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How do they do it? : an exploratoration of program supports within agency settings and levels of compassion fatigue and compassion satisfaction among direct care staff members working in residential treatment facilities

Kathryn Philomena Welch
Smith College

Kathryn P. Welch

How do they do it: An Exploration of Program Supports within Agency settings and levels of Compassion Fatigue and Compassion Satisfaction among Direct Care Staff Members Working In Residential Treatment Facilities

Abstract

This quasi-experimental study examines the impact of program supports in agency settings on levels of compassion fatigue and compassion satisfaction among direct care staff members working in residential treatment settings, with consideration of demographics and personal characteristics inherent in the worker, by asking the following questions: Are there significant differences in levels of compassion fatigue and compassion satisfaction depending on utilization of program supports among direct care staff members? Do variables of gender, ethnicity, income, education and training, previous work experience and length of time working in current position impact levels of compassion fatigue and compassion satisfaction?

This study utilizes the Professional Quality of Life Scale (ProQOL), an existing and reliable instrument measuring compassion satisfaction and compassion fatigue. The sample in this study consists of 8 direct care staff members currently employed among Bay Area residential treatment facilities serving adolescent populations. The low response rate could have been related to lack of time allotted to take the survey at work and lack of access to personal email and the skewed demographics towards a younger, non-African American population could have related to the electronic recruitment and participation via an online scale.

There were no major findings of this study because the sample size is too small to infer meaning. Descriptive statistics were used to analyze the findings and were 1. The compassion satisfaction levels ranged from average to high and the compassion fatigue levels ranged from average to low. 2. The majority of direct care staff members had access to and utilized program supports within their agency and perceived the majority of program supports favorably. 3. Perceptions of income were identified as most disagreeable and time off allowed for within group comparison, where lower burnout scores were reported among some staff who felt they could take time off.

HOW DO THEY DO IT: AN EXPLORATION OF PROGRAM SUPPORTS WITHIN AGENCY SETTINGS AND LEVELS OF COMPASSION FATIGUE AND COMPASSION SATISFACTION AMONG DIRECT CARE STAFF MEMBERS WORKING IN RESIDENTIAL TREATMENT FACILITIES

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Kathryn P. Welch

Smith College School for Social Work
Northampton, Massachusetts 01063

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Chapter I

Introduction

The plight of the mental health worker in agency settings has been an inquiry of research due to high turnover rates (Meyers & Cornille, 2002; Nelson-Gardell & Harris, 2003) and high costs associated with turnover (Ford & Honnor, 2000; Larson, Hewitt & Anderson, 1999; Meyers & Cornille, 2002; Nelson-Gardell & Harris, 2003). Researchers first identified burnout as a construct relating to organizational stressors among workers in human service agencies (Maslach, Schaufeli & Leiter, 2001; Motta et al., 1999; Nelson-Gardell & Harris, 2003; Sprang, Clark & Whitt-Woosley, 2007). The unique treatment relationship with traumatized clients offers another influence on the worker's experience in an agency setting in addition to organizational issues within the agency structure. Research focusing on the unique work with trauma victims in human service agencies has attempted to understand the influence of the treatment relationship on worker (Bell, Kulkarni & Dalton, 2003; McCann & Pearlman, 1990; Meyers & Cornille, 2002; Motta et al., 1999).

Early understandings of the negative effects associated with helping trauma victims were discovered in the experiences of war veterans and their families, where close family and friends were negatively affected by the primary trauma experienced by the veteran (Figley, 1995; McCann & Pearlman, 1990; Stamm, 1999). Emerging from this finding was the understanding of empathy as the catalyst for which secondary traumatic stress may take place on the helper/worker when bearing witness to another's trauma (Adams & Riggs, 2008; Bell, Kulkarni & Dalton, 2003; Figley, 1995; Motta et al., 1999; Nelson-Gardell & Harris, 2003; Pearlman &

Mac Ian, 1995; Sexton, 1999; Stamm, 1999). Through empathic engagement, helping professionals in agency settings were found to experience secondary traumatic stress, which was referred to as compassion fatigue or vicarious trauma (Jenkins & Baird, 2002; Motta et al., 1999; Nelson-Gardell & Harris, 2003; Sexton, 1999; Stamm, 2002; Stamm, 2010). Symptoms of secondary trauma/compassion fatigue are similar to PTSD symptoms (Kassam-Adams, 1995), yet more mild in their effects (Motta et al., 1999) and can lead the trauma worker to become ineffective in their work (Jacobson, 2006).

Previous researchers studying compassion fatigue or vicarious trauma have primarily focused on therapists or professionals working with trauma victims in agency settings (Adams & Riggs, 2008; McCann & Pearlman, 1990; Neumann & Gamble, 1995; Pearlman & Mac Ian, 1995; Rodolfa, Kraft & Reilley, 1988; Sexton, 1999) with less research attention focused on direct care staff members serving traumatized populations in residential treatment facilities (Lakin, Leon & Miller, 2008). Direct care staff members serve as the leading provider of care (Ford & Honnor, 2000; Lakin, Leon & Miller, 2008; Lyman & Barry, 2006) to highly traumatized children (Guterman, Cameron & Hahm, 2003; Lakin, Leon & Miller, 2008; Shane et al., 2006), indicating research efforts need to consider the direct care staff member. While research looking at the negative effects of working with trauma survivors has been adequately represented, the positive effects of working with this population have been overlooked (Jacobson, 2006; Stamm, 2002). Compassion satisfaction was included in measurements looking at compassion fatigue to better account for the wide range of experiences one can have when working in close relationship with trauma survivors.

Mediators to the trauma worker's experience concerning burnout, compassion fatigue, and compassion satisfaction are evident in the literature. Personal characteristics one brings to

the work in agency settings can affect their experience, such as sex (Kassam-Adams, 1995; Sprang, Clark & Whitt-Woosley, 2007), age (Beck, 1987; Leon, Lakin & Miller, 2008; Maslach, Schaufeli & Leiter, 2001; Pearlman & Mac Ian, 1995), training (Sprang, Clark & Whitt-Woosley, 2007; Stamm, 1999), and duration of work experience (Adams & Riggs, 2008; Bell, Kulkarni & Dalton, 2003; Neumann & Gamble, 1995; Pearlman & Mac Ian, 1995; Sexton, 1999). Mediators relating to the culture of program supports within agency settings have been found to affect the experience of compassion fatigue among workers (Bell, Kulkarni & Dalton, 2003; Sexton, 1999). Program supports relating to individual supervision (Bell, Kulkarni & Dalton, 2003; Jacobson, 2006), peer group supervision (Bell, Kulkarni & Dalton, 2003; Jacobson, 2006), positive professional acknowledgement (Bell, Kulkarni & Dalton, 2003; Neumann & Gamble, 1995), and access to mental health benefits (Saakvitne & Pearlman, 1996) have been found to help the worker process difficult material when working with trauma survivors and lessen the effects of compassion fatigue.

Due to the lack of reference to the direct care staff member, this study will examine if the utilization of program supports in an agency setting influence compassion satisfaction and compassion fatigue experienced by direct care staff members working in a residential treatment setting. Demographic and personal characteristics of direct care staff members will be considered when predicting outcomes of compassion satisfaction and compassion fatigue. The Professional Quality of Life Scale (ProQOL), developed by Stamm (2010), will allow for reliable measurement of compassion satisfaction and compassion fatigue.

Chapter II

Literature Review

Treating difficult populations in human service agencies has long been considered emotionally taxing on its employees. Researchers have reported high turnover rates as a common reaction to negative work experiences in human service agencies (Meyers & Cornille, 2002; Nelson-Gardell & Harris, 2003) and higher turnover can lead to higher costs to the agency due to recruitment and training for new employees (Ford & Honnor, 2000; Larson, Hewitt & Anderson, 1999; Meyers & Cornille, 2002; Nelson-Gardell & Harris, 2003). Because negative experiences in human service agencies can motivate staff to leave the work (Meyers & Cornille, 2002), less consistency in care for clients may result (Connis et al., 1979; Meyers & Cornille, 2002)

The quality of care for client's in human service agencies is important to understand, and the way in which staff experience the work in agency settings can influence client care (Connis et al., 1979; Meyers & Cornille, 2002). Research concerning the negative effects on staff members in human service agencies has evolved from references of burnout to include findings in trauma research. The literature first identified burnout, relating to organizational issues for the worker, when attempting to understand the worker's challenging experience within human service agencies (Nelson-Gardell & Harris, 2003; Sprang, Clark & Whitt-Woosley, 2007). Findings in trauma research have identified another pathway attempting to explain challenging affects on the worker, where the way in which employees' engage in the work via empathic engagement with trauma victims has been found to negatively influence staff members (Bell,

Kulkarni & Dalton, 2003; McCann & Pearlman, 1990; Meyers & Cornille, 2002; Motta et al., 1999). To fully understand the worker's experience, it is useful to look at both burnout affects on the worker concerning organizational influences as well as the staff person's experience of the treatment relationship with difficult clients.

Residential treatment facilities, a human service agency, serve children and adolescent client populations with a highly traumatized background (Shane et al., 2006). Direct care staff in residential treatment facilities serve as the leading provider of care (Ford & Honnor, 2000; Lakin, Leon & Miller, 2008; Lyman & Barry, 2006) to highly traumatized clients (Guterman, Cameron & Hahm, 2003; Lakin, Leon & Miller, 2008; Shane et al., 2006). Direct care staff members are operationally defined as, "Those staff who work in the milieu with the children through their entire shift" (Lakin, Leon & Miller, 2008, p. 254). When researchers have studied the direct care staff member's experience, burnout effects were the focus of inquiry (Beck, 1987; Ford & Honnor, 2000; Lakin, Leon & Miller, 2008). To better understand direct care staff members, further research is needed looking at ways in which the treatment relationship with traumatized clients influences direct care staff member's experiences in addition to burnout affects.

Researchers studying the effects of working with traumatized individuals in agency settings have primarily focused on therapists or mental health professionals (Adams & Riggs, 2008; McCann & Pearlman, 1990; Neumann & Gamble, 1995; Pearlman & Mac Ian, 1995; Rodolfa, Kraft & Reilley, 1988; Sexton, 1999). There has been less research attention on direct care staff members in agency settings serving traumatized populations (Lakin, Leon & Miller, 2008), where direct care staff members engage in the most contact with clients in residential treatment facilities (Bell, Dalton, & Kulkarni, 2003; Lyman & Barry, 2006; Rosen, 1999).

Direct care staff members may be at higher risk of experiencing negative effects when compared to mental health professionals and/or therapists due to having more contact with highly traumatized children (Figley, 1995; Figley, 1995a; Meyers & Cornille, 2002; Sprang, Clark & Whitt-Woosley, 2007) with less training to inform their experience (Adams & Riggs, 2008; Bell, Kulkarni & Dalton, 2003).

