

**COMPASSION SATISFACTION IN VICTIM SERVICES: FOCUSING ON THE  
REWARDS OF TRAUMA WORK**

**ALISHA M. SHIVJI**

B.A., Mount Royal University, 2013

A Project  
Submitted to the School of Graduate Studies  
of the University of Lethbridge  
in Partial Fulfillment of the  
Requirements for the Degree

**MASTER OF EDUCATION  
COUNSELLING PSYCHOLOGY**

**FACULTY OF EDUCATION**

**LETHBRIDGE, ALBERTA**

November 2015

**COMPASSION SATISFACTION IN VICTIM SERVICES: FOCUSING ON THE  
REWARDS OF TRAUMA WORK**

**ALISHA M. SHIVJI**

Approved:

---

Supervisor: Dawn McBride, Ph.D. Date

---

Committee Member: Lynn Davis, Ph.D. Date

---

Assistant Dean of Graduate Studies and Research in Education: Date  
Kerry Bernes, Ph.D.

## **Dedication**

To all victim support workers, thank you for making a difference.

## **Abstract**

My intent with this project is to offer a valuable resource for individuals who are involved in offering police-based victim support services. Altogether, I have three aims to fulfill: (a) to provide a comprehensive review of the literature on compassion fatigue and compassion satisfaction, and subsequently identify the need for more focus on compassion satisfaction; (b) to describe the current status of training that is provided to volunteer victim support workers in the Province of Alberta; and (c) to make a case for greater emphasis on compassion satisfaction to be incorporated into this training. The applied element of this project entails publication of a manuscript to help victim support volunteers maximize their experience of compassion satisfaction and promotion of a shift towards a more optimistic perspective of trauma work.

*Keywords:* compassion satisfaction, compassion fatigue, vicarious trauma, victim support, volunteers, training

## **Acknowledgments**

My success is the result of the support, encouragement, and valuable input provided by many people. I would like to express my gratitude to the following individuals and organizations for inspiring me and assisting me with the completion of this project:

To Sheilla and Moez Shivji, I could not have come this far without your endless love and support. Thanks mom and dad.

To Dawn McBride, for helping me turn an idea into reality. You were my friend, philosopher, and guide throughout this entire process. Your patience and positivity helped me to improve in ways that I never imagined would be possible. I could not have achieved this without you.

To Thelma Gunn, Richard Butt, and Lynn Davis, thank you for helping me to refine my ideas so that I could get to this point in my work. It was an honour to be able to work with each of you and to learn from your experiences and expertise.

To the Calgary Police Service, thank you for giving me the opportunity to make a difference in the lives of those who have been affected by crime and tragedy.

To Hazel Koschel, you supported me and helped me get on my feet. Thank you for believing in me.

Finally, to everyone who has contributed feedback and knowledge in the creation of this work—editors, consultants, friends, and colleagues. Thank you for your time and assistance.

## Table of Contents

Dedication.....	iii
Abstract.....	iv
Acknowledgments.....	v
Table of Contents.....	vi
List of Tables.....	x
Chapter 1: Introduction.....	1
Statement of the Problem.....	1
Statement of Interest.....	2
Proposed Project.....	3
Significance of the Project.....	4
Glossary of Terms.....	4
Overview of the Project.....	5
Summary.....	6
Chapter 2: Methods.....	7
Research and Development of the Project Topic.....	7
Ethical Considerations.....	8
Project Structure.....	8
Summary.....	9
Chapter 3: Review of the Literature on Compassion Fatigue and Compassion Satisfaction.....	10
Compassion Fatigue.....	10

Posttraumatic Stress Disorder: A Clinical Framework for Compassion	
Fatigue.....	11
Comparing Compassion Fatigue to Other Constructs .....	14
Countertransference .....	14
Burnout .....	16
Vicarious traumatization.....	18
Factors Contributing to Compassion Fatigue .....	22
Age and experience.....	22
Gender.....	23
Education .....	23
Empathy .....	24
Social support.....	25
Workload.....	25
Unresolved trauma .....	26
Coping and the Prevention of Compassion Fatigue.....	28
Coping style .....	28
Peer support .....	29
Self-care .....	30
Supervision .....	31
Training and education .....	32
Shifting the Focus to Compassion Satisfaction .....	35
Conceptualizing compassion satisfaction .....	36
Factors contributing to compassion satisfaction in helpers .....	37

Summary .....	38
Chapter 4: Training and Peer Support in Victim Services.....	40
The Role of Victim Services in Alberta.....	40
Victim Services Training .....	41
Online training .....	42
Classroom training .....	43
Peer Support.....	44
Integrating Compassion Satisfaction into Victim Services Training.....	45
Summary .....	46
Chapter 5: Discussion .....	47
Research Objectives.....	47
Objective one: Current literature on compassion fatigue and compassion satisfaction .....	47
Objective two: Victim services training in the Province of Alberta.....	48
Objective three: Incorporating compassion satisfaction into victim services training .....	48
Project Limitations.....	48
Project Strengths .....	49
Future Directions .....	50
Conclusion .....	52
References.....	53
Appendices.....	63

A: From Traumatized to Energized: Helping Victim Support Volunteers  
Cultivate Compassion Satisfaction in the Face of Crisis .....63

B: Professional Quality of Life Scale (ProQOL).....82

C: Scoring Guide for ProQOL .....84

D: Instructions for Authors from *Crisis: The Journal of Crisis Intervention  
and Suicide Prevention* .....87

## **List of Tables**

Table 1	A Comparison of Posttraumatic Stress Disorder and Compassion Fatigue Symptomatology .....	13
Table 2	A Comparison of Vicarious Traumatization and Compassion Fatigue .....	19

## **Chapter 1: Introduction**

My intent in this chapter is to introduce the subject matter for this project and share its significance to the counselling field. In order to familiarize the reader with the layout and content of subsequent chapters, I also provide an overview of the project. To provide context, I am specifically interested in the positive effects of trauma work—especially in adults who volunteer their time as victim support workers. Victim support volunteers work with the police to help individuals cope with the consequence of witnessing or experiencing a traumatic event, usually a criminal act or a motor vehicle accident. Although mental health professionals recognize that such work may have both positive and negative effects on the worker (Harr, 2013; McKim & Smith-Adcock, 2014; Radey & Figley, 2007; Stamm, 2002), I am curious as to the lack of attention that appears to be placed on teaching these volunteers how to capitalize on the more fulfilling aspects of their work.

### **Statement of the Problem**

Within the counselling field, researchers recognize that the development of secondary traumatic stress symptoms is an inherent risk of helping people to heal from trauma (Figley, 1995; Pearlman & Saakvitne, 1995a). The act of serving in a helping role requires workers to continuously listen to stories of trauma, a process which can impact them on a cognitive, emotional, and/or behavioural level (Bride, Radey, & Figley, 2007). This occupational hazard of trauma work has been referred to as compassion fatigue or vicarious traumatization (Bride, Radey, et al., 2007). Both terms will be elaborated upon in Chapter 3.

