by correlating them with stress exposure, psychological resource, and psychological distress variables, and to each other. Finally, to test the predictive utility of the scales, we estimated a series of ordinary least-squares (OLS) regressions with the GHQ as the dependent variable and the demographic, stress exposure, psychological resource, and CF scales as independent variables, respectively. SPSS version 11.5 was used for all data analysis and all p-values shown were based 2-tail tests.

Results

Since the demographic profile of our sample has been discussed elsewhere (Boscarino, Figley, and Adams 2004), we present only a brief description here. The sample was predominately female (80%), white (89%), were in long-term relationships—married, living as if married—(63%), and older, with more than 80% of the respondents 50 year old or older. The majority of the sample also had more than 20 years experience in professional counseling, at least one negative life event in the past 2 years, and at least one traumatic event in their life-time. Finally,

our sample was very involved in working with clients who had some exposure to the events of September 12, 2001, with 94% reporting at least some involvement. On the other hand, less than 20% had a practice with a high percentage of clients who were survivors of violence.

Since a central focus of the study was to assess the psychometric properties a Compassion Fatigue scale, we first conducted a factor analysis on the 30 items in the CF scale (available upon request). We then eliminated items from future factor analyses based on three criteria: loading on a factor with the lowest eigenvalue when that factor is dropped in subsequent factor analyses, having a factor score of .400 or greater on two or more components, or having a communality of less than .500. We also assessed the items in terms of whether or not they pertained to stress symptoms related to working with clients or job burnout.

Items were dropped until only 2 factors remained (Table 1). Component 1 consisted of items related to work burnout (feeling trapped by work). Those in Component 2 focused on secondary trauma (flashbacks, troubling dreams related to client interactions). We summed the items to form a work burnout (8 items) and a secondary trauma scale (5 items). Each of the scales showed good internal reliability, with the work burnout scale having a Cronbach's alpha of .90 and the secondary trauma scale an alpha of .80. We also combined all 13 items into a CF-short scale (alpha=.90).

Table 2 presents Pearson correlation coefficients for the original 30-item CF scale (CF-Long), work burnout scale, secondary trauma scale, and the 13-item CF-Short with the GHQ, stress, and psychological resource variables. The primary purpose of these analyses was to assess the scales' concurrent validity. First, it is clear that the work burnout, secondary trauma, and CF-Short scales were highly correlated with the original CF-Long scale, and with each other. Second, all four scales are significantly related to psychological distress as measured by the GHQ. Third, work burnout was negatively associated with social support, having information to work

effectively, and sense of mastery, suggesting that an unsupportive work environment can increase this work-related hazard. Secondary trauma was related to none of the stress/resource variables, while the CF -Short was related to the same four variables that burnout was. Finally, none of four scales were significantly correlated to either percent of clients who were survivors of violence or 9/11 counseling activities. Thus, these analyses seem to indicate that exposure to traumatized clients does not, in and of itself, lead to compassion fatigue.

Overall, our multivariate OLS regressions (Table 3) explained about 40% of the variance in our dependent variable, the GHQ-12 scale, regardless of which scales were in the models. All four scales were significantly related to psychological distress, even after controlling for other variables. That is, taking into account recent negative life events, lifetime trauma, social support, the work environment, and sense of mastery the associations between compassion fatigue, secondary trauma, or burnout and psychological distress were not eliminated. The regression models also support the notion that job burnout and secondary trauma were separate contributors to psychological distress. As shown in model 4, both burnout and secondary trauma were statistically significant, controlling for other variables in the model. Finally, the CF-Short (model 5) did just as well at predicting psychological distress as the 30-item CF-Long.

The regression equations also supported several other expected associations. Respondents reporting more negative life events also had higher levels of distress, while those with higher sense of mastery were less distressed. Interestingly, having adequate information to work effectively with clients was significantly associated with *lower* distress in all, but one of the five models. Finally, none of the demographic characteristics consistently predicted scores on the GHQ. This last finding was surprising, given that most research shows some statistically significant associations between demographics and psychological distress (Pearlin 1981; Thoits 1995).

Discussion

Using a random sample of social work practitioners in New York City, we assessed the psychometric properties of Figley's Compassion Fatigue Scale-Revised (Gentry, Baranowsky, Dunning 2002). Our analyses showed that the original 30 item scale measured multiple underlying factors. Eliminating items with the goal of producing measures consistent with secondary trauma and burnout, we were successful in developing two reliable and parsimonious scales. The strength of the separate scales (or the combined CF-Short) was that they contain fewer items overall (13 versus 30), while remaining highly correlated with the original scale. In addition, with separate scales we could explicitly test the claim that secondary trauma is different from burnout, which was supported by our analyses. Finally, the original scale contained items that could be interpreted as measuring psychological distress (e.g., I have difficulty falling or staying asleep; I startle easily) or direct, personal trauma (e.g., I have had first-hand experience with traumatic events in my childhood) rather than vicarious trauma. Thus, the associations between psychological distress and secondary trauma, burnout, and CF-Short were not artificially high due to the scales containing similar items.