The first researchers looking at the negative outcomes on workers within human service agencies found burnout to explain the emotional and interpersonal factors negatively affecting workers (Maslach, Schaufeli & Leiter, 2001; Motta et al., 1999; Sprang, Clark & Whitt-Woosley, 2007). Burnout is defined as a defensive response to interpersonal stressors experienced on the job over time (Beck, 1987; Figley, 1995; Jenkins & Baird, 2002; Nelson-Gardell & Harris, 2003). Three dimensions categorize burnout: exhaustion, depersonalization (or cynicism) and diminished personal accomplishment (Beck, 1987; Cropanzano, Rupp & Byrne, 2003; Halbesleben, 2006; Jenkins & Baird, 2002; Lakin, Leon & Miller, 2008; Maslach, Jackson & Leiter, 1997; Maslach, Schaufeli & Leiter, 2001; Reid et al., 1999; Sprang, Clark & Whitt-Woosley, 2007). Maslach, Schaufeli and Leiter (2001) define exhaustion, the leading dimension of burnout (Cropanzano, Rupp & Byrne, 2003; Figley, 1995; Maslach, Jackson & Leiter, 1997; Maslach, Schaufeli & Leiter, 2001) as, “The basic individual stress dimension of burnout. It refers to feelings of being overextended and depleted of one’s emotional and physical resources” (p. 399).

Work overload, an organizational influence on the worker’s experience, can be a catalyst for emotional exhaustion and can lead to a reaction of depersonalization (Maslach, Jackson & Leiter, 1997). Depersonalization is defined by Maslach, Schaufeli and Leiter (2001) as, “negative, callous, or excessively detached response to various aspects of the job” (p. 399), and

"an attempt to put distance between oneself and service recipients by actively ignoring the qualities that make them unique and engaging people" (p. 403). The experience of both exhaustion and depersonalization can influence the worker to avoid the treatment relationship due to exhaustion and justify this in ignoring parts of the client's character (Maslach, Schaufeli &Leiter, 2001).

The third component of burnout is diminished personal accomplishment, and is defined by Maslach, Jackson and Leiter (1997) as, "The tendency to evaluate oneself negatively, particularly with regard to one's work with clients. Workers may feel unhappy about themselves and dissatisfied with their accomplishments on the job" (p. 192). Diminished personal accomplishment is essentially one's idea of efficacy in their role and relates more to resources available to the worker (Maslach, Schaufeli &Leiter, 2001), such as social supports (Jenkins & Baird, 2002).

The literature has identified burnout to involve organizational stressors for the worker within human service agencies (Meyers & Cornille, 2002; Nelson-Gardell & Harris, 2003; Sprang, Clark & Whitt-Woosley, 2007), where increasing work load, lack of resources and social supports can negatively influence the worker's experience of the client and themselves (Meyers & Cornille, 2002). The unique treatment relationship with traumatized clients offers another avenue of influence over the worker's experience in an agency setting, where burnout cannot explain these affects (Stamm, 1999). Trauma research focusing on the unique work with trauma victims in human service agencies has attempted to understand the influence of the treatment relationship on worker (Bell, Kulkarni & Dalton, 2003; McCann & Pearlman, 1990; Meyers & Cornille, 2002; Motta et al., 1999).

The study of negative affects on workers treating trauma victims is of relatively recent empirical focus (Stamm, 2010). Early studies looking at the experiences of war veterans and their families found that close family and friends were negatively affected by the primary trauma experienced by the veteran (Figley, 1995; McCann & Pearlman, 1990; Stamm, 1999). Empathy was identified as the pathway for which the negative changes take place on the helper/worker when bearing witness to another's trauma (Adams & Riggs, 2008; Bell, Kulkarni & Dalton, 2003; Figley, 1995; Motta et al., 1999; Nelson-Gardell & Harris, 2003; Pearlman & Mac Ian, 1995; Sexton, 1999; Stamm, 1999).

Various terms identifying the psychological effects on trauma workers as a result of empathic engagement with traumatized populations have been compared in previous literature, including secondary trauma, secondary traumatic stress, vicarious trauma, and compassion fatigue (Figley, 1995a; Jacobson, 2006; Jenkins & Baird, 2002; Motta et al., 1999; Nelson-Gardell & Harris, 2003; Sexton, 1999; Stamm, 1999; Stamm, 2002; Stamm, 2010). Researchers have had difficulty in identifying substantial differences between these constructs (Sprang, Clark, & Whitt-Woosley, 2007; Stamm, 2010). Each term acknowledges the transmission of negative symptoms to the trauma worker through empathic engagement (Jenkins & Baird, 2002; Motta et al., 1999; Nelson-Gardell & Harris, 2003; Sexton, 1999; Stamm, 2002; Stamm, 2010), where the differences between the constructs lie in specific affects on the worker.

The first term to identify the result of empathic engagement with a traumatized individual was coined secondary trauma or secondary traumatic stress and emerged from research on Post Traumatic Stress Disorder (PTSD) (Stamm, 1999). Secondary trauma, if not treated, could lead to secondary traumatic stress disorder (STSD), an adjustment disorder (Figley, 1995; Meyers & Cornille, 2002; Nelson-Gardell & Harris, 2003). Secondary trauma is defined as, "The sudden

adverse reactions people can have to trauma survivors whom they are helping or wanting to help" (Jenkins & Baird, 2002, p. 424). Secondary trauma was renamed compassion fatigue because it is believed to be less stigmatizing (Jenkins & Baird, 2002; Sprang, Clark & Whitt-Woosley, 2007; Stamm, 1999). Compassion fatigue was coined by Charles Figley to describe secondary trauma/secondary traumatic stress (Jenkins & Baird, 2002; McCann & Pearlman, 1990) and is a natural response (Jenkins & Baird, 2002; Nelson-Gardell & Harris, 2003; Sprang, Clark & Whitt-Woosley, 2007) to the empathic engagement with a traumatized individual (Jenkins & Baird, 2002; Meyers & Cornille, 2002; Motta et al., 1999).

Symptoms of secondary trauma/compassion fatigue are similar to PTSD symptoms, especially on the intrusion and avoidance criterion in the DSM-IV diagnosis (Kassam-Adams, 1995), and are not usually experienced to the degree of PTSD symptomology (Motta et al., 1999). Symptoms can occur when one re-experiences the trauma of someone they care about, or has knowledge that a traumatic event has occurred (Stamm, 1999), through the dialogue of the trauma survivor (Adams & Riggs, 2008; Bell, Kulkarni & Dalton, 2003; Figley, 1995; Jenkins & Baird, 2002; Motta et al., 1999; Pearlman & Mac Ian, 1995; Sexton, 1999; Stamm, 2010) and the helper/worker has the desire to help this person (Stamm, 1999). Symptoms can include sleep disturbances (Motta et al., 1999), intrusive thoughts of the trauma they have born witness to (Jenkins & Baird, 2002; Motta et al., 1999; Sexton, 1999), avoidance of reminders of the traumatic material (Jenkins & Baird, 2002; Sexton, 1999); numbing in the face of reminders of the traumatic material (Bell, Kulkarni and Dalton, 2003; Jenkins & Baird, 2002), disturbances in relationships with friends, family and colleagues (Sexton, 1999), and concentration problems (Motta et al., 1999).

Researchers have built upon Figley's description of compassion fatigue symptomology regarding PTSD-like reactions to include repeated empathic connection with traumatized individuals, where memories of traumatic material overtime influence the therapists' world view and is referred to as vicarious trauma (McCann & Pearlman, 1990; Neumann & Gamble, 1995; Pearlman & Mac Ian, 1995; Saakvitne & Pearlman, 1996; Schauben & Frazier, 1995; Sprang, Clark & Whitt-Woosley, 2007; Stamm, 1999). Symptoms of vicarious trauma include both PTSD-like effects on the worker, as well as changes in world view and are described by Bell, Kulkarni and Dalton (2003) as

physiological symptoms that resemble posttraumatic stress reactions, which may manifest themselves either in the form of intrusive symptoms, such as flashbacks, nightmares and obsessive thoughts, or in the form of constrictive symptoms, such as numbing and dissociation. It may also result in disruptions to important beliefs, called cognitive schemas that individuals hold about themselves, other people, and the world (p. 464).

Vicarious Trauma research begins to combine these constructs through constructivist self-development theory, where "The therapist's unique response to client material (is) shaped by both characteristics of the situation and the therapist's unique psychological needs and cognitive schemas" (McCann & Pearlman, 1990, p. 136). Researchers of constructivist self-development theory postulate the therapist's distinct cognitive schemas will be challenged by empathic engagement with traumatized individuals depending upon their cognitive schemas in combination with the traumatized individual's traumatic material and behavior with the therapist (McCann & Pearlman, 1990). Researchers suggest that the changes to the cognitive schemas can be lifelong, especially if working long term with highly traumatized individuals (McCann & Pearlman 1990; Saakvitne & Pearlman, 1996). Research on therapists and mental health

professionals' experience of vicarious trauma has contributed to the understanding of secondary traumatic stress but has overlooked those who provide the most care to highly traumatized individuals, direct care staff members (Ford & Honnor, 2000; Lakin, Leon & Miller, 2008; Lyman & Barry, 2006).

Researchers have criticized the overlapping similarities between burnout, secondary traumatic stress/compassion fatigue and vicarious trauma and have identified measurement strategies as a place to examine the differences (Stamm, 2010). Jenkins & Baird (2002) compared the measurement tools of compassion fatigue using the Compassion Fatigue Self-Test for Psychotherapists (CFST), the basis to the current measure called the Professional Quality of Life Scale (ProQOL) (Stamm, 2010), vicarious trauma using the TSI Belief Scale, Revision L (now referred to as the Trauma and Attachment Belief Scale), and burnout using the Maslach Burnout Inventory (MBI), which has been considered an historically valid measure of burnout (Jenkins & Baird, 2002). The comparison found that the burnout measure in the CFST was not as valid at measuring burnout effects when compared to the MBI measure, but the CFST measure and the TSI revision L were found to strongly correlate in their measurements of traumatic stress (Jenkins & Baird, 2002). The CFST measure, when compared to the TSI revision L, was found to be the more valid measure at studying negative effects on the trauma worker due to empathic engagement (Jenkins & Baird, 2002). This finding suggests compassion fatigue as the better construct to identify the direct care staff member's experience in residential treatment facilities.

Figley (Jenkins & Baird, 2002) when first developing the CFST, as the basis to the now widely used ProQOL (Stamm, 2010), utilized Kahill's research to inform the measure of burnout. Figley (1995a) describes Kahill's research on symptoms of burnout, where five

categories identify burnout affects on the worker to include physical, emotional, behavioral, work-related, and interpersonal effects. Burnout can have negative outcomes in the worker's home life and introduce feelings of loneliness, as well as induce somatic problems involving gastrointestinal issues, heart problems, headaches and sleep disturbances (Beck, 1987). Stamm (1999) reports similar symptoms relating to secondary traumatic stress when looking to several articles on therapists' responses working with traumatized individuals where she states "intrusive imagery related to the client's traumatic disclosures, avoidant responses, physiological arousal, other somatic complaints, distressing emotions, addictive or compulsive behaviors, and functional impairment" (p. 30). Sexton (1999) reports on therapists as well, and reports changes in interpersonal relationships as a result of empathic engagement in treating trauma survivors.

Overlapping symptoms are apparent when looking to both burnout research and trauma research, where pathways to symptomology differ between the two constructs. A difference in the symptomology lies in onset of symptoms, where burnout affects the worker over time and negative affects relating to secondary traumatic stress can evoke sudden changes in the worker (Figley, 1995; Sexton, 1999). Because symptomology can overlap, it is important to include the study of both secondary traumatic stress and burnout affects on the worker. Symptoms relating to secondary traumatic stress have historically been reported based on therapists' experiences and it is important to include the study of direct care staff members in human service agencies that serve a highly traumatized population, such as residential treatment facilities, where "The primary care provider is likely to see far more of the sequelae of trauma than any therapist" (Stamm, 1999, p. xl).