In recent years, some of the traumatology literature has been geared towards determining the various factors that may influence a trauma worker's susceptibility to compassion fatigue. Common factors that researchers have investigated include age, gender, empathy, workload, amount of experience, and unresolved personal trauma (Bell, Kulkarni, & Dalton, 2003; Dunkley & Whelan, 2006; Figley, 1995; Hargrave, Scott, & McDowall, 2006; Lerias & Byrne, 2003; Sprang, Clark, & Whitt-Woosley, 2007).

In addition to highlighting various risk factors of compassion fatigue, researchers have also focused on identifying preventative measures that can be taken to reduce and/or eliminate the symptoms of compassion fatigue in trauma workers. With respect to understanding how to reduce and prevent compassion fatigue, researchers have touched on a number of factors, including coping style, self-care, training and education, supervision, and peer support (Bell et al., 2003; Cicognani, Pietrantonio, Palestini, & Prati, 2009; Cummins, Massey, & Jones, 2007; Dunkley & Whelan, 2006; Kinzel & Nanson, 2000). In my view, this continuous focus on compassion fatigue has led to an overabundance of research on the negative aspects of trauma work.

### **Statement of Interest**

During my time as a victim support volunteer, I developed an interest in understanding how trauma work impacts individuals who take on the role of helping a person who has witnessed or experienced trauma. Through my Victim Services training, which will be elaborated upon in Chapter 4 of this project, I became aware of the possibility that serving in a helper role may affect a trauma worker in both positive and negative ways. However, I noticed that much of my training focused primarily on preventing and/or reducing the symptoms of compassion fatigue, not on the positive

elements of compassion satisfaction. I began to wonder whether more could be done to help victim support volunteers (and other populations of trauma workers) develop a greater appreciation for the fulfilling aspects of this type of work.

While reviewing the literature in this subject area, I was surprised by the limited information regarding the gains and rewards of being a person who helps individuals who have been traumatized to cope with and heal from the effects of witnessing or experiencing an event that is unexpected, overwhelming, and causes a great deal of helplessness. I decided that I wanted to learn more about how workers may gain a sense of fulfillment from helping others (Collins & Long, 2003), an experience that is referred to as compassion satisfaction and is described as being overlooked within the counselling literature (Lawson & Meyers, 2011). Consequently, I align with Radey and Figley's (2007) contention that compassion satisfaction needs to be studied more in order to determine its significance in the lives of trauma workers.

### **Proposed Project**

My interest in this population stems from the extent to which victim support volunteers' responsibilities differ from counsellors. First, victim support volunteers are required to physically go to the scene where victims need help. As a result, these workers are exposed to a wide variety of trauma-related cases "outside the "safety" of a counselling room" (Hargrave et al., 2006, p. 42), which is in sharp contrast to those counsellors who invite clients to come to their agency to seek assistance. Second, victim support volunteers, unlike paid trauma workers, generally take on the helping role in addition to other life responsibilities without any expectation of compensation for their work. Therefore, these volunteers are not necessarily bound to the helping role and are

free to leave at any time. Third, it is likely that many victim support volunteers may not have access to specific training and knowledge that is provided to those individuals who pursue trauma work as a professional career. Hence, I believe it is important to teach these volunteers not only how to counter and prevent the draining effects of compassion fatigue, but also how to fully experience the rewards of serving in a helping role.

### **Significance of the Project**

By completing this project, I sought to provide victim support volunteers (and possibly other trauma workers) with a practical resource to assist them in enhancing their experiences of compassion satisfaction. With this information at their fingertips, it is possible that these workers may learn to experience greater gratification and motivation in their work. Furthermore, by highlighting the need for increased emphasis on compassion satisfaction, I intended to promote a shift towards a more optimistic perspective of trauma work and open the door for further research on compassion satisfaction.

### **Glossary of Terms**

*Helper* refers to any individual who interacts with and provides support and/or services to trauma survivors.

*Mental health professionals* are individuals who provide support and/or services that are directed at improving a person's mental health. This generally includes nurses, psychologists, psychiatrists, counsellors, and social workers.

*Schema* denotes a cognitive structure or framework within the brain that is used to organize and categorize knowledge, thoughts, beliefs, actions, and experiences.

*Trauma survivor* refers to any individual who has witnessed or experienced a traumatic event.

*Trauma work* is the process of interacting with and providing support and/or services to trauma survivors.

### **Overview of the Project**

I have divided the entire project into five chapters plus an appendix. In this first chapter, I intended to provide the reader with a brief introduction to the project topic, as well as describe the problem statement that this project addresses. In addition to providing a brief rationale for pursuing this particular topic, I highlighted the significance of this project by briefly discussing the contributions I had hoped to make by completing it.

In Chapter 2, I detail the process of researching and developing the project topic. In addition to describing how I conducted the literature review for this project, I specify the ethical considerations in the creation of this project. I also briefly highlight the structure of the project.

My focus in Chapter 3 is to provide the reader with an extensive review of the literature on compassion fatigue and compassion satisfaction. I begin Chapter 3 with a detailed description of compassion fatigue and its underlying theoretical framework. I then compare and contrast compassion fatigue with a number of similar constructs, and take the reader through an exploration of each related construct. I also summarize literature on the factors contributing to compassion fatigue and various preventative measures. I close Chapter 3 by providing a definition of compassion satisfaction and touching on the importance of examining the positive side to trauma work.

My intention in Chapter 4 is to set the stage for the project manuscript by presenting a closer look into Victim Services. In Chapter 4, I describe what being victim support volunteer entails and establish how training and peer support is delivered in the context of Victim Services. I also refer to some of my own observations and personal experience as a victim support volunteer.

In Chapter 5, I take the reader through an exploration of the strengths and limitations of this project. Ample attention is also placed on identifying several directions for future research, as well as summarizing the intent and implications of this project.

I conclude the project with Appendix A, through which I present a manuscript to be submitted for publication in *Crisis: The Journal of Crisis Intervention and Suicide Prevention*. This applied component of the project is my gift to victim support volunteers, and I elaborate upon this in the following chapter.

## **Summary**

My intent with Chapter 1 was to provide the reader with an introduction to the focus and purpose of this project. In this first chapter, I provided a description of the problem being addressed—namely, the lack of emphasis on teaching victim support volunteers how to capitalize on their overall sense of compassion satisfaction—and presented a brief overview of the key concepts surrounding this topic. I also touched on the significance of pursuing this particular topic and brought forth the contributions that I hope to make with this project. Last, but not least, I provided a chapter-by-chapter outline that serves to prepare the reader for the remainder of this project.

## **Chapter 2: Methods**

My focus in this chapter is to outline the methods undertaken in researching and developing the idea for this project. I begin by highlighting the various search terms and databases used to conduct the literature review on compassion fatigue and compassion satisfaction. I then present a statement of ethical conduct, and conclude with a description of the overall project structure.

### **Research and Development of the Project Topic**

The literature review for this project was informed by available published works on compassion fatigue and compassion satisfaction. The following databases were accessed in order to search for and collect resources: Academic Search Complete, PsychINFO, Science Direct, and Ovid. Relevant books and articles were found through use of the following keywords, both separately and in combination: compassion fatigue, compassion satisfaction, professional quality of life, burnout, vicarious trauma, secondary traumatic stress, countertransference, volunteer, volunteer trauma worker, crisis line volunteer, satisfaction, mindfulness, training, peer support, and coping.