A second goal of our study was to gauge the validity of the CF-Long, burnout, secondary trauma, and CF-Short scales by examining their associations with other reliable and valid measures. All four scales were correlated with psychological distress (as measured by the GHQ), but none of them had correlations with stress exposure or resource variables greater than .33. These results support the hypothesis that secondary trauma, burnout and, more generally, compassion fatigue are unique features of the workplace environment and not merely different designations for negative life events, personal trauma, lack of social support, or low mastery.

Finally, we tested the predictive power of the CF scales, burnout, and secondary trauma in a multivariate model. The regression findings clearly indicated that original CF scale and the

reduced burnout, secondary trauma, and CF-Short scales predicted psychological distress very well, even after controlling for demographic, stress exposure, and psychological resource factors. The burnout and secondary trauma scales, therefore, seemed to be quite appropriate assessment tools, either separately or combined into the CF-Short, for identifying caregiving professionals at risk for CF and psychological problems.

There are limitations which make our conclusions tentative. First, the sample was smaller than desired for factor analyzing a thirty item scale. Nevertheless, the secondary trauma, burnout and CF-Short scales match the clinically-based concepts as developed by Figley (1995, 2002a). Given the overall consistency of our results, there is little reason to believe that they were seriously biased by sample size. Second, we cannot fully disentangle the casual ordering of psychological distress and CF, due to the cross-sectional nature of our data. Theoretically, Figley (1995) and others (Jenkins & Baird 2002; Schauben & Frazier 1995) have assumed a casual direction from CF to psychological problems. It is possible, however, that psychologically distressed individuals may interpret their interactions with clients such that they increase their vulnerability to CF. Only longitudinal data and further theoretical work can adequately address these issues.

A third limitation reflects the evolving conceptualization of compassion fatigue. In her history of the concept, Stamm (2002) argues that the scale should have both positive and negative items in order to measure both compassion fatigue and compassion satisfaction. The present study used one version of the Figley scale which did not contain satisfaction items. This may be part of the reason that exposure to survivors of violence was not significantly related to CF. The ongoing discussion of how to measure the concept makes for analytic difficulties and obviously necessitates further research on both the concept and its operationalization.

Other limitations include that only certain types of social workers might be members of NASW, the professional database from which we drew our sample. Thus, our sampling frame may have been biased in some way. Furthermore, our response rate was somewhat below 50%, which while not significantly lower than other mail surveys in urban areas (Kessler, Little and Groves 1995), may have introduced some selection bias. Finally, it may not be possible to generalize our results beyond social workers practicing in NYC. Although social workers around the country face similar work environment problems, there may be other aspects of work unique to less urban settings. In addition, psychiatrists, psychologists, and trauma workers may have different responses to working with survivors of traumatic experiences as a consequence of working in different occupational settings.

Conclusion

These limitations should not overshadow the strengths of this study. It is one of the few to closely examine the psychometric properties of Figley's (1995) CF scale and use it to predict psychological distress. The CF-Short, secondary trauma, and burnout scales employed in the present study have good reliability, good concurrent and predictive validity, and include only 13 items. Even after accounting for other factors, both scales are clearly related to psychological distress. In addition, other scales used in the study are all well established, with good reliability and validity.

An additional strength of this study was our attempt to clarify the conceptual differences between secondary trauma, burnout, and CF. Such clarity is necessary for scale construction and has been generally lacking for CF (Jenkins & Baird 2002). Thus, we argued that therapists can suffer from compassion fatigue, which contains two components, secondary trauma and job burnout. Developing a valid and reliable instrument to detect CF is also a prelude to devising intervention strategies designed to mitigate its negative effects on the care giving practitioner. As

Figley (2002b: 1440) has noted, “It is, therefore, up to all of us to elevate these issues to a greater level of awareness in the helping professions. Otherwise, we will lose clients and compassionate psychotherapists.”