The study of compassion fatigue has evolved to include two areas negatively affecting the worker, burnout and secondary traumatic stress (Stamm, 2010). Differences between

burnout and secondary traumatic stress lie in the pathway in which symptoms form, where burnout affects are more gradual (Figley, 1995a) and relate to organizational influences within agencies (Sprang, Clark & Whitt-Woosley, 2007; Nelson-Gardell & Harris, 2003) and secondary traumatic stress can evoke sudden changes in the worker (Jenkins & Baird, 2002) when interacting empathically with traumatized populations. The study of burnout, as a dimension of compassion fatigue, provides an understanding of the emotional exhaustion involved when providing ongoing treatment for suffering individuals in an agency setting (Jenkins & Baird, 2002) and addresses issues of self-efficacy when wanting to do your job well (Stamm, 2010). Secondary trauma, the other dimension of compassion fatigue, involves the transmission of negative effects through secondary trauma (Stamm, 2010; Jenkins & Baird, 2002). Stamm (2010) suggests the separating element between the two is fear, where the worker through secondary traumatic stress may be fearful they will experience similar trauma as the victim whom they are helping.

While researchers have studied the negative effects of working closely with trauma survivors by examining burnout, compassion fatigue and vicarious trauma, the positive effects of working with this population has been overlooked (Jacobson, 2006; Stamm, 2002). By understanding compassion satisfaction, defined as a contributing motivation to continue in the empathic work with traumatized individuals while experiencing the negative effects of the work, a more complete understanding of both the positive and negative effects on the worker can be observed (Stamm, 1999; Stamm, 2002). Compassion satisfaction is defined as, “The positive reactions of feeling satisfied with one’s ability to offer care and to connect with another person using empathy” (Jacobson, 2006, p. 135). The introduction of compassion satisfaction as a unique element to be considered in the worker’s experience is reported to lower bias in

understanding compassion fatigue (Stamm, 1999). The inclusion of compassion satisfaction will better contribute to continuing research on compassion fatigue, especially among staffing populations who have historically been overlooked in their experience of compassion fatigue, such as direct care staff members in residential treatment facilities.

The Professional Quality of Life Questionnaire (ProQOL) combines the study of compassion satisfaction and compassion fatigue, made up of burnout and secondary traumatic stress. The ProQOL is the most widely used measure to study both the positive and negative affects of trauma work and a form of the ProQOL has been implemented in half of all studies looking at compassion fatigue/secondary traumatic stress (Stamm, 2010). The ProQOL was first developed by Figley and Stamm in 1993 and in the late 1990's the measure was attributed to Stamm alone (Stamm, 2010).

Mediators to the trauma worker's experience concerning burnout, compassion fatigue, and compassion satisfaction are evident in the literature. Stamm (1999) reports that compassion fatigue is, "mediated by risk and resiliency factors which include the therapist's personal characteristics, characteristics of the client and the trauma, the therapists attempt to cope and the environment in which the therapy takes place" (Stamm, 1999, pg. 30). When trying to appreciate the experience of the direct care staff member in a residential facility, understanding personal and agency characteristics, as well as the specific client population being served are imperative. Understanding personal and organizational influences on direct care staff members, in addition to the understanding of such mediators reported on therapists, is essential to future research.

Personal characteristics one brings to the work in agency settings can affect their experience, where researchers have identified females as experiencing higher rates of secondary

traumatic stress and burnout (Kassam-Adams, 1995; Sprang, Clark & Whitt-Woosley, 2007), whereas Beck (1987) found males to experience higher rates of burnout compared to females when working in family service agencies. Age has been found to mediate effects of the trauma worker's experience, where the younger the worker, the greater amount of burnout is experienced (Beck, 1987; Leon, Lakin & Miller, 2008; Maslach, Schaufeli & Leiter, 2001; Pearlman & Mac Ian, 1995) as well as the greater amount of vicarious trauma that is experienced (Bell, Kulkarni & Dalton, 2003).

Workers who have had training specific to trauma work experienced higher levels of compassion satisfaction and lower levels of compassion fatigue (Sprang, Clark & Whitt-Woosley, 2007; Stamm, 1999), and direct care staff members have had less training than other professionals in agency settings (Adams & Riggs, 2008; Bell, Kulkarni & Dalton, 2003) . Researchers have found higher rates of vicarious trauma in workers with less training specific to trauma work (Adams & Riggs, 2008; Bell, Kulkarni & Dalton, 2003), whereas Beck (1987) found training to have no significant affect on levels of burnout. Workers who have had more education have been found to have lower levels of burnout (Lakin, Leon & Miller, 2008). Other findings have indicated higher education to increase levels of burnout (Lakin, Leon & Miller, 2008; Maslach, Schaufeli & Leiter, 2001) while other researchers have found no relationship with burnout and education (Beck, 1987; Lakin, Leon & Miller, 2008).

The duration of time the trauma worker has treated traumatized individuals has been shown to mediate the effects of secondary traumatic stress, where researchers have indicated that the longer the worker is in the field of helping trauma victims, the higher the secondary traumatic stress (Meyers & Cornille, 2002). Other researchers have indicated that higher levels of vicarious trauma have been experienced for workers with less experience in the work (Adams &

Riggs, 2008; Bell, Kulkarni & Dalton, 2003; Neumann & Gamble, 1995; Pearlman & Mac Ian, 1995; Sexton, 1999). Researchers have also indicated that the more experienced worker has lower levels of burnout (Pearlman & Mac Ian, 1995). The duration that direct care staff members have had in treating trauma survivors in residential treatment facilities will inform our understanding of compassion fatigue, burnout and compassion satisfaction.

Characteristics within the agency setting can mediate the trauma worker's positive and negative experiences. Residential treatment facilities provide unique environments informing staff experiences, due to the contained living environment for clients and milieu treatment including individual, group and family therapy (Shane et al., 2006) to children struggling with extreme emotional and behavioral problems (Guterman, Cameron & Hahm, 2003; Lakin, Leon & Miller, 2008). Researchers have found that children treated in residential treatment facilities have experienced sexual and/or physical violence at a higher rate than compared to children in outpatient treatment (Shane et al., 2006), and experience emotional problems due to being exposed to violence within their communities (Guterman, Cameron & Hahm, 2003). Negative affects associated with trauma work are exacerbated when treating traumatized children (Figley, 1995; Figley, 1995a; Meyers & Cornille, 2002; Sprang, Clark & Whitt-Woosley, 2007) and in the amount of contact the worker has with the traumatized individuals each week; where working longer hours, one can experience higher levels of secondary traumatic stress (Meyers & Cornille, 2002; Sprang, Clark & Whitt-Woosley, 2007; Stamm, 1999). These organizational characteristics in a residential treatment facility provide higher risks to direct care staff members to experience secondary traumatic stress due to working with traumatized children for the majority of their work week. Organizational factors have been found to mediate the experience of the trauma worker (Bell, Kulkarni & Dalton, 2003; Jacobson, 2006; Sexton, 1999).

Program supports can help ameliorate the negative effects of trauma work. Social support for the trauma worker within agency settings has been found to affect negative symptoms related to trauma work (Figley, 1995) and has been reported to decrease the effects of burnout (Reid et al., 1999). Access to training within agencies has been found to increase social support (Sprang, Clark & Whitt- Woosley, 2007) and researchers have reported that women experienced more benefits to social support than men (Halbesleben, 2006). Supervision, one form of social support, has been reported to lower levels of secondary traumatic stress, where the trauma worker is provided a safe and consistent space to process the traumatic material of their clients (Bell, Kulkarni & Dalton, 2003), lower levels of compassion fatigue (Jacobson, 2006) and lower levels of burnout have been reported (Leon, Lakin & Miller, 2008). By understanding the individual supervision opportunities to direct care staff members in residential treatment facilities, the measure of compassion fatigue and compassion satisfaction will be better informed. The quality of the supervision while considering the gender of the supervisor to the supervisee has been studied, where Worthington and Stern (1985) found that male supervisees reported good supervision relationships regardless of gender when compared to female supervisees, and overall supervisees reported better relationships with same-gender supervisors.

Peer support, another form of social support within agency settings, has been found to lower the effects of compassion fatigue (Jacobson, 2006), where Leon, Lakin and Miller (2008) found no effects on burnout when studying peer support and Beck (1987) found lack of support to increase the rate of burnout experienced. Bell, Kulkarni and Dalton (2003) identify the benefits of peer support groups in processing the traumatic material of their clients, but suggest structure to the group so members do not feel more traumatized. By understanding the structured

peer supervision opportunities to direct care staff members in residential treatment facilities, the measure of compassion fatigue, compassion satisfaction and burnout will be better informed.

When program practices are in place that can help ameliorate the negative effects of trauma work, barriers to the effectiveness of these strategies may result when organizations do not encompass a supportive culture (Bell, Kulkarni & Dalton, 2003; Sexton, 1999). An accepting and encouraging culture to work towards personal and professional self-care strategies within the organization is essential to allowing the worker to process their negative symptoms (Bell, Kulkarni & Dalton, 2003; McCann & Pearlman, 1990; Meyers & Cornille, 2002; Neumann & Gamble, 1995; Sexton, 1999; Sprang, Clark & Whitt-Woosley, 2007). When working with traumatized clients, organizations have a responsibility to allow staff to make mistakes without blame, celebrate the staff by acknowledging their accomplishments, and promote professional development (Bell, Kulkarni & Dalton, 2003; Neumann & Gamble, 1995). Organizational commitment to personal self-care strategies, such as offering the ability to take time off for illness or vacation, can help in the treatment of negative symptoms related to trauma work (Bell, Kulkarni & Dalton, 2003; Neumann & Gamble, 1995; Saakvitne & Pearlman, 1996). Health benefits for the worker to include mental health coverage and good enough pay is also an important strategy the organization can offer to support the personal efforts at treatment and prevention efforts (Saakvitne & Pearlman, 1996), where Stamm (1999) indicated lower secondary traumatic stress to those who had higher income. By including the elements that create an organizational culture in the study of direct care staff member's experiences with program supports in residential treatment facilities; a better understanding of compassion satisfaction, compassion fatigue and burnout will result.

Workers who experience negative symptoms due to their work with traumatized individuals may be ineffective in their work with clients (Jacobson, 2006). The study of staff experiences in agency settings started with findings in burnout research (Sprang, Clark & Whitt-Woosley, 2007; Nelson-Gardell & Harris, 2003) and have since included trauma research to inform understanding of staff behaviors (Bell, Kulkarni & Dalton, 2003; McCann & Pearlman, 1990; Meyers & Cornille, 2002; Motta et al., 1999). Researchers studying the effects of working with traumatized clients in an agency setting have primarily focused on therapists or mental health professionals (Adams & Riggs, 2008; McCann & Pearlman, 1990; Neumann & Gamble, 1995; Pearlman & Mac Ian, 1995; Rodolfa, Kraft & Reilley, 1988; Sexton, 1999) and less research attention has focused on direct care staff members in agency settings serving traumatized populations (Lakin, Leon & Miller, 2008). Direct care staff members engage in the most contact with clients in residential treatment facilities (Bell, Dalton, & Kulkarni, 2003; Lyman & Barry, 2006; Rosen, 1999) and serve as the leading provider of care (Ford & Honnor, 2000; Lakin, Leon & Miller, 2008; Lyman & Barry, 2006) to highly traumatized children (Guterman, Cameron & Hahm, 2003; Lakin, Leon & Miller, 2008; Shane et al., 2006), indicating the importance of understanding direct care staff's level of secondary traumatic stress in a residential treatment facility.