The University of Lethbridge library was accessed using the above-mentioned search terms. After obtaining several books from the library, I cross-referenced the authors' names with reference lists from the articles. This process led to the unearthing of further resources on compassion fatigue and compassion satisfaction. I then expanded the search to include other books and/or articles that had been written by these particular researchers. I also continued to review the reference lists of articles that I had already located, which resulted in the acquisition of more resources.

Given the limited literature available on compassion satisfaction, I accessed Google Scholar using the same search terms. Suitable web resources were located that provided direction for discovering additional scholarly resources on the topic, and I returned to the Academic Search Complete and Ovid databases to access the articles found through Google. The entire research process evolved over a span of 12 months.

### **Ethical Considerations**

Throughout the completion of this project, I have, at all times, complied with the *Canadian Code of Ethics for Psychologists* (Canadian Psychological Association, 2000; see also Canadian Psychological Association, 2001). As this project did not include the collection of any human data, ethics approval was not required. In compiling this project, I also adhered to the standards outlined in the 6th edition of the *Publication Manual of the American Psychological Association* (American Psychological Association, 2010).

### **Project Structure**

This project consists of two major components. The first component is an extensive review of the literature on compassion fatigue and compassion satisfaction. This first component sets the stage for future research by identifying gaps in the existing literature and justifying the need for greater emphasis on compassion satisfaction. The second major component of the project is a manuscript for publication, the content of which was informed by my review of the literature on compassion fatigue and compassion satisfaction. Specifically, the manuscript is designed in the form of eight meaningful, well-thought-out recommendations on how victim support volunteers may maximize their experience of compassion satisfaction, while minimizing the drain of the position. This second component of the project is included as a standalone document in

the appendix of the project. Overall, this project is an important contribution to traumatology literature, as the information and research on compassion satisfaction appears to be fairly limited.

### **Summary**

My purpose in this chapter was to describe the research methodology for the literature review component of this project (see Chapter 3). In addition to highlighting the various search terms and databases utilized in collecting resources for this project, I provided the reader with a brief overview of the project manuscript, which is essentially the applied component of this work.

In the following chapter, I seek to deliver my review of the literature on compassion fatigue, compassion satisfaction, and other concepts relevant to this project. My end goal with the succeeding chapter is to justify the significance of the project topic by pinpointing gaps in the existing literature. Overall, this project has taught me many elements about the research process and has assisted me in further developing my skills as a researcher. Furthermore, it has enabled me to give back to the community that helped me gain some valuable counselling skills and prompted me to embark on the journey of becoming a counsellor. My intention and hope is for this work to be used by Victim Services departments across Alberta to showcase how to experience greater fulfillment from helping others who are suffering.

### **Chapter 3: Review of the Literature on Compassion Fatigue and Compassion Satisfaction**

In this chapter I critically examine and summarize some of the current issues surrounding compassion fatigue and compassion satisfaction. I begin with a detailed description of compassion fatigue and its connection to posttraumatic stress disorder (PTSD). I then compare compassion fatigue to a number of similar constructs—namely, countertransference, burnout, and vicarious trauma—and explore each construct briefly. Next, I provide the reader with a summary of the factors that are said to contribute to compassion fatigue and will highlight the most commonly proposed preventative measures. In contrast to the negative elements of trauma work, I introduce the concept of compassion satisfaction. I then conclude the chapter by emphasizing the importance of focusing on the rewards that trauma workers may find when helping trauma survivors. Ultimately, my purpose in this chapter is to provide the theoretical rationale for my project manuscript.

#### **Compassion Fatigue**

Compassion fatigue describes the stressful reactions that workers may experience as a result of helping survivors of trauma to cope with their situation (Figley, 1995). The term was popularized by Figley (1995), who ultimately defined compassion fatigue as being “the natural consequent behaviours and emotions resulting from knowing about a traumatizing event experienced by a significant other – the stress resulting from helping or wanting to help a traumatized or suffering person” (p. 7). In other words, the act of hearing details of a traumatizing event and/or possessing the desire to help individuals

who have experienced trauma has the potential to generate feelings of traumatic stress within the helper.

Bride (2007) outlined that compassion fatigue results in symptoms that are similar to those observed in people who have been directly exposed to a traumatic event and may then suffer from PTSD. Compassion fatigue, according to Figley (as cited in Bride, 2007), is characterized by three core symptoms that are also inherent in PTSD: intrusion, avoidance, and physiological arousal. Salston and Figley (2003) mentioned that helpers who develop compassion fatigue may dream the same dreams as the victim, be subject to a number of intrusive thoughts and/or images, and may even experience distress when reminded of the victim's traumatic experiences. In a study of 282 social workers, Bride found that approximately 55% met the criteria for at least one of the three core PTSD symptoms. Hence, it appears that compassion fatigue in those who help survivors of trauma can present itself much in the same manner as PTSD that is experienced in those who have directly faced a traumatic event (Bride, 2007).

### **Posttraumatic Stress Disorder: A Clinical Framework for Compassion Fatigue**

Figley (1995) argued that although compassion fatigue results in effects that are similar to PTSD, it should be classified separately as a secondary traumatic stress disorder. Similarly, other researchers viewed compassion fatigue as being not PTSD, but rather a syndrome of secondary traumatic stress that mimics PTSD (Baird & Kracen, 2006). However, given the similarities between the two constructs, perhaps it is relevant to consider PTSD as a starting point for understanding compassion fatigue. In the following section, I aim to enhance the reader's understanding of compassion fatigue by comparing it to PTSD. To accomplish this particular goal, I provide a brief overview of

PTSD, as described in the latest edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5; American Psychiatric Association, 2013).

PTSD is a mental disorder that refers to a set of characteristic symptoms that may develop after a person has been exposed to one or more traumatic events, in which the response was one of powerlessness, helplessness, or fear (American Psychological Association, 2013). Terror, shame, and helplessness appear to highlight the presence of PTSD in individuals, and are considered to be hallmarks of this syndrome (Krippner, Pitchford, & Davies, 2012). As such, researchers believe that any event that poses an actual or potential threat to the life and/or well-being of an individual contains a possibility of giving rise to PTSD; this includes natural disasters, motor vehicle accidents, kidnapping, torture, harassment, injuries or illnesses, and even witnessing death or harm to others (Krippner et al., 2012).

The DSM-5 has established that an individual may be diagnosed with PTSD symptoms in the event of witnessing or learning about a traumatic event and/or being repeatedly exposed to aversive details of the traumatic event (American Psychiatric Association, 2013). Thus, from a clinical standpoint, it appears that traumatic stress symptoms may occur when individuals take on the role of “learning” about a trauma via a process of helping and supporting victims. Given that the act of being a helper (i.e., counsellor, psychologist, crisis-line volunteer) requires a person to repeatedly listen to the unpleasant details of traumatic events, and become empathetically involved with survivors of trauma, perhaps compassion fatigue is a form of PTSD? This question is not uncommon, as Figley (1995) argued that the symptoms characterizing compassion

fatigue appear to be nearly identical to the symptoms of PTSD. To illustrate, Table 1 compares PTSD symptomatology to that of compassion fatigue.