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Table 1: Final Rotated Component Matrix for Factor Analysis of 13
 Items in Figley's Compassion Fatigue Scale (n=233)

Compassion Fatigue Item	Components	
	1	2
Q9: Flashbacks connected to clients		0.781
Q14: Troubling dreams similar to client's		0.615
Q15: Intrusive thoughts after working w/ difficult clients		0.718
Q16: Suddenly recalled frightening exp while working w/ client		0.846
Q17: Losing sleep over client's traumatic experience		0.630
Q20: I have felt trapped by my work	0.766	
Q21: Sense of hopelessness working w/ clients	0.701	
Q25: Felt tired due to work as caregiver	0.616	
Q26: Felt depressed as a result of work	0.788	
Q27: Unsuccessful at separating work from personal life	0.731	
Q28: Sense of worthlessness associated w/ work	0.872	
Q29: Feel like a "failure" in work	0.765	
Q30: Thoughts about not achieving goals	0.747	
Eigenvalues for rotated components	4.741	3.269

Table 2: Correlations between Compassion Fatigue-Long Scale, Work Burnout, Secondary Trauma, and Compassion Fatigue-Short and the General Health Questionnaire, Stress, and Psychological Resource Scales (N=206)

	CF (Long)	Work Burnout	Secondary Trauma	CF (Short)
General Health Questionnaire	0.462**	0.481**	0.421**	0.494**
Negative Life Events	0.293**	0.242**	0.131	0.233**
Trauma Scale	0.202*	0.092	0.132	0.098
9/11 Counseling Involvement	0.152	0.106	0.145	0.123
% Clients Survivors of Violence	0.065	0.034	0.020	0.039
Social Support Scale	-0.235**	-0.204*	-0.078	-0.193*
Have Info to Work Effectively	-0.211*	-0.191*	-0.144	-0.186*
Sense of Mastery Scale	-0.322**	-0.329**	-0.147	-0.290**
Compassion Fatigue Scale (long)	1.000	0.801**	0.645**	0.832**
Work Burnout Scale		1.000	0.545**	0.939**
Secondary Trauma Scale			1.000	0.753**

* p<.01

** p<.001

Table 3: Linear Regression for Compassion Fatigue (Long), Work Burnout, Secondary Trauma, and Compassion Fatigue Short Predicting Scores on the General Health

Questionnaire (N=206)

Independent Variables	Model 1: Compassion Fatigue-Long	Model 2: Work Burnout	Model 3: Secondary Trauma	Model 4: Burnout & Secondary Trauma	Model 5 Compassion Fatigue-Short
	b (beta)	b (beta)	b (beta)	b (beta)	b (beta)
Age	-0.05 (-.12)	-0.05 (-.11)	-0.07 (-.16)*	-0.06 (-.14)*	-0.06 (-.13)
Gender of R (female)	-0.65 (-.08)	-0.50 (-.06)	-0.82 (-.09)	-0.71 (-.08)	-0.65 (-.07)
Marital Status (married)	0.99 (.14)*	0.71 (.10)	0.70 (.10)	0.76 (.11)	0.72 (.10)
Race/ethnicity (white)	0.26 (.02)	0.26 (.02)	0.14 (.01)	0.07 (.01)	0.11 (0.1)
Years Prof. Counselor	0.02 (.05)	0.02 (.05)	0.03 (.06)	0.03 (.06)	0.04 (.08)
Negative Life Events	0.48 (.17)**	0.48 (.17)**	0.58 (.20)***	0.51 (.18)**	0.48 (.17)**
Trauma History Scale	0.01 (.01)	0.08 (.04)	0.02 (.01)	0.03 (.01)	0.07 (.03)
9/11 Counseling Involvement	-0.13 (-.06)	-0.11 (-.05)	-0.18 (-.08)	-0.18 (-.08)	-.13 (-.06)
% Clients Survivors of Violence	-0.40 (-.05)	-0.33 (-.04)	-0.31 (-.03)	-0.32 (-.04)	-.35 (-.04)
Social Support Scale	-0.11 (-.10)	-0.11 (-.10)	-0.13 (-.12)	-0.12 (-.11)	-.11 (-.10)
Have Info to Work Effectively	-0.38 (-.13)*	-0.39 (-.13)*	-0.36 (-.12)*	-0.33 (-.11)	-.37 (-.13)*
Sense of Mastery Scale	-0.23 (-.25)***	-0.22 (-.24)***	-0.27 (-.29)***	-0.23 (-.25)***	-.23 (-.24)***
Compassion Fatigue Scale (long)	1.33 (.33)***				
Work Burnout Scale		1.06 (.33)***		0.58 (.18)*	
Secondary Trauma Scale			1.34 (.36)***	1.01 (.27)***	
Compassion Fatigue Scale (short)					1.22 (.37)***
Constant	31.564	33.526	36.614	34.215	33.301
R ²	.37	.38	.40	.42	.40