Residential treatment facilities offer a unique agency structure due to employing direct care staff members to provide care to traumatized populations (Mohr, Mahon & Noone, 1998; Rosen, 1999), where direct care staff members enter into the position without much training (Adams & Riggs, 2008; Bell, Kulkarni & Dalton, 2003). Direct care staff members can also experience organizational stressors, including low pay, long hours, and shortages of staff support during shifts (Lakin, Leon & Miller, 2008), and higher pay has been found to lower negative

affects on the worker (Stamm, 1999). By addressing the relationship between mediators on compassion fatigue, compassion satisfaction, and burnout, a better attempt at understanding the experience of direct care staff members may be achieved.

Mediators to compassion fatigue, burnout and compassion satisfaction identified in previous research are apparent in direct care staff member's experience, such as sex, age, experience, education, training, and income. Mediating variables can have positive and negative effects on staff members depending on agency culture (Bell, Kulkarni & Dalton, 2003; Sexton, 1999). Ways in which mediators have positive and negative influences on the direct care staff members' level of experienced compassion fatigue, compassion satisfaction and burnout can be better understood by examining the rate of agreement staff have around available program practices within residential treatment facilities. In naming the symptoms of compassion fatigue and burnout within an organization context by understanding the mediators within an agency setting, a more complete picture of the worker's experience may be understood. Both the staff member and the agency can begin to address potential challenges and make positive changes to potentially improve the continuity of care for the clients to their staff (Jacobson, 2006; Shauben & Frazier, 1995; Stamm, 2002).

Chapter III

Methodology

The purpose of this study is to examine how direct care staff in residential treatment facilities serving a traumatized adolescent population differ in their compassion fatigue based on their experience within their agency and personal characteristics they bring to the job. With this purpose in mind, the research question is: How do direct care staff members who utilize available program supports within their agency experience compassion fatigue, burnout and compassion satisfaction when compared to staff who do not utilize or do not have access to program supports while considering demographic variables such as age, sex, income, level of education and training, previous work experience and length of time working as a direct care staff member.

One hypothesis will be investigated in this quantitative, quasi-experimental study. The hypothesis is: Direct staff who utilize institutional support will have improved scores for compassion fatigue than staff who do not use these supports. When considering the demographic variables, I predict direct care staff that identify as female, are younger, have less pay, and have less trauma specific training will experience higher levels of compassion fatigue and burnout and have lower levels of compassion satisfaction. Researchers have reported mixed results concerning education and duration of work experience on the level of compassion fatigue experienced when working with a traumatized population, where this study has attempted to better understand the influence, if one exists, of these characteristics on the relationship of experienced compassion fatigue of direct care staff members' working with traumatized

individuals and no prediction has been made. Because this study only looks at staff members who spend the majority of their shift with traumatized adolescents in a residential treatment facility, I predict the overall rates of compassion fatigue and burnout between groups will be higher in my study than average scores reported in Stamm (2010) for the ProQOL measure, where researchers have primarily focused on therapists' experience with trauma victims.

This study uses a quantitative, quasi-experimental design because of the preexisting ProQOL variable to measure compassion fatigue, burnout and compassion satisfaction as well as the lack in randomization in sampling procedures as is required in a true experimental design. A quasi-experimental design involves controlling for threats to internal validity, and this study attempts to do this by including demographic variables when testing the hypotheses, selecting a sample that controls for the professional role within the agency structure by sampling only direct care staff members, controlling for history effects by only including currently employed direct care staff members, and controlling for the types of secondary trauma staff are exposed to by limiting the sample to residential agencies serving traumatized adolescent populations in the San Francisco Bay Area.

A quantitative design was chosen for this study to quantify the differences among direct care staff members' levels of compassion fatigue, burnout and compassion satisfaction by using the ProQOL. Good internal validity is reported for the ProQOL measure in studying the effects of compassion fatigue, burnout and compassion satisfaction among helping professionals. The alpha reliability for the ProQOL is reported as good to excellent, with a compassion fatigue reliability score of .81, a burnout reliability score of .75 and a compassion satisfaction reliability score of .88. Two questionnaires were developed for the purpose of this study called the Personal Characteristics questionnaire to capture the demographic variables and the Perceptions

of Program Practices questionnaire to capture the availability and utilization of program supports within the agency setting. Good reliability is assumed in the Personal Characteristics questionnaire and the Program Practices questionnaire because they include closed-ended, self-reporting variables designed to be easily understood and the answers are, in most cases, analogous in design.

Sample

8 participants were recruited from 3 residential facilities, where approximately 100 staff members were eligible to participate. I utilized my knowledge of residential treatment facilities in the Bay Area who treated traumatized adolescents to inform my recruitment efforts, where two out of three agencies agreed to participate. Seneca Center agreed to participate in this research project with the participation of two residential facilities, one located in San Francisco, CA and another in Concord, CA. Edgewood Center for Children and Families agreed to participate in this study and they are located in San Francisco, CA. Fred Finch Youth Center located in Oakland, CA declined to participate in this research project. The study consisted of a non-probability purposive sample design and was implemented by gaining permission from each agency's program director to recruit subjects from within their agency. From this population and previous research, inclusion criteria were developed.

Data Collection

At the introduction of the survey, a brief welcome page will be included with definitions of direct care staff members and residential treatment facilities followed by inclusion criteria. For inclusion in this study, participants need to be 18 years old or older, work the majority of

their work week in the residential milieu with clients, be actively employed in a residential treatment facility serving adolescent populations, the adolescent populations served have a trauma history including one of the following: sexual abuse, abandonment, physical abuse, and/or neglect, and direct care staff eligible to participate have held no other position in any residential facility other than the role of direct care staff member. Participants who do not meet all of these criteria will be disqualified from the study and will be thanked for their interest in participation.

If the participant is eligible to participate in this study by meeting five out of five inclusion criteria, they will be taken to the Informed Consent form (Appendix E) to be reviewed, where the purpose of the study will be outlined, highlighting the guarantee of anonymity and voluntary participation. Anonymity will be maintained on the online survey by not having participants reveal their names or the name of their agency. Once agreeing to participation by checking a box stating "I agree," participants will be taken to the Personal Characteristics questionnaire to begin the survey. If participants do not wish to continue, they will be thanked for their participation and exit the survey. Participants will be encouraged to print a copy of the Informed Consent for their records.

To begin recruitment efforts, I will provide each agency a flier (Appendix F) to hand out at a staff meeting with a brief description of the study, the inclusion criteria and the link to the survey. Following the flier distribution, I will provide a description of the study with a link to participation to all staff member email addresses (Appendix G). I will visit the San Francisco agencies to offer further recruitment efforts and provide a description of the study in person (Appendix H). At each agency visit I will acquire personal email addresses on a voluntary basis

in order to increase access to my survey link, and I will send an email two times to recruited personal email addresses before closing my survey.

Each participant will complete three questionnaires as part of one online survey through surveygizmo. Demographics will be included in the Personal Characteristics questionnaire (Appendix C) as the first part of the survey developed for this study, where questions of age, race, sex, amount of education completed, length of time in current position at current agency, relationship status, personal yearly income and household yearly income will be included. Umbrella questions in this survey will include inquiry about previous work experience regarding work with adolescent traumatized clients and/or traumatized clients other than adolescents, if they have received any training specific to treating traumatized populations and if so, participants will be asked to rate the quantity and quality of these trainings.

The second questionnaire that will be included in the survey is called The ProQOL (Appendix B), a 30 item survey using a Likert scale of 1= *never* to 5= *very often* measuring compassion satisfaction and compassion fatigue as determined by elements of burnout and secondary trauma. Researchers may use this measure without permission from the authors. The ProQOL allows for separate measurement of compassion fatigue, burnout and compassion satisfaction by piecing out specific items in the survey to identify each construct.

The third questionnaire and final part of the survey will be the Perceptions of Program Practices questionnaire (Appendix D), where questions asked will identify program supports offered by the agencies, to what level staff utilized these supports and how helpful staff perceived the supports to influence their work with adolescent clients in their agency. Questions will include the direct care staff member's experience of individual and group supervision, pay,

health benefits, time off, agency acknowledgement of professional accomplishments, and opportunities to promote professional development.

After closing my survey online, Survey Gizmo will allow me to transfer the data into SPSS and Excel. No one except me and the statistical analyst affiliated with Smith College School for Social Work will have access to the data. After entering the data, the surveys will be stored in a secured data file, which will be kept on my computer. After the data analysis is complete, I will keep all survey materials in the secure data file for three years according to Federal regulations. After three years, the data will be destroyed. If I need the data longer than three years, I will keep it secure and destroy it when no longer needed.

Data Analysis

The dependent variables are compassion fatigue, compassion satisfaction, and burnout and will be measured by the Professional Quality of Life Scale (ProQOL). The independent variable, the utilization of available program supports within agency settings by direct care staff members, will be measured by the Perceptions of Program Practices questionnaire. Other independent variables, demographics and personal characteristics, will be measured by the Personal Characteristics questionnaire. The demographic variables include: age, race, gender, relationship status, and income of self and household. The personal characteristic variables include: education level, amount of time in current position as direct care staff member, previous experience and previous training.

This study considers the experience of direct care staff members' in residential treatment facilities serving adolescent populations and utilized both nominal and ordinal data. Multiple independent variables are considered when looking at the dependent variables of experienced

compassion fatigue, compassion satisfaction and burnout. The quantitative design of this study may allow for a few statistical strategies in order to analyze the data. When looking to nominal data, such as the demographic variables, and the affect on the dependent variables, a chi squared analysis can be utilized to measure the statistical significance. When looking to ordinal data, such as the measures used in the ProQOL to measure the dependent variables and survey questions measuring perceptions of program supports , bivariate analysis by way of t-tests, or one-way ANOVA'S may be utilized in order to understand between group differences. Multivariate analysis, when looking at more than one independent variable as having an affect on the dependent variables, F-tests may be utilized to understand group variance.

Chapter IV

Findings

The major question addressed in this study is how do direct care staff members in residential treatment facilities serving a traumatized adolescent population differ in their compassion fatigue and compassion satisfaction based on their experience with program supports within their agency. It was predicted that staff who utilized program supports will have lower levels of compassion fatigue and higher levels of compassion satisfaction. It was predicted that demographics and personal characteristics of direct care staff members concerning those who identify as female, are younger, receive less pay, and receive less trauma specific training will experience higher levels of compassion fatigue, as measured by way of burnout and secondary traumatic stress and have lower levels of compassion satisfaction.

No prediction was made regarding levels of compassion fatigue based on personal characteristics of education received and duration of current and previous work experience with trauma victims. It was further predicted that the overall rate of compassion fatigue, by way of burnout and secondary traumatic stress, would be higher for direct care staff members than the average scores reported by Stamm (2010) based on previous research utilizing the Professional Quality of Life Scale (ProQOL).