Table 1

*A Comparison of Posttraumatic Stress Disorder and Compassion Fatigue*

*Symptomatology*

Posttraumatic Stress Disorder	Compassion Fatigue
<p>According to the APA (2013), the general symptoms indicative of PTSD include:</p> <ul style="list-style-type: none"> <li>• Re-experiencing the traumatic event (through recurrent dreams, memories, flashbacks, and/or distress resulting from reminders of the event).</li> <li>• Persistent avoidance of or numbing associated with reminders of the event (efforts to avoid thoughts, feelings, people, places, and anything else that serves as a reminder of the traumatic event).</li> <li>• Negative changes in cognitive and affective states (inability to remember critical details of the traumatic event, blaming self, negative beliefs about self and/or others, reduced interest in regular activities, detachment, and/or reduced sense of affect).</li> <li>• Persistent sense of arousal (sleep difficulties, irritability, emotional outbursts, hypervigilance, high physiological reactivity, reckless behaviour).</li> </ul>	<p>According to Figley (1995), compassion fatigue is characterized by:</p> <ul style="list-style-type: none"> <li>• Re-experiencing the traumatic event (dreams, recollections, memories of the victim, and/or suddenly experiencing of the event).</li> <li>• Persistent avoidance of or numbing associated with reminders of the event (efforts to avoid thoughts and feelings, reduced interest in regular activities, detachment, and/or reduced sense of affect).</li> <li>• Persistent sense of arousal (sleep difficulties, irritability, emotional outbursts, high physiological reactivity, hypervigilance, and/or difficulties with concentration).</li> </ul>

*Note.* APA = American Psychological Association; PTSD = posttraumatic stress disorder.

Based upon *Compassion Fatigue: Coping with Secondary Traumatic Stress Disorder in Those Who Treat the Traumatized*, by C. R. Figley, 1995, New York, NY:

Brunner/Mazel. Copyright 1995 by C. R. Figley. *Diagnostic and statistical manual of mental disorders* (5th ed.), American Psychiatric Association, 2013, Washington, DC: Author. Copyright 2013 by American Psychiatric Association.

Despite the similarities between the two clinical states, as outlined in Table 1, Figley (1995) noted that the distinguishing factor is that compassion fatigue is experienced indirectly through a process of empathetically engaging with the traumatized individual, whereas PTSD is a directly lived phenomenon. Figley's (1995) belief is supported by the writings of Salston and Figley (2003), who implied that exposure to the traumatic experiences of another person could be deemed equivalent to the act of actually experiencing a traumatic event.

In this project, I take the stance that compassion fatigue overlaps with PTSD. This is evident in my project manuscript in which victim support volunteers are advised to utilize a scale to rate how often they have experienced PTSD-like symptoms as a result of working with trauma survivors. However, in order to offer a comprehensive overview of how stress affects those who help trauma survivors, there is merit in examining other constructs that help to explain the phenomenon.

### **Comparing Compassion Fatigue to Other Constructs**

A review of the research and practice literature on compassion fatigue reflects the use of several constructs to explain the phenomenon. Terms such as countertransference, burnout, and vicarious traumatization have all been used to describe the negative consequences of trauma work (Collins & Long, 2003; Kadambi & Ennis, 2004; Newell & MacNeil, 2010; Salston & Figley, 2003). In the following section, I present a brief overview of each construct.

**Countertransference.** Stemming from the psychodynamic approach to therapy, countertransference has often been referred to as an “unconscious defence mechanism” (Collins & Long, 2003, p. 420). Thus, when a person is said to be suffering from

countertransference, he or she is unconsciously reacting to the experiences of another. Such reactions can be influenced by the person's personality and life experiences (Saakvitne, Gamble, Pearlman, & Lev, 2000).

Corey (as cited in Collins & Long, 2003) declared that countertransference may emerge when a helper overidentifies with the client and/or attempts to meet his or her own needs through the client. The helper's reaction towards the client, directly or indirectly, may involve overwhelming feelings of grief and/or helplessness, various somatic responses, movement into rescuer-like behaviours, questioning the validity of the story that is being told, and/or a sense of disassociation or distance from the client (Salston & Figley, 2003). The development of a countertransference reaction may also result in a process in which the helper essentially absorbs the traumatic feelings described by the client, and this particular process may lead to the development of compassion fatigue (Figley, 1995). Thus, compassion fatigue may be related to countertransference, or may even occur as a result of a countertransference reaction.

The strongest argument against compassion fatigue being similar to countertransference came from Stamm (as cited in Collins & Long, 2003), who noted that countertransference describes the reactions that a helper may have towards a trauma survivor, whereas compassion fatigue is basically a description of the effects of trauma work on the helper and may occur outside of the helper role. Stamm wrote that compassion fatigue is best described as a process that induces greater negative changes to the beliefs, values, and behaviours of the helper. Unfortunately, the literature I reviewed was not clear if countertransference is a causal factor for compassion fatigue, is somewhat related to compassion fatigue, or is a different construct altogether. However,

for the purposes of this project, countertransference was reviewed to provide additional insight on the notion that listening to stories of trauma can negatively impact the listener.

**Burnout.** Another common term used to describe the emotional effects and stress that accompanies human service work is burnout (Jenkins & Baird, 2002). Like countertransference, burnout is often conceptualized as being a personal coping mechanism in situations that produce emotional stress (Jenkins & Baird, 2002), such as witnessing or hearing of a traumatic event.

A review of the literature revealed the use of several conceptualizations to describe the effects of burnout. One of the earliest definitions, established by Pines and Aronson (as cited in Collins & Long, 2003) in 1988, described burnout as “a state of physical, emotional, and mental exhaustion caused by long-term involvement in emotionally demanding situations” (p. 420). Several years later, Figley (1995) expanded this particular definition by stating that burnout is not only a collection of symptoms that indicate emotional exhaustion but is also a process that leads to an erosion of one’s idealism and a reduction in one’s sense of achievement.

Perhaps the most popular definition of burnout is Maslach’s (as cited in Collins & Long, 2003), in which burnout is defined as a syndrome consisting of three dimensions—namely, emotional exhaustion, depersonalization, and a sense of reduced personal accomplishment. Maslach and Jackson (1981) described each of these dimensions as follows:

- Emotional exhaustion results when the helper’s emotional resources become depleted as a result of work, and the helper no longer can give his or her best at a psychological level.

- Depersonalization refers to the cynical or negative attitudes and detached responses helpers give to clients.
- Reduction in personal accomplishment exemplifies the helper's tendency to feel unhappy and dissatisfied with his or her work (p. 99).

This three-dimensional model emerged from Maslach and Jackson's (1981) work in constructing a measurement scale for burnout—the Maslach Burnout Inventory. A factor analysis by Lee and Ashforth (1990) and the work of other researchers (Kalliath, O'Driscoll, Gillespie, & Bluedorn, 2000) acknowledged the existence of the three aforementioned dimensions, but only obtained strong support for the dimensions of emotional exhaustion and depersonalization. Based on these findings, perhaps reduced personal accomplishment might not be one of the core reactions associated with burnout. Future research will need to confirm this finding.

Burnout is similar to compassion fatigue as it may negatively impact the helper's ability to provide effective services to trauma survivors (Collins & Long, 2003). Cyr and Dowrick (1991) conducted one of the very rare studies that used a similar target group as this project (volunteer victim support workers); they studied 39 crisisline volunteers. In their mixed-methods study, Cyr and Dowrick found that burnout has the potential to impact the overall sense of satisfaction with the work, which may contribute to the provision of a lower quality of services to victims. For instance, 39% of participants in Cyr and Dowrick's sample stated that they had doubts about the effectiveness and/or value of their work, while 28% indicated feeling emotionally detached from their work. Burnout was also found to contribute to a high turnover rate for crisisline volunteers, as nearly half the sample resigned after a period of 1 year or less (Cyr & Dowrick, 1991).

No other studies could be located that replicated, supported, or challenged this 20-year-old study.

Although the effects of burnout appear to overlap with compassion fatigue, I have taken the position that the two are not entirely the same. While compassion fatigue is unique to trauma work, burnout seems to apply to any work setting (Newell & MacNeil, 2010). Therefore, my focus was on constructs that are related to the impact of trauma work and are not generalizable to other areas of work. Figley (1995) claimed that burnout is a process that emerges gradually, whereas the onset of compassion fatigue occurs almost immediately and without warning. Consequently, researchers insisted that the concept of burnout is too vague to accurately capture the consequences of trauma work (Salston & Figley, 2003).

**Vicarious traumatization.** To continue to explore how compassion fatigue is and is not similar to other constructs in traumatology literature, in this project I have defined vicarious traumatization as being a permanent transformation of inner experience that results from empathetic engagement with survivors of trauma (Saakvitne & Pearlman, 1996). Vicarious traumatization is unique in that it highlights how exposure to the traumatic experiences of victims negatively impacts the helper's affective and cognitive states (Salston & Figley, 2003). To demonstrate how vicarious traumatization may be distinguished from compassion fatigue, Table 2 compares the effects of vicarious traumatization to the symptoms of compassion fatigue.

Table 2

*A Comparison of Vicarious Traumatization and Compassion Fatigue*

Vicarious Traumatization	Compassion Fatigue
<p>According to Saakvitne and Pearlman (1996), the effects of vicarious traumatization include:</p> <ul style="list-style-type: none"> <li>• General changes within the helper (loss of time and energy, a sense of disconnection from loved ones, social withdrawal, cynicism, nightmares, heightened sensitivity to violence, and/or a generalized sense of despair or hopelessness).</li> <li>• Specific changes within the helper (disruptions in cognitive schemas and frame of reference, disruptions in psychological and/or emotional needs, alterations in world view, sensory experiences, identity, and/or view of spirituality, impairment of ego resources, and/or a reduction in self-capacities).</li> </ul>	<p>According to Figley (1995), compassion fatigue is characterized by the following:</p> <ul style="list-style-type: none"> <li>• Re-experiencing the traumatic event (dreams, recollections, memories of the victim, and/or suddenly experiencing of the event).</li> <li>• Persistent avoidance of or numbing associated with reminders of the event (efforts to avoid thoughts and feelings, reduced interest in regular activities, detachment, and/or reduced sense of affect).</li> <li>• Persistent sense of arousal (sleep difficulties, irritability, emotional outbursts, high physiological reactivity, hypervigilance, and/or difficulties with concentration).</li> </ul>

*Note.* Based upon *Compassion Fatigue: Coping with Secondary Traumatic Stress Disorder in Those Who Treat the Traumatized*, by C. R. Figley, 1995, New York, NY: Brunner/Mazel. Copyright 1995 by C. R. Figley. *Transforming the Pain: A Workbook on Vicarious Traumatization*, by K. W. Saakvitne & L. A. Pearlman, 1996, New York, NY: W. W. Norton. Copyright 1996 by K. W. Saakvitne & L. A. Pearlman. Reprinted with permission.

As evidenced by Table 2, some of the effects of vicarious trauma appear to be similar to the symptoms of compassion fatigue (e.g., withdrawal and high reactivity or sensitivity). On a conceptual level, both terms describe the negative effects of working with trauma survivors (Jenkins & Baird, 2002). However, the emphasis for each concept appears to differ in that vicarious trauma is focused primarily on cognitive disruptions, which will be highlighted next. In contrast, compassion fatigue is focused on

posttraumatic symptomatology including reexperiencing the traumatic event, persistent avoidance and/or numbing, and increased arousal (Jenkins & Baird, 2002).

With respect to cognitive disruptions, McCann and Pearlman (1990) referenced seven schemas that may be affected as result of a helper's exposure to trauma:

- esteem—leading helpers to take on a more cynical and pessimistic view of human nature and/or experience a sense of reduced esteem for the human race;
- frame of reference—leading helpers to experience a loss of meaning and/or changes in perspectives of the world, others, and the self;
- independence—leading helpers to experience a loss of control and freedom;
- intimacy—leading helpers to experience a sense of isolation and/or a loss of emotional connectedness with others;
- power—leading helpers to experience a general sense of helplessness and despair;
- safety—leading helpers to experience a heightened sense of vulnerability and/or a increased sense of awareness surrounding the possibility of harm or death; and
- trust or dependency—leading helpers to become overly suspicious, cynical, or distrustful of others (pp. 138–141).

In order to provide a measure of levels of disruption in the aforementioned schemas, Pearlman (1996) designed the Traumatic Stress Institute (TSI) Belief scale—now termed the Traumatic and Attachment Belief Scale (Varra, Pearlman, Brock, & Hodgson, 2008). However, it seems that the scale only serves to measure five of the

seven referenced schemas. The schemas of power and frame of reference do not appear to be included in the scale. Nonetheless, studies have utilized TSI Belief (Pearlman, 1996) scale to measure cognitive disruptions in helpers. For example, Cunningham (2003) conducted a quantitative study involving 182 social work clinicians and reported that those who worked primarily with survivors of sexual abuse displayed significant cognitive disruptions in the subscales of self-safety and other-esteem. In the same study, Cunningham conducted *t*-tests that also revealed significant disruptions ( $t = 1.98$ ) in clinicians' perceptions of trust towards others.

On the other hand, studies examining levels of cognitive disruptions in helpers may not always yield significant results. For instance, in a group of 25 professionals in a treatment centre for survivors of torture, Birck (2001) noticed that all of the participants in this sample reported only "minor cognitive disruptions" (p. 88). Despite the low levels of visible cognitive disruption in this study, the researcher claimed that the most affected schemas were that of other-safety and other-esteem (Birck, 2001).

In summary, I reviewed three constructs (countertransference, burnout, and vicarious traumatization) to provide greater insight into compassion fatigue. At this point, it appears that no consensus has been reached in terms of identifying a single, unitary concept to describe the psychological stress that accompanies work with trauma survivors. To continue to examine the impact that trauma work has on helpers, I present literature on the factors that have been suggested to contribute to this negative phenomenon. Thereafter, I introduce compassion satisfaction, which is in sharp contrast to compassion fatigue.

## **Factors Contributing to Compassion Fatigue**

In this section, I identify seven factors that may influence a helper's susceptibility to compassion fatigue. This will help to further enhance the reader's understanding of the construct by explaining why some helpers may be more prone to the impact of compassion fatigue than others. Each factor is briefly described and supported with empirical evidence. The factors are, in order of presentation, age and experience, gender, education, empathy, social support, workload, and a history of unresolved trauma.