Demographics of Participants

The participants in this sample were currently employed direct care staff members living in the San Francisco Bay area who volunteered to take an online anonymous survey. The total

population of the sample was eight participants (N = 8), with two participants only partially filling out the survey who were not included in the data analysis. Demographic data outlined the age, gender, race, relationship status, individual income and household income and data are outlined in Table 1. Personal characteristics data outlined level of education, length of time in current position as a direct care staff member, trauma specific training attended and previous work experience with traumatized individuals and adolescents and data are outlined in Table 2.

Table 1. Demographics of Participants

Age	*Frequency*	*Valid Percent*
22 - 25	3	37.5
26 - 30	3	37.5
31 - 35	2	25.0
Total	8	100.0
Gender	*Frequency*	*Valid Percent*
Male	5	62.5
Female	3	37.5
Total	8	100.0
Race	*Frequency*	*Valid Percent*
Caucasian	4	50.0
Asian / Pacific Islander	2	25.0
Hispanic	2	25.0
Other / Multi-Racial	0	0.0
Total	8	100.0
Relationship Status	*Frequency*	*Valid Percent*
Single	5	62.5
Partnered	1	12.5
Married	2	25.0
Separated / Divorced / Widowed	0	0.0
Total	8	100.0
Individual Yearly Income	*Frequency*	*Valid Percent*
Less than $10,000	0	0.0
$10,000 - $19,999	1	12.5
$20,000 - $29,999	3	37.5
$30,000 - $39,999	4	50.0
$40,000 - $60,000 or more	0	0.0
Total	8	100.0
Household Yearly Income	*Frequency*	*Valid Percent*
Less than $10,000 - $19,999	0	0.0
$20,000 - $29,999	1	12.5
$30,000 - $39,999	2	25.0
$40,000 - $49,999	1	12.5
$50,000 - $59,999	1	12.5
$60,000 or more	3	37.5
Total	8	100.0

Table 2. Personal Characteristics of Participants

Education Completed	*Frequency*	*Valid Percent*
12th Grade or Less - Associates	0	0.0
Bachelor's Degree	8	100.0
Post Graduate Degree	0	0.0
Total	8	100.0
Time in Current Position	*Frequency*	*Valid Percent*
0 – 3 months	1	12.5
4 months – 1 year	0	0.0
1 – 1.5 years	1	12.5
1.5 – 2 years	3	37.5
2 – 3 years	2	25.0
3 – 5 years	0	0.0
5 years or more	1	12.5
Total	8	100.0
Previous Work Experience with traumatized clients (not adolescents)	*Frequency*	*Valid Percent*
Yes	4	50.0
No	4	50.0
Total	8	100.0
Previous Work Experience with traumatized clients (with adolescents)	*Frequency*	*Valid Percent*
Yes	2	25.0
No	6	75.0
Total	8	100.0
Training attended on working with Traumatized Individuals	*Frequency*	*Valid Percent*
Yes	6	75.0
No	1	12.5
Unsure	1	12.5
Total	8	100.0

Descriptive Statistics for sample as a whole

Responses from the Personal Characteristics questionnaire provided demographic statistics, where it was found that the majority of participants were between the ages of 22 and 30 (75%), male (62.5%), Caucasian (50%), single (62.5%), and individually earned between $30,000 & $39,000 a year (50%). Household income ranged from $20,000 to over $60,000. Concerning personal characteristics, the majority of participants had a bachelor's degree (100%), had been working in their current position as direct care staff member for 1 to 3 years (75%), had not worked with adolescent traumatized clients previously (75%), and had received training specific to trauma work (75%). Those with trauma specific training had found the trainings

helpful to some degree and the majority of had attended 5 or more trainings (85.7%) within three months of taking the survey (57%). Half of participants (50%) had worked with traumatized individuals before, excluding adolescents, and half of participants (50%) had no previous experience working with traumatized clients. Participants with previous experience working with traumatized individuals (50%) had three years or less work experience to this aim.

The ProQOL measure was divided into sub-groups consisting of compassion satisfaction and compassion fatigue determined by secondary traumatic stress and burnout. Within the sample (N = 8), 62.5% had average compassion satisfaction and 37.5% had high compassion satisfaction. Concerning the burnout measure, 75% of the sample had average burnout and 25% had low burnout. Average secondary traumatic stress was experienced by 87.5% of the participants and 12.5% had low stress. Therefore, the majority of the sample had average compassion fatigue. ProQOL data can be found in Table 3.

Table 3. Professional Quality of Life Scale (ProQOL) Data of Participants

Compassion Satisfaction	*Frequency*	*Valid Percent*
Low	0	0.0
Average	5	62.5
High	3	37.5
Total	8	100.0
Compassion Fatigue	*Frequency*	*Valid Percent*
Burnout		
Low	2	25.0
Average	6	75.0
High	0	0.0
Total	8	100.0
Secondary Traumatic Stress	Frequency	Valid Percent
Low	1	12.5
Average	7	87.5
High	0	0.0
Total	8	100.0

The Perceptions of Program Practices questionnaire provided information on participants' perceptions and utilization of program supports within their agency made up of questions relating to individual supervision, peer group supervision, health care, positive professional acknowledgement from the agency, time off, pay, ability to call in sick and on site

and off site professional development trainings. The majority of participants received individual supervision (87.5%), peer supervision (87.5%), adequate health care from their employer (87.5%), positive acknowledgement from their agency for their work (75%), the opportunity to attend on-site trainings for professional development (87.5%), and the opportunity to attend off-site trainings for professional development (62.5%). The majority of participants (62.5%) reported feeling strongly dissatisfied with their pay as a direct care staff member. The majority of participants (50%) felt they were unable to call in sick when feeling ill. 50% of the participants reported they felt their agency allowed for adequate time off from work. Perceptions of program practices data can be found in Table 4.

Table 4. Perceptions of Program Practices of Participants

Receive Individual Supervision	*Frequency*	*Valid Percent*
Yes	7	87.5
No	1	12.5
Total	8	100.0
Receive Peer Group Supervision	*Frequency*	*Valid Percent*
Yes	7	87.5
No	1	12.5
Total	8	100.0
Receive Adequate Health Care	*Frequency*	*Valid Percent*

Strongly Agree	3	37.5
Agree	3	37.5
Neutral	1	12.5
Strongly Disagree / Disagree	0	0.0
Not Applicable	1	12.5
Total	8	100.0
Acknowledgment of Positive Professional Accomplishments	*Frequency*	*Valid Percent*
Yes	6	75.0
No	2	25.0
Total	8	100.0
Opportunity to Attend On-site Trainings	*Frequency*	*Valid Percent*
Yes	7	87.5
No	1	12.5
Total	8	100.0
Opportunity to Attend Off-site Trainings	*Frequency*	*Valid Percent*
Yes	5	62.5
No	1	12.5
Unsure	2	25.0
Total	8	100.0
Receive Adequate Pay	*Frequency*	*Valid Percent*
Strongly Agree / Agree	0	0.0
Neutral	1	12.5
Disagree	2	25.0
Strongly Disagree	5	62.5
Total	8	100.0
Ability to Call in Sick	*Frequency*	*Valid Percent*
Strongly Agree / Agree	0	0.0
Neutral	3	37.5
Disagree	1	12.5
Strongly Disagree	4	50.0
Total	8	100.0
Ability to Take time Off	*Frequency*	*Valid Percent*
Strongly Agree / Agree	0	0.0
Neutral	4	50.0
Disagree	1	12.5
Strongly Disagree	3	37.5
Total	8	100.0

Participants receiving individual supervision reported receiving it regularly within a month's time, where 42.9% reported having it once a week, 28.6% reported having it every two weeks and 28.6% reported having it every month. Of those participants receiving individual supervision, the majority (85.8%) found it helpful in processing their positive and negative experience with clients. The majority of participants receiving peer group supervision reported receiving it once each week (71.4%) and the majority of these participants (85.8%) found peer

group supervision helpful in processing their positive and negative experiences with clients. The majority of participants (87.5%) believe they receive adequate healthcare from their agency and 71.4% of these participants have access to mental health benefits, where 33% of those with access to mental health benefits have received counseling.

Of those participants who believe they receive positive recognition from their agency, 66.7% believe they receive this recognition frequently and 50% of participants receiving positive recognition believed this recognition positively influenced their experience with clients in the milieu. Of those participants having access to on-site trainings furthering professional development, 57.1% reported these trainings were not optional, all had attended at least one training on issues relating to working with traumatized adolescents and all found the trainings helpful when working with adolescent clients in the milieu. Of those participants having access to off-site trainings furthering professional development, the majority (85.7%) reported these were optional to attend and one participant (14.3%) had attended an off-site training and had found it somewhat helpful.

Descriptive Stats for hypotheses

Because the sample size was small (N = 8), descriptive statistics were utilized to analyze the data. Therefore, any findings or relationships could not be inferred as meaningful. The major question addressed was: do direct care staff members' differ in their compassion satisfaction and compassion fatigue, by way of burnout and secondary traumatic stress, based on having access to and utilizing program supports within their agency. The findings of this study

showed the majority of direct care staff members had access to and utilized program supports, such as individual supervision (87.5%), peer group supervision (87.5%), adequate health care (87.5%) with mental health benefits (71.4%), positive professional acknowledgement (75%), and access to on-site (87.5%) and off-site trainings (62.5%).

Because the majority of participants had received and utilized program supports, due to the small sample size (N = 8), it was not possible to run a statistical test looking at the differences in compassion satisfaction and compassion fatigue based on the ProQOL measure. I was able to consider descriptive statistics comparing program practices and compassion fatigue and compassion satisfaction rates when looking at the program supports that were more evenly split with participants' responses, which included questions relating to ability to take time off, call in sick and feelings toward pay. When looking to the descriptive statistics of this analysis, 100% of those who felt they could not take time off had average burnout while 67% of those who could take time off had average burnout. 33% of those who could take time off had low burnout. The two groups had similar percents in compassion fatigue and identical percents in secondary trauma. Therefore, it was found that 33% of the group who felt they could take time off had low compassion fatigue while participants within the group who could not take time off reported average compassion fatigue.

Also of consideration was to what affect do demographics, such as gender, age, race, and income; and personal characteristics, such as pay, education, training and previous work experience, have on the compassion satisfaction and compassion fatigue, by way of burnout and secondary traumatic stress, experienced by the direct care staff member. It was predicted that direct care staff that identified as female, younger, reported receiving less pay, and reported receiving less trauma specific training would experience higher levels of compassion fatigue, as

measured by way of burnout and secondary traumatic stress and have lower levels of compassion satisfaction. Because the sample size was small (N = 8), it was not possible to break down the sample into smaller groups to compare the demographic variables with levels of compassion fatigue and compassion satisfaction.

The final hypothesis predicting a higher level of compassion fatigue among the sample population of direct care staff members compared to the average scores reported in Stamm (2010) was not supported by the findings of this research study. For each subcategory in the ProQOL measure, all scores concerning compassion satisfaction and compassion fatigue by way of burnout and secondary traumatic stress were below the average scores reported in Stamm (2010). A comparison between the participant data and the average scores reported by Stamm (2010) can be found in Tables 3 and 5.

Table 5. Professional Quality of Life Scale (ProQOL) Average Scores (Stamm, 2010)

Compassion Satisfaction Average Scores	*Valid Percent*
Low	25.0
Average	50.0
High	25.0
Total	100.0

Compassion Fatigue Average Scores	*Valid Percent*
Burnout	
Low	25.0
Average	50.0
High	25.0
Total	100.0

Secondary Traumatic Stress of participants	*Valid Percent*
Low	25.0
Average	50.0
High	25.0
Total	100.0

Chapter V

Discussion

The purpose of this research study was to examine if the utilization of program supports in an agency setting influence compassion satisfaction and compassion fatigue experienced, made up of secondary traumatic stress and burnout, by direct care staff members working in a residential treatment setting. Demographic and personal characteristics, such as age, sex, income, and level of training as a direct care staff member were predicted to have an effect on experienced compassion fatigue based on previous findings. Level of education and duration of work experience in treating traumatized individuals were considered in the questionnaire to add to the research question but were not predicted to have an effect on compassion fatigue due to mixed results evident within previous research. It was further predicted that direct care staff members, due to their role within the residential treatment setting as having the most contact (Bell, Dalton, & Kulkarni, 2003; Lakin, Leon & Miller, 2008; Lyman & Barry, 2006; Rosen, 1999) as the leading provider of care (Ford & Honnor, 2000; Lakin, Leon & Miller, 2008; Lyman & Barry, 2006) to highly traumatized children (Figley, 1995; Figley, 1995a; Meyers & Cornille, 2002; Shane et al., 2006; Sprang, Clark & Whitt-Woosley, 2007) would experience higher levels of compassion fatigue than average scores reported in the manual on the Professional Quality of Life Scale (ProQOL) by Stamm (2010), which are based on previous research spanning various contexts in working with traumatized individuals.

This study, due to the low sample size of 8 participants, will not be able to infer meaning from the descriptive statistics that were utilized in the analysis of results. However, when

looking to the first hypothesis, the majority of direct care staff members had access to and utilized program supports within their agency setting. Average to high rates of compassion satisfaction were reported by participants and average to low rates of compassion fatigue were reported, as measured by burnout and secondary traumatic stress items on the ProQOL measure. It can be perceived, based on participant reports on compassion satisfaction and compassion fatigue, that program supports may have an effect on the management and/or the amelioration of compassion fatigue among direct care staff members who work with highly traumatized children. This observance is in line with findings in previous research on lower levels of compassion fatigue among staff within supportive agency settings (Bell, Kulkarni & Dalton, 2003; McCann & Pearlman, 1990; Meyers & Cornille, 2002; Neumann & Gamble, 1995; Sexton, 1999; Sprang, Clark & Whitt-Woosley, 2007).

Program practices or supports making up a supportive culture were included within the survey, where the majority of direct care staff members within the sample found a helpful and supportive culture within their agency. These supports, supported by previous research in helping staff members process emotional material from traumatized individuals to diminish compassion fatigue, included access to individual supervision (Bell, Kulkarni & Dalton, 2003; Jacobson, 2006), access to peer group supervision (Bell, Kulkarni & Dalton, 2003; Jacobson, 2006), experience of positive professional acknowledgement (Bell, Kulkarni & Dalton, 2003; Neumann & Gamble, 1995), and access to mental health benefits (Saakvitne & Pearlman, 1996). Because the sample size was small, it would be beneficial in future research to consider the hypothesis regarding the utilization of program supports on experienced compassion fatigue and compassion satisfaction in order to better understand the experience of the direct care staff member.

The ability to take time off for vacation or illness as a program support was reported on within the survey and was seen unfavorably by the majority of direct care staff members. It has been reported that agency support regarding time off for vacation or illness has had positive effects on staff members, where a lower level of compassion fatigue has been reported (Bell, Kulkarni & Dalton, 2003; Neumann & Gamble, 1995; Saakvitne & Pearlman, 1996). Within this study, all participants who perceived they were not able to take time off had average burnout, and among those who felt they could take time off, the majority had average burnout. However, the remainder of those who felt they could take time off had low burnout, indicting a difference within this measure. It is interesting to note the measure of burnout provided this difference versus secondary traumatic stress and it would be beneficial for future researchers using the ProQOL measure to consider this difference when looking to direct care staff members' level of compassion satisfaction and compassion fatigue in residential treatment settings.

Level of pay was seen unfavorably by the direct care staff members within this survey, where the majority of participants within the sample reported feeling strongly dissatisfied with their pay for their job responsibilities. Previous researchers have reported that the higher the pay, the lower the secondary traumatic stress is experienced (Saakvitne & Pearlman, 1996; Stamm, 1999). Because the findings of this research study could not be viewed as meaningful, it would be beneficial to continue research efforts looking at perceptions of pay among the direct care staff member influences compassion satisfaction and compassion fatigue.

Because of the low sample size, it was not possible to break the sample down into smaller groups to better understand the influence of demographic and personal characteristics on compassion satisfaction and compassion fatigue. Therefore, it was not possible to understand within this sample the influence of sex on the levels of compassion fatigue, where previous

researchers have stated that females have experienced higher levels of compassion fatigue, as measured by burnout and secondary traumatic stress (Kassam-Adams, 1995; Sprang, Clark & Whitt-Woosley, 2007). To the same degree, it was not possible to examine the effect of age on compassion fatigue, where previous researchers have found the younger the person, the more burnout (Beck, 1987; Leon, Lakin & Miller, 2008; Maslach, Schaufeli & Leiter, 2001; Pearlman & Mac Ian, 1995) and vicarious trauma (Bell, Kulkarni & Dalton, 2003) was experienced.

Another personal characteristic considered within the study were questions on previous trainings specific to treating trauma survivors. Previous researchers have reported that the more trauma-specific training one had access to indicated lower levels of compassion fatigue and higher levels of compassion satisfaction (Sprang, Clark & Whitt-Woosley, 2007; Stamm, 1999) and researchers have reported that higher levels of vicarious trauma were experienced by those with less training in treating trauma survivors (Adams & Riggs, 2008; Bell, Kulkarni & Dalton, 2003). Although it is unable to be compared to level of compassion satisfaction or compassion fatigue, is interesting to note that the majority of staff members had received training specific to trauma work and had attended at least 1 training provided by their agency. Those who reported receiving trauma specific training had found the trainings helpful in their work with adolescents in the milieu. It would be beneficial for future researchers to consider the influence of personal characteristics on levels of experienced compassion satisfaction and compassion fatigue, such as sex, age, and training opportunities.

Previous researchers looking to the level of education and experienced compassion fatigue has been mixed, where higher education has been liked to higher burnout effects on workers (Lakin, Leon & Miller, 2008; Maslach, Schaufeli & Leiter, 2001), less education has been linked to higher burnout on workers (Lakin, Leon & Miller, 2008), and other researchers

have reported no relationship between the two (Beck, 1987; Lakin, Leon & Miller, 2008). Because of the low sample size, it was not possible to contribute to the question regarding the level of education on experienced compassion fatigue or compassion satisfaction. To the same end, it was not possible to examine the level of compassion satisfaction or compassion fatigue as influenced by duration of work with trauma victims as direct care staff members, measured by questions relating to previous work experience and length of time as a direct care staff member within their agency setting. Mixed results have been reported concerning duration of work in the field of treating trauma survivors on experienced compassion fatigue, where Meyers and Cornille (2002) have indicated the longer the duration, the higher the secondary traumatic stress; where other researchers have indicated that higher levels of vicarious trauma have been experienced for workers with less experience in the work (Adams & Riggs, 2008; Bell, Kulkarni & Dalton, 2003; Neumann & Gamble, 1995; Pearlman & Mac Ian, 1995; Sexton, 1999). Future researchers looking at direct care staff members' level of compassion satisfaction and compassion fatigue would benefit by addressing levels of education and duration of work experience.

Previous researchers have indicated that the negative effects associated with trauma work are exacerbated when treating traumatized children (Figley, 1995; Figley, 1995a; Meyers & Cornille, 2002; Sprang, Clark & Whitt-Woosley, 2007). As outlined by the inclusion criteria, it was indicated that direct care staff members studied within this sample worked with highly traumatized children in a residential treatment setting, where their primary responsibility involved working in the milieu with the children for the majority of their shift. Previous researchers have found that in working longer hours and having more contact with traumatized individuals each week, one can experience higher levels of secondary traumatic stress (Meyers & Cornille, 2002; Sprang, Clark & Whitt-Woosley, 2007; Stamm, 1999). Therefore, I had

predicted higher levels of compassion fatigue among the direct care staff members within my sample when compared to average rates of compassion fatigue reported by Stamm (2010). This prediction was not supported, where the level of compassion fatigue experienced within the sample ranged from average to low scores on the burnout and secondary traumatic stress measures of the ProQOL. Because the sample size was small, it would be interesting to consider this hypothesis in future research to see if a larger sample size maybe infer differences in average scores relating to compassion satisfaction and compassion fatigue when compared to the average population of trauma workers.

The strengths of this research study exist in the design. When studying compassion fatigue, burnout and compassion satisfaction effects on direct care staff members in a residential milieu setting, the Professional Quality of Life Scale (ProQOL) has been identified as a better construct to identify staff experiences when compared to other measurements' of compassion fatigue (Jenkins, 2002) and utilizes benign language to better include those working with trauma survivors, regardless of status or position with an online component for easy accessibility. The ProQOL has been improved upon, first starting as the Compassion Fatigue Self-Test for Psychotherapists (CFST) initiated by Figley, and eventually including compassion satisfaction (Stamm, 2010), improving the construct validity to the measurement of direct care staff members' level of compassion fatigue. The ProQOL measure is the most widely used measure to understand compassion satisfaction and compassion fatigue, through separate measures of burnout and secondary traumatic stress (Stamm, 2010) and has good to excellent alpha reliability, with a compassion fatigue reliability score of .81, a burnout reliability score of .75 and a compassion satisfaction reliability score of .88.. The ProQOL identifies positive effects on the worker through the measurement of compassion satisfaction, which has been shown to lower

bias in the study of compassion fatigue (Stamm, 1999), and in the measurement of compassion fatigue, two areas negatively affecting the worker are identified by a burnout component and secondary traumatic stress component (Stamm, 2010).

Another strength in the design of the research study was the inclusion criteria, where it was attempted to control for threats to internal validity by selecting a sample that controls for the professional role within the agency structure by sampling only direct care staff members, controlling for history effects by only including currently employed direct care staff members, and controlling for the types of secondary trauma staff are exposed to by limiting the sample to residential agencies serving traumatized adolescent populations in the San Francisco Bay Area.

Limitations to this research study surmounted strengths, where the low sample size proved to be too small to make any inferences on the research question. Recruitment efforts involved an introduction to the survey by the program director, multiple emails sent to staff members at their work and personal email address' with a brief description and link to the survey, and a visit to the agency to better describe the purpose and design of the research study. I find it an interesting result, that given the recruitment efforts, a very low number of staff members took the survey, which may infer the level of burnout among direct care staff members is above average. Because of this limitation, it would be beneficial to re-test the hypotheses among a larger sample to be able to understand if program practices have an influence on experienced compassion satisfaction and compassion fatigue. Ways in which to accomplish this may include contracting time within agencies to allow for staff to take the survey while on a break or offering a small incentive to participants for their time.