**Age and experience.** On average, it seems that younger helpers possess a higher risk of being affected by trauma work. In fact, researchers have discovered that the risk of developing symptoms of compassion fatigue and/or burnout decreases with age (Sprang et al., 2007). In a sample of 259 therapists, Bober and Regehr (2006) observed that trauma scores, as measured by the Impact of Event scale (Zilberg, Weiss, & Horowitz, 1982), were negatively correlated ( $r = -0.14$ ) to age; older therapists demonstrated lower stress levels than younger ones.

This tendency for younger helpers to portray an increased susceptibility to compassion fatigue may possibly be the result of a lack of experience. For example, Bell et al. (2003) hypothesized that younger counsellors generally possess a lack of experience, which may result in fewer opportunities to develop effective coping strategies for alleviating the effects of traumatic stress. Likewise, Baird and Jenkins (as cited in Hargrave et al., 2006) proposed that possessing less experience in trauma work likely leads the helper to relate more closely to the victim, and thus increases the helper's chances of developing the symptoms of countertransference or compassion fatigue. While investigating traumatic stress in a sample of 105 American court judges,

researchers found that judges with 7 or more years of experience generally portrayed more symptoms of traumatic stress than their less-experienced counterparts (Jaffe, Crooks, Dunford-Jackson, & Town, 2003).

**Gender.** Researchers have also examined the effects of gender relative to the risk of developing compassion fatigue and/or vicarious trauma (Lerias & Byrne, 2003). Findings have often indicated that being female puts one at a significantly higher risk of developing traumatic stress symptoms (Lawson & Myers, 2011; Sprang et al., 2007). In their study of 105 court judges, Jaffe et al. (2003) noticed that female judges tended to report more traumatic stress symptoms than males. Similarly, in a sample of 1,121 mental health professionals, Sprang et al. (2007) found that females significantly reported higher compassion fatigue scores, as measured by Stamm's (2002, 2005) Professional Quality of Life scale (ProQOL).

It appears that "the finding of a gender-specific female vulnerability to stress responses is robust across many studies" (Sprang et al., 2007, p. 272). However, it is relevant to consider that findings may be biased due to an overrepresentation of female participants (Sprang et al., 2007). No data could be found primarily on male trauma workers and their rates of compassion fatigue.

**Education.** Researchers have claimed that level of education is a reliable predictor of stress responses in individuals (Lerias & Byrne, 2003). Possessing a higher level of education is deemed to mitigate burnout and/or traumatic stress symptoms, as those with higher levels of education may be more likely to better utilize available social support networks, possess a clearer understanding as to why traumatic stress is being experienced, and employ effective coping strategies to deal with the stress (Lerias &

Byrne, 2003). However, in their sample of 1,121 mental health professionals, regression analyses by Sprang et al. (2007) determined that possessing a higher education level predicted increased levels of compassion fatigue and burnout. No other empirically driven studies were found to confirm or challenge Sprang et al.'s (2007) findings.

**Empathy.** Figley (1995) claimed that the process of empathetically engaging with a trauma survivor transfers the traumatic material from the victim to the helper, which he viewed as ultimately causing the helper to become a secondary victim of the trauma. In other words, being empathetic may not only allow the helper to understand the trauma survivor's experiences, but may also cause the helper to internalize the experiences—this internalization of the victim's traumatic experiences is likely to increase the helper's level of traumatic stress.

Researchers who examined the connection between empathy and compassion fatigue in helpers have found inconsistent results. For example, MacRitchie and Leibowitz (2010) quantitatively studied a group of 64 trauma workers and found a positive relationship ( $r = 0.33$ ) between empathy and compassion fatigue scores (as determined by the TSI Belief scale and the Compassion Fatigue Self-Test). However, the results of the study appear to be contradicted by Thomas and Otis's (2010) investigation of 171 social workers, as they were unable to discern whether empathy was a predictor of compassion fatigue, as measured by the ProQOL (Stamm, 2005) and the Interpersonal Reactivity Index (Davis, 1983). This study might have been more powerful than the previous one because of its larger sample size. Due to the inconclusiveness of these two findings, it appears that the role of empathy as contributor to compassion fatigue may not yet be fully understood by the research community.

**Social support.** Generally speaking, social support is a factor that is regarded to help with decreasing the amount of distress experienced by a person (Lerias & Byrne, 2003). Thus, researchers have insisted that lack of social support often results in greater levels of distress and an increased severity of traumatic stress symptoms (Lerias & Byrne, 2003). Killian (2008) conducted qualitative interviews with 20 clinicians who worked with trauma survivors and found that lack of social support was identified as a key factor in the development of compassion fatigue and work-related stress. Additionally, in a sample of 64 trauma workers, MacRitchie and Leibowitz (2010) identified a negative correlation ( $r = -0.36$ ) between levels of traumatic stress and social support. From their study, it appears that trauma workers who perceived greater levels of available social support were more likely to portray low levels of traumatic stress, as measured by the Crisis Support Questionnaire (Joseph, Andrews, Williams, & Yule, 1992), Stamm and Figley's (1996) Compassion Fatigue Self-Test, and Pearlman's (1996) TSI Belief scale (MacRitchie & Leibowitz, 2010). To offer extended support to this notion of social support being a protective mechanism against compassion fatigue, in this project I speak to the influence of peer support on compassion satisfaction. Further information on peer support is provided later on this chapter.

**Workload.** Research has shown that mental health professionals who spend increased amounts of time with traumatized clients tend to possess a higher risk of developing the symptoms of traumatic stress (Bell et al., 2003). For instance, an empirical study by Schauben and Frazer (1995), involving a sample of 148 counsellors, revealed a positive correlation ( $r = 0.26$ ) indicating that counsellors who worked with a higher percentage of trauma survivors experienced higher levels of traumatic stress, as

determined by scores on the TSI Belief scale (Pearlman, 1996) and self-reports of vicarious trauma. Similarly, Lawson and Myers (2011) administered the ProQOL (Stamm, 2005) to a sample of 506 mental health professionals and found that those who possessed a larger caseload of trauma survivors also exhibited higher levels of compassion fatigue—as demonstrated by a positive correlation between the two variables ( $r = 0.14$ ). Based on these findings, it appears that greater exposure to the traumatic experiences of others is likely to increase a helper's susceptibility to compassion fatigue.

Some populations of trauma workers (such as victim support volunteers and counsellors) have the opportunity to provide both face-to-face and telephone service to survivors of trauma. Hence, the manner in which a helper is exposed to traumatic material may differ. Perhaps speaking to a trauma survivor over the telephone affects the helper differently than actually meeting the survivor in person. For instance, O'Sullivan and Whelan (2011) hinted that the provision of services over the telephone may result in increased levels of distress for the helper; primarily because, unlike face-to-face work, the provision of services via telephone makes it impracticable for the helper to read into nonverbal cues and poses the risk that the survivor may hang up the phone at any moment, without warning. However, no studies have been found that investigate this variable of work modality.

**Unresolved trauma.** Of the various factors that are deemed to contribute to a helper's risk of developing compassion fatigue, the most commonly discussed is personal trauma history (Hargrave et al., 2006). Research on trauma history is disparate in that some studies have found personal trauma to be a risk factor for compassion fatigue, while others have found personal trauma to be a factor that actually helps individuals to cope

with the consequences of trauma work (Hargrave et al., 2006). To illustrate, Pearlman and Mac Ian (1995) studied a sample of 188 self-identified trauma therapists and, using the TSI Belief scale (Pearlman, 1996), uncovered that the 60% of therapists who claimed to have possessed a history of personal trauma portrayed higher levels of distress and traumatic stress symptoms, compared to the 40% of therapists who did not report a history of trauma. At the same time, however, in a sample of 148 sexual violence counsellors, researchers were unable to discern any difference between the levels of distress exhibited by those with a personal history of trauma and those without a trauma history (Schauben & Frazer, 1995).

Perhaps the focus is not if the helper has a traumatic past, but whether or not unresolved personal trauma increases a helper's susceptibility to compassion fatigue (Hargrave et al., 2006). This reframe is in line with Figley's (1995) work, as he initially suggested that unresolved trauma in the helper is likely to be reactivated when a trauma survivor reports similar traumatic experiences. Hence, the emotions surrounding unresolved trauma may reemerge when the helper overidentifies with the trauma survivor (Figley, 1995). In testing the possible relationship between unresolved trauma and compassion fatigue risk, Hargrave et al. (2006) conducted a quantitative study of 64 victim support volunteers and found a positive correlation ( $r = 0.30$ ) between unresolved past trauma and levels of traumatic stress, as measured by the Impact of Event scale (Horowitz, Wilner, & Alvarez, 1979). This was the only study that could be found that examined how unresolved trauma may influence compassion fatigue risk.

Since my focus is compassion satisfaction, there is merit in examining the factors that may influence trauma workers' abilities to cope with the impact of compassion

fatigue. This examination occurs in the next section, and has the potential to further ground the reader's understanding of compassion fatigue by explaining how trauma workers may be able to effectively counter the negative impact of their work and retain a sense of satisfaction from being able to help others.

### **Coping and the Prevention of Compassion Fatigue**

With regards to preventing the impact of compassion fatigue, researchers have reported, albeit not frequently, on the importance of factors such as coping style, peer support, self-care, supervision, and training and education (Bell et al., 2003; Cicognani et al., 2009; Cummins et al., 2007; Dunkley & Whelan, 2006; Kinzel & Nanson, 2000; Pearlman & Saakvitne, 1995a, 1995b). Each factor is presented below.

**Coping style.** Empirical research on coping strategies appears to suggest the use of an active coping style to ameliorate the effects of compassion fatigue and/or burnout (Kinzel & Nanson, 2000). Active coping strategies include support seeking, relaxation, and being problem-focused (Cicognani et al., 2009; Kinzel & Nanson, 2000). It has been argued that helpers who adopt an active coping style are more successful in dealing with compassion fatigue because they tend to actively generate solutions to deal with the stress (Dunkley & Whelan, 2006). By contrast, the use of negative coping strategies (such as using alcohol and drugs, as well as avoiding people or situations) is believed to perpetuate the symptoms of traumatic stress (Kinzel & Nanson, 2000).

To verify these anecdotal reports, Cicognani et al. (2009) conducted a study on 764 emergency workers and discovered that those who adopted an active coping style were more likely to avoid compassion fatigue, compared to those who adopted dysfunctional coping strategies. Positive correlations noted how the use of negative or

dysfunctional coping strategies—namely, distraction ( $r = 0.30$ ) and self-criticism ( $r = 0.33$ )—would predict higher compassion fatigue scores (Cicognani et al., 2009). A similar trend was noticed in a study of 62 telephone counsellors, wherein the adopting of a nonproductive coping style was positively correlated ( $r = 0.32$ ) to traumatic stress scores (Dunkley & Whelan, 2006).

**Peer support.** Newell and MacNeil (2010) suggested the use of peer-support meetings, a system in which helpers meet to discuss and/or share the experiences of working with trauma survivors, as a method of impeding the effects of compassion fatigue. For example, Kinzel and Nanson (2000) have suggested that being able to talk about experiences and feelings that are triggered during trauma work helps to normalize the effects of traumatic stress. They further hypothesized that the sharing of experiences may even be a method by which helpers can expand and develop a repertoire of coping strategies (Kinzel & Nanson, 2000).

Although the literature on this particular factor seems to be limited, available research findings seem to note that support from peers is a favourable tactic for reducing and/or preventing the effects of compassion fatigue. For example, an empirical study involving 187 child protection workers revealed that higher levels of peer support were associated with lower levels of traumatic stress symptoms ( $r = -0.14$ ; Bride, Jones, & Macmaster, 2007).

Peer support has also been found to relate to gratification in the workplace. For example, in qualitatively studying the autobiographical accounts of teachers, researchers noted that peer support was thematically linked to teachers' perceptions of satisfaction

with their work (Butt & Retallick, 2002, 2004). Hence, peer support may be a method by which trauma workers can learn to capitalize on the rewards of their work.

**Self-care.** Researchers have emphasized a necessity for trauma workers to engage in personal self-care in order to be able to effectively counter the negative effects of trauma work (Bell et al., 2003; Cummins et al., 2007; Pearlman & Saakvitne, 1995a). Strategies such as maintaining work–life balance, nurturing social connections, and investing time in leisure and spirituality have all been recommended for reducing and/or preventing the symptoms of compassion fatigue (Cummins et al., 2007; Pearlman & Saakvitne, 1995a, 1995b).

A recent development has been the introduction of mindfulness as a self-care strategy. Perhaps the best way to define mindfulness would be to describe it as a process of being purposefully aware and attending to thoughts, emotions, and sensations in a nonjudgmental manner (Christopher & Maris, 2010). According to Kabat-Zinn (as cited in Dorian & Killebrew, 2014), mindfulness entails “paying attention in a particular way: on purpose, in the present moment, and nonjudgmentally” (p. 156). Researchers have specifically investigated the use of mindfulness in “addressing self-care and helping to prevent burnout, compassion fatigue, and vicarious traumatization” (Christopher & Maris, 2010, p. 114). For example, Thieleman and Cacciatore (2014) empirically examined the relationship between mindfulness, compassion fatigue, and compassion satisfaction in a sample of 41 professional and volunteer trauma workers. The results revealed a moderate negative correlation ( $r = -0.39$ ) between participants’ mindfulness and compassion fatigue scores, as measured by Brown and Ryan’s (2003) Mindful Attention Awareness scale and Stamm’s (2005) ProQOL (Thieleman & Cacciatore,

2014). Similarly, in a qualitative study with 21 graduate psychology students, Dorian and Killebrew (2014) found that all participants reported a decreased sense of stress and improved ability to cope, as result of engaging in mindfulness-based practices. Thus, it appears that the research in this particular area has generally supported the use of mindfulness as a “means of self-care” (Dorian & Killebrew, 2014, p. 156).