Another limitation involved the construct validity of the two survey's designed specifically for this research study to measure demographic and personal characteristics as well

as staff perceptions of program practices. Because the two questionnaires were not widely tested, construct validity and reliability of the measures were low. If this study were to be replicated, it would be beneficial to pre-test using these two surveys and consult with a specialist in designing reliable and valid measures. The survey was open to eligible staff members to take online with no limitation as to environmental conditions on when it was taken. Therefore, the reliability of this study is low. For future replication, it would be beneficial for the instructor to create an environment when taking the survey that was consistent among participants. There is low external validity for this study, where the low sample size is not able to infer meaning within the sample itself or to generalize to a wider community. To better improve the validity of this study, it would be beneficial to recruit eligible participants concerning more diverse demographic information and a larger randomized sample.

Low response rate in this study indicates not only low external validity, but raises questions about the demographics represented in this study as well as questions about the measurement instruments. It is interesting that participants range between 22 and 35 years of age and the racial background of participants consist of four Caucasian, two were Asian / Pacific Islander and two Hispanic participants. The sample, therefore, consisted of young, non-African American participants and this may be meaningful when considering access to the instrument was electronically situated. Basing participation and recruitment on a technological medium through an online survey and email messages may have excluded a wider age range and a racially diverse population who may respond and participate to other mediums, such as paper questionnaires or paper mailings.

Compassion satisfaction and compassion fatigue, indicated by burnout and secondary traumatic stress, are important constructs to understand among those working with trauma

survivors in agency settings. Because previous research has primarily focused on therapists and other professionals working with traumatized individuals, it is beneficial to continue to question how these constructs affect staff members who are in the front line of contact with traumatized children, direct care staff members in residential treatment settings. Previous researchers have added to the understanding of social support to ameliorate the negative affects when working with trauma survivors, where it is important to better understand the influence of program supports in agency settings for direct care staff members who are treating traumatized children. By continuing to understand these effects, it will add to the understanding of turnover in agency settings treating difficult populations. In understanding turnover affects, agencies may better control for turnover and may improve consistent care to the children who need it most.

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Appendix A

Human Subjects Review Approval Letter

SMITH COLLEGE
School for
Social Work

Smith College
Northampton, Massachusetts 01063
T (413) 585-7950
F (413) 585-7994

February 6, 2011

Kathryn Welch

Dear Kathryn,

The Human Subjects Review Committee has reviewed your revised materials and they are fine. Your Consent is still pretty long and we hope it doesn't discourage your participants. We are happy to now give this interesting and useful study our final approval.

Please note the following requirements:

Consent Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Good luck with your project.

Sincerely,

Ann Hartman | Chair

Ann Hartman, D.S.W.
Chair, Human Subjects Review Committee

CC: Diana Fuery, Research Advisor

Appendix B

Data collection Instrument: Compassion Satisfaction and Compassion Fatigue (ProQOL) version 5 (2009)

When you *[help]* people you have direct contact with their lives. As you may have found, your compassion for those you *[help]* can affect you in positive and negative ways. Below are some questions about your experiences, both positive and negative, as a *[helper]*. Consider each of the following questions about you and your current work situation. Select the number that honestly reflects how frequently you experienced these things in the *last 30 days.*

1=Never 2=Rarely 3=Sometimes 4=Often 5=Very Often

____ 1. I am happy.
____ 2. I am preoccupied with more than one person I *[help]*.
____ 3. I get satisfaction from being able to *[help]* people.
____ 4. I feel connected to others.
____ 5. I jump or am startled by unexpected sounds.
____ 6. I feel invigorated after working with those I *[help]*.
____ 7. I find it difficult to separate my personal life from my life as a *[helper]*.
____ 8. I am not as productive at work because I am losing sleep over traumatic experiences of a person I *[help]*.
____ 9. I think that I might have been affected by the traumatic stress of those I *[help]*.
____ 10. I feel trapped by my job as a *[helper]*.
____ 11. Because of my *[helping]*, I have felt "on edge" about various things.
____ 12. I like my work as a *[helper]*.
____ 13. I feel depressed because of the traumatic experiences of the people *[help]*.
____ 14. I feel as though I am experiencing the trauma of someone I have *[helped]*.
____ 15. I have beliefs that sustain me.
____ 16. I am pleased with how I am able to keep up with *[helping]* techniques and protocols.
____ 17. I am the person I always wanted to be.
____ 18. My work makes me feel satisfied.
____ 19. I feel worn out because of my work as a *[helper]*.
____ 20. I have happy thoughts and feelings about those I *[help]* and how I could help them.
____ 21. I feel overwhelmed because my case [work] load seems endless.
____ 22. I believe I can make a difference through my work.
____ 23. I avoid certain activities or situations because they remind me of frightening experiences of the people I *[help]*.
____ 24. I am proud of what I can do to *[help]*.
____ 25. As a result of my *[helping]*, I have intrusive, frightening thoughts.
____ 26. I feel "bogged down" by the system.
____ 27. I have thoughts that I am a "success" as a *[helper]*.
____ 28. I can't recall important parts of my work with trauma victims.
____ 29. I am a very caring person.
____ 30. I am happy that I chose to do this work.

Appendix C

Data collection Instrument: Personal Characteristics

What is your Age:

- ☐ 18-21
- ☐ 22-25
- ☐ 26-30
- ☐ 31-35
- ☐ 36-40
- ☐ 41-50
- ☐ 50+

What is your Race:

- ☐ Caucasian
- ☐ Black/African American
- ☐ Hispanic
- ☐ Asian Pacific Islander
- ☐ Native American/Alaska Native
- ☐ Other/Multi-Racial
- ☐ Decline to Respond

What is your Gender:

- ☐ Male
- ☐ Female
- ☐ Transgender
- ☐ Decline to Respond

Approximately how long have you been working in your *current* position as direct care staff member:

- ☐ 0 – 3 months
- ☐ 4 – 6 months
- ☐ 7 months – 1 year
- ☐ 1 year – 1.5 years
- ☐ 1.5 years – 2 years
- ☐ 2 - 3 years
- ☐ 3 – 4 years
- ☐ 4 – 5 years
- ☐ 5+ years

How much schooling have you completed:

- ☐ 12th grade or less
- ☐ Graduated High School or equivalent
- ☐ Some college, no degree
- ☐ Associates Degree
- ☐ Bachelor's Degree
- ☐ Post-graduate degree

Please check one indicating your relationship status:

- ☐ Single
- ☐ Partnered
- ☐ Married
- ☐ Divorced
- ☐ Separated
- ☐ Widowed
- ☐ other

Please check one indicating your own yearly income:

- ☐ Less than $10,000
- ☐ $10,000 - $19,999
- ☐ $20,000 - $29,999
- ☐ $30,000 - $39,999
- ☐ $40,000 - $49,999
- ☐ $50,000 - $59,999
- ☐ $60,000 or more

Please check one indicating your household yearly income:

- ☐ Less than $10,000
- ☐ $10,000 - $19,999
- ☐ $20,000 - $29,999
- ☐ $30,000 - $39,999
- ☐ $40,000 - $49,999
- ☐ $50,000 - $59,999
- ☐ $60,000 +

1: Have you had any previous work experience (other than your current direct care staff position) working with traumatized adolescents?

- ☐ Yes (answer question 1A)
- ☐ No (skip to question 2)

(1A) For approximately how long did you work with traumatized adolescents:

- ☐ 0 – 3 months
- ☐ 4 – 6 months

- ☐ 7 months – 1 year
- ☐ 1 year – 1.5 years
- ☐ 1.5 years – 2 years
- ☐ 2 – 3 years
- ☐ 3 – 4 years
- ☐ 4 – 5 years
- ☐ 5+ years

2: Have you had any previous work experience (other than your current direct care staff position) working with traumatized individuals other than adolescents?

- ☐ Yes (answer question 2A)
- ☐ No (skip to question 3)

2A: For approximately how long did you work with traumatized individuals other than adolescents:

- ☐ 0 – 3 months
- ☐ 4 – 6 months
- ☐ 7 months – 1 year
- ☐ 1 year – 1.5 years
- ☐ 1.5 years – 2 years
- ☐ 2 – 3 years
- ☐ 3 – 4 years
- ☐ 4 – 5 years
- ☐ 5+ years

3: Have you received any training with a specific aim of working with traumatized individuals?

- ☐ Yes (if checked, answer the following questions: 3A, 3B, 3C)
- ☐ No (skip to next part of survey (ProQOL)
- ☐ Unsure (If checked, answer the following questions: 3A, 3B, 3C)

3A: How many trainings have you attended focusing on working with traumatized individuals?

- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5 or more
- ☐ Unsure
- ☐ Not Applicable

3B: When did you attend the most recent training on working with traumatized individuals:

- ☐ 0 – 3 months ago
- ☐ 4 – 6 months ago
- ☐ 7 months – 1 year ago
- ☐ 1 year – 1.5 years ago
- ☐ 1.5 years – 2 years ago
- ☐ 2 years ago or more
- ☐ Not Applicable

3C: how helpful did you find the training(s) you attended in regards to working with traumatized individuals:

- ☐ Very Helpful
- ☐ Helpful

- ☐ Somewhat helpful
- ☐ Not very helpful
- ☐ Not Applicable
- ☐ Unsure

Appendix D

Data collection Instrument: Perceptions of Program Practices

The following questions address your experience with program supports within the residential treatment facility for which you currently work. Please rate your agreement with each statement below.

I receive adequate pay for my job responsibilities as a direct care staff member

- ☐ Strongly Agree
- ☐ Agree
- ☐ Neutral
- ☐ Disagree
- ☐ Strongly Disagree

My agency allows for adequate time off Strongly Agree

- ☐ Strongly Agree
- ☐ Agree
- ☐ Neutral
- ☐ Disagree
- ☐ Strongly Disagree

I feel able to call-in sick to my agency when feeling ill?

- ☐ Strongly Agree
- ☐ Agree
- ☐ Neutral
- ☐ Disagree
- ☐ Strongly Disagree

1: I have received individual supervision at work from someone who's job title is above that of direct care staff member? (ex: from a manager, supervisor, therapist, clinical director, etc). Individual supervision is defined as: "1-on-1 supervision with a supervisor and a supervisee

- ☐ Yes (if checked, skip to question: 1A. 1B, 1C, 1D)
- ☐ No (If checked, please skip to question: 2)
- ☐ Unsure (If checked, skip to question: 1A, 1B, 1C, 1D)

1A: Please choose from the options below to finish the sentence with the best option that works for you.

I have received individual supervision within my agency _____?

- ☐ once per week
- ☐ once every other week
- ☐ once every 3 weeks
- ☐ 1 time per month
- ☐ Once a month
- ☐ Only a few times
- ☐ Only once
- ☐ Unsure
- ☐ Not Applicable

1B: Please choose from the options below to finish the sentence with the best option that works for you.

The individual supervision that I have received (from my primary supervisor) has been _____ for me in processing positive and negative experiences with clients at the residential treatment facility

- ☐ Very Helpful
- ☐ Helpful
- ☐ Somewhat helpful
- ☐ Not Helpful
- ☐ Not Applicable

1C: What is the gender of your current primary individual supervisor?

- ☐ male
- ☐ female
- ☐ transgender
- ☐ Unsure
- ☐ Not Applicable

1D: Have you had more than one supervisor over the course of your employment within your agency?

- ☐ Yes (skip to question 1E)
- ☐ No (skip to question 2)
- ☐ Not Applicable (skip to question 2)

1E: Please choose from the options below to finish the sentence with the best option that works for you

The individual supervision that I have received, *other than from my primary supervisor*, has been _____ for me in processing positive and negative experiences with clients at the residential treatment facility

- ☐ Very Helpful
- ☐ Helpful
- ☐ Somewhat helpful
- ☐ Not Helpful
- ☐ Not Applicable

2: I have received peer-group supervision at work form someone who's job title is above that of direct care staff member? (ex: from a manager, supervisor, therapist, clinical director, etc). Peer-group supervision is defined as: "supervision with a supervisor and other work colleagues who share in your same job title and/or job responsibilities

- ☐ Yes (skip to question 2A, 2B)
- ☐ No (skip to question: 3)
- ☐ Unsure (skip to question 2A, 2B)

2A: Please choose from the options below to finish the sentence with the best option that works for you

I have received group supervision within my agency _____?

- ☐ once per week
- ☐ once every other week
- ☐ once every 3 weeks
- ☐ 1 time per month
- ☐ Once a month
- ☐ Only a few times
- ☐ Only once
- ☐ Unsure
- ☐ Not Applicable

2B: Please choose from the options below to finish the sentence with the best option that works for you

The peer group supervision that I have received has been _____ for me in processing positive and negative experiences with clients at the residential treatment facility.

- ☐ Very Helpful
- ☐ Helpful
- ☐ Somewhat helpful
- ☐ Not Helpful
- ☐ Not Applicable

3: I receive adequate health benefits through my employer, where I work as a direct care staff member?

- ☐ Strongly Agree (skip to question 3A)
- ☐ Agree (skip to question 3A)
- ☐ Neutral (skip to question 3A)
- ☐ Disagree (skip to question 3A)
- ☐ Strongly Disagree (skip to question 3A)
- ☐ Not Applicable (skip to question 4)

3A: My health care benefits offered by my employer include mental health benefits

- ☐ Yes (skip to question 3B)
- ☐ No (skip to question 4)
- ☐ Unsure (Skip to question 3B)

3B: I have utilized the mental health care benefits included in my health care coverage

- ☐ Yes
- ☐ No
- ☐ Not Applicable

4: My agency acknowledges positive professional accomplishments for direct care staff members? (ex: awards, announced personalized thank-you in group meetings, awarded gift cards, verbal appreciations)

- ☐ Yes (skip to question 4A, 4B)
- ☐ No (skip to question 5)
- ☐ Unsure (skip to question 4A, 4B)

4A: Please choose from the options below to finish the sentence with the best option that works for you

My Agency _____ acknowledges positive professional accomplishments to direct care staff members

- ☐ Very Often
- ☐ Often

- ☐ Sometimes
- ☐ Rarely
- ☐ Never

4B: I have received positive professional acknowledgement within my agency for my accomplishments as a direct care staff member?

- ☐ Yes (skip to question 4C, 4D)
- ☐ No (skip to question 5)

4C: The positive professional acknowledgment I received for my accomplishments as a direct care staff member made me feel appreciated

- ☐ Strongly Agree
- ☐ Agree
- ☐ Neutral
- ☐ Disagree
- ☐ Strongly Disagree

4D: The professional recognition I received from my agency positively influenced my experience as a direct care staff member when working in the milieu with the clients

- ☐ Strongly Agree
- ☐ Agree
- ☐ Neutral
- ☐ Disagree
- ☐ Strongly Disagree

5: My agency offers opportunities for professional development for direct care staff members in the form of on-site trainings?

- ☐ Yes (skip to question 5A, 5B)
- ☐ No (skip to question 6)
- ☐ Unsure (skip to question 5A, 5B)

5A: The on-site trainings offered by my agency are optional to attend

- ☐ Yes
- ☐ No
- ☐ Not Applicable

5B: I have attended at least 1 on-site training relating to issues in treatment for traumatized individuals within a residential treatment facility.

- ☐ Yes (skip to question 5C)
- ☐ No (skip to question 6)
- ☐ Unsure (skip to question 5C)

5C: Please choose from the options below to finish the sentence with the best option that works for you

The on-site training(s) I have attended have been _____ in my role as a direct care staff member when working in the milieu with the clients.

- ☐ Very Helpful
- ☐ Helpful
- ☐ Somewhat helpful

- ☐ Not Helpful
- ☐ Not Applicable

6: My agency offers opportunities for professional development for direct care staff members in the form of off-site trainings?

- ☐ Yes (skip to question 6A. 6B)
- ☐ No (taken to thank you page; finished with survey)
- ☐ Unsure (skip to question 6A, 6B)

6A: The off-site trainings are optional to attend?

- ☐ Yes
- ☐ No
- ☐ Not Applicable

6B: I have attended at least 1 off-site training relating to issues in treatment for traumatized individuals within a residential treatment facility.

- ☐ Yes (skip to question 6C)
- ☐ No (taken to thank you page; finished with survey)
- ☐ Unsure (skip to question 6C)

6C: Please choose from the options below to finish the sentence with the best option that works for you

The off-site training(s) I have attended have been _____ in my role as a direct care staff member when working in the milieu with the clients.

- ☐ Very Helpful
- ☐ Helpful
- ☐ Somewhat helpful
- ☐ Not Helpful
- ☐ Not Applicable

Appendix E

Informed Consent Form

Dear participant:

My name is Kathryn Welch and I am a graduate student at Smith College School for Social Work. I am required to complete a master's thesis while working on my Masters in Social Work and my master's thesis will be used to fulfill graduation requirements (presenting the results to the academic Smith community) and may be submitted for publication. The purpose of my research is to look at the experiences of direct care (DC) staff members currently working in residential treatment facilities treating adolescents with a trauma history. Within this sample, I am interested in the quality of your experience as a DC staff member looking at both positive and negative experiences in your current position, your experience with program practices that promote staff development and organizational culture, and personal characteristics you bring to the job.

I am asking you to be a participant for my study based on the fact that you are a direct care staff member, currently working in the milieu for the majority of your shift, serving traumatized adolescent populations in a residential treatment facility. You may not participate in this study if you are a supervisor, therapist, teacher, nurse, psychiatrist, or other management. To be a participant in this study you will need to complete three sections of a survey online via Survey Monkey where your responses will be anonymous. This process (completing three sections of a survey) will take approximately forty-five minutes. Compensation will not be offered for participation in this survey.

Potential risks as a participant in this study might include emotional distress in exploring your negative experiences when working with traumatized individuals and you may experience emotional distress if you are dissatisfied with the organizational supports in place at your agency. If you need additional support services to process feelings that may come up for you, I have attached a list of mental health referral sources for you to use as needed.

A benefit of participation in this study is that you may gain insight into your own range of experiences in working with traumatized clients within your agency setting. As a result of this examination, you may take further advantage of the program practices offered within your agency setting to help process your experience. At the completion of my study, at your request, I will send a summary of the results. These findings may give useful information of how other direct care staff members in the sample experience and manage their positive and negative experiences. It is possible that the results of this study will generate further research on the experience of the direct care staff member in residential treatment facilities.

Anonymity will be maintained by answering the three sections of a survey online through a website called Survey Monkey. After I have received completed surveys, I will record the data on my computer as well as seek statistical assistance from Marjory Postal, Research Analyst affiliated with Smith College. No one except me, my thesis advisor, Diana Fuery, and the statistical research analyst will have access to the data. All data will be kept in a secure location for a period of three years as required by Federal guidelines and data stored electronically will be protected. If I need the data longer than three years, I will keep it secure and destroy it when no longer needed. If you have any questions or concerns, you are encouraged to call me at 415-833-5105 or the Chair of the Smith College School for Social Work Human Subjects Review Committee at (413) 585-7974.

Participating in this study is completely voluntary. You may omit any question that feels uncomfortable for you to answer. You may decide to withdraw from the study during the data collection process, but due to the inherent anonymity of participation, you will be unable to withdraw responses

once answers have been submitted because online surveys cannot be identified with an individual. You can contact me by the address and/or phone number provided if you have any questions and you will have a copy of this form for yourself if you choose to participate.

BY CHECKING "I AGREE" YOU ARE INDICATING THAT YOU HAVE READ AND UNDERSTAND THE INFORMATION ABOVE AND THAT YOU HAVE HAD AN OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY.

I Agree _____
(Please print a copy for your records)

If you have any questions please contact:
Kathryn P. Welch
Social Work Intern

Department of Psychiatry
Kaiser Permanente
4141 Geary Boulevard, 4th floor
San Francisco, CA 94118
Direct Line: 415-833-5105
Email: Directcarestudy@gmail.com

Appendix F

Recruitment material: Flier

ATTENTION
Direct Care Staff Members

Are you…

- A Direct Care Staff member currently working in a residential treatment facility?
- 18 years old or older?
- working in a milieu setting with the adolescent clients for the majority of your shift?

If so, you may be eligible to participate in this online study!

The purpose of my research is to look at the experiences of direct care (DC) staff members working in residential treatment facilities.

Those interested in participating should contact the principal investigator, Kathryn Welch (contact information below). Or follow this link: (link provided). Participants should expect to spend between 30 and 45 minutes completing an anonymous online survey.

Kathryn Welch
Masters Student, Smith College School for Social Work
(415) 833-5105
Directcarestudy@gmail.com

Appendix G

Recruitment material: Recruitment e-mail

Subject line: Attention Direct Care Staff Members: You may be eligible to participate in this research study.

Body of email:

My name is Kathryn Welch and I am a graduate student at Smith College School for Social Work. I am required to complete a master's thesis while working on my Masters in Social Work and would like to invite you to participate in my research study. The purpose of my research is to look at the experiences of direct care (DC) staff members working in residential treatment facilities, specifically looking at ways DC staff members have experienced working with adolescents who have a trauma history. I am interested in the quality of your experience as a DC staff member, your experience with program practices that promote staff development and organizational culture, and your individual demographics including a question relating to the presence of a personal trauma history.

The process, completing three sections of a survey online, will take approximately thirty minutes, your anonymity will be maintained, and participation is completely voluntary. If you are interested in participating, please go to this link:

http://edu.surveygizmo.com/s3/467647/Direct-Care-Staff-Member-s-Experience-in-Residential-Treatment-Facilities

You will be taken to a welcome page with an introduction to the study and eligibility requirements will be offered before taking you to a more detailed description informing your consent to participation.

Thank you for your time and participation.

Sincerely,

Kathryn Welch
Social Work Intern
Department of Psychiatry
Kaiser Permanente
4141 Geary Boulevard, 4th floor
San Francisco, CA 94118
Direct Line: 415-833-5105
Email: Directcarestudy@gmail.com

Appendix H

Recruitment material: Talking points to agencies

- My name is Kathryn Welch and I am a graduate student at Smith College School for Social Work. I am required to complete a master's thesis while working on my Masters in Social Work and would like to invite you to participate in my research study.
- The purpose of my research is to look at the experiences of direct care (DC) staff members working in residential treatment facilities, specifically looking at ways DC staff members have experienced working with adolescents who have a trauma history.
- I am interested in the quality of your experience as a DC staff member, your experience with program practices that promote staff development, your experience with the culture of your residential treatment facility, and your individual demographics including a question relating to the presence of a personal trauma history.
- The process, completing three sections of a survey online, will take approximately forty-five minutes, your anonymity will be maintained, and participation is completely voluntary.

If you are interested in participating, please go to the link that is found on the flier I will distribute to those interested at the end of this meeting. If you follow the link, you will be taken to a welcome page that will introduce the study and address eligibility requirements before taking you to a more detailed description informing your consent to participation.