From their sample of 259 therapists, Bober and Regehr (2006) found that self-care appeared to be useful in helping to cope with traumatic stress. In fact, it was discovered that self-care was negatively correlated ( $r = -0.04$ ) with participants’ traumatic stress scores, as measured by the Impact of Event scale (Zilberg et al., 1982). Although the finding was not overly significant, the researchers stated that participants in their sample expressed a general belief that self-care was highly beneficial to combating their traumatic stress symptoms (Bober & Regehr, 2006). To offer support to this latter finding, Eastwood and Ecklund (2008) studied a group of 57 residential childcare workers and conceded that workers’ perceptions of success in using self-care strategies was inversely related to reported levels of burnout ( $r = -0.27$ ) and traumatic stress ( $r = -0.25$ ). Both of these studies lend credibility to the notion that self-care can mitigate compassion fatigue symptoms. However, further investigation is needed in order to evaluate the effectiveness of specific self-care strategies.

**Supervision.** The use of effective supervision is deemed to be essential to the prevention of traumatic stress in helpers (Bell et al., 2003). Researchers have claimed that adequate supervision is necessary for the purpose of identifying and/or intervening when traumatic stress begins to impact the helper’s ability to work (Cummins et al., 2007). In other terms, supervision may not only serve to assess and monitor compassion

fatigue in helpers, but may also provide a source of emotional support. In their study on telephone counsellors, Dunkley and Whelan (2006) discovered that perception of a strong supervisory relationship was associated with lower levels of traumatic stress ( $r = -0.36$ ).

**Training and education.** A sizeable amount of literature appears to have emphasized the use of training and education to increase awareness of compassion fatigue and ultimately prevent trauma workers from experiencing the symptoms of secondary traumatic stress (Bell et al., 2003; Kinzel & Nanson, 2000; Salston & Figley, 2003; Sprang et al., 2007). This approach seems to be working, as Sprang et al. (2007) discovered that professionals with specialized trauma training tended to report lower levels of compassion fatigue than those who did not possess this training. This particular study was based on a sample of 1,121 mental health professionals, of which approximately 40% reported having specialized training in trauma work (Sprang et al., 2007). In addition to reporting lower compassion fatigue scores, this 40% also reported higher scores of compassion satisfaction (Sprang et al., 2007). No other studies could be found that have examined the relationship between specialized trauma training and compassion satisfaction.

In the following chapter, ample detail is provided on the specialized training that is provided to victim support volunteers. However, in this chapter, the remaining focus is on introducing some of the material that typically appears in training programs for trauma workers. For instance, a training manual designed by Saakvitne et al. (2000) detailed eight broad topics relating to vicarious traumatization in helpers working with survivors of child abuse. The authors included a trauma framework, defined vicarious traumatization, described the effects of trauma work on the helper, and provided tips on

how to recognize and prevent secondary traumatic stress. With respect to preparing helpers for trauma work, this manual highlighted the importance of adopting proper self-care strategies, developing awareness of when traumatic stress is beginning to impact the helper, and taking advantage of organizational resources (such as supervision) when necessary (Saakvitne et al., 2000). The information in the manual was also supplemented by case examples and practice exercises, many of which seem to serve the purpose of helping workers to integrate the material in a practical manner.

Material covered in other specialized training programs, such as the Accelerated Recovery Program for Compassion Fatigue and Certified Compassion Fatigue Specialist Training, appears to overlap with the aforementioned training manual. For example, the Certified Compassion Fatigue Specialist Training program was specifically designed to familiarize trainees with the “etiology, phenomenology, and treatment/prevention of compassion fatigue” (Gentry, 2002, p. 45). Major components of this training include the practice of self-care and management of anxiety (Gentry, 2002). However, unlike the training manual, this program seems to have incorporated a focus on administering hands-on practice with interventions for compassion fatigue (Gentry, 2002). This unique approach to training has resulted in a training-as-treatment model for dealing with helpers’ compassion fatigue symptoms (Gentry, 2002).

From an empirical perspective, Potter et al. (2013) conducted a modified version of the Certified Compassion Fatigue Specialist Training program for oncology nurses to evaluate the effectiveness of the training. In Potter et al.’s study, the sample of 13 nurses attended two 5-week sessions and were assessed for compassion fatigue a total of four times each: immediately before and after the program was completed, 3 months after the

program was completed, and 6 months after the program was completed. A repeated-measures analysis revealed a decline in all participants' traumatic stress scores immediately after training, as well as a significant drop in these scores 6 months following the completion of the program (Potter et al., 2013).

Based on the information presented thus far in this chapter, additional topics that might be incorporated into a training program may include mindfulness, active coping strategies, and the building of social support systems. To illustrate a more tangible example, in my training as a victim support volunteer, I was taught the importance of incorporating regular self-care practices into my routine and the benefits of establishing a system of peer support.

Overall, it seems that specialized trauma training likely has an influential role in the prevention of compassion fatigue and/or its management. However, some of the research that has investigated this variable reveals the existence of possible deficits in the training that is being provided to trauma workers. For instance, in a sample of 62 telephone counsellors, Dunkley and Whelan (2006) found that over one third did not know what compassion fatigue was; this was despite the fact that 80% of the counsellors had received specialized training in trauma. Although no other studies could be found that replicated their findings, it is interesting to note that Dunkley and Whelan saw no significant differences between counsellors who had received specialized trauma training and counsellors who had not. Their conclusion was based on a series of multiple regression analyses between training and traumatic stress scores, and the methodology appeared fairly sound. Nevertheless, it seems that further research is needed in order to determine the validity of these findings.

In addition to examining training as a preventative measure for compassion fatigue, future research should seek to test the proposed relationship between trauma-focused training and compassion satisfaction. For example, Radey and Figley (2007) have asserted that certain steps can be taken in order to maximize the levels of satisfaction experienced by trauma workers. Specifically, they recommended providing continuous training to increase helpers' awareness of compassion satisfaction, increasing helpers' positivity, and ensuring that helpers understand the value of self-care and social support (Radey & Figley, 2007). In this project, I build upon some of the recommendations set forth by Radey and Figley by describing some of the ways in which victim support volunteers (and other trauma workers) may be able to capitalize on compassion satisfaction.

### **Shifting the Focus to Compassion Satisfaction**

Much of the research and practice literature on compassion fatigue appears to support Radey and Figley's (2007) contention that too much attention is placed on "disorders, psychopathology, dysfunction, and problems" (p. 208). Instead, Radey and Figley emphasized the importance of focusing on compassion satisfaction, which Stamm (2010) defined as being the pleasure and gratification that is gained from being able to effectively help a trauma survivor. Thus far, I have demonstrated what compassion satisfaction is by describing what it is not (compassion fatigue). In the following section, greater attention is paid to compassion satisfaction. The caution is that despite extensive secondary research investigating this topic, the literature on compassion satisfaction seems to be scarce.

**Conceptualizing compassion satisfaction.** In contrast to compassion fatigue, the term compassion satisfaction captures the rewarding aspects of helping individuals recover from trauma. Stamm (2002) described compassion fatigue and compassion satisfaction as a debit and credit system, in which compassion fatigue refers to the costs of being a helper and compassion satisfaction denotes the benefits. Stamm (2002) further asserted, “to understand the negative costs of caring, it is necessary to understand the credits or positive payments that come from caring” (p. 109).

Theoretically speaking, I believe that not all helpers are prone to compassion fatigue, and many are likely to experience the unique rewards of their work (Phelps, Lloyd, Creamer, & Forbes, 2009). For example, Stamm (2010) proposed that trauma workers who experience high levels of compassion satisfaction may feel invigorated and proud of their ability to help others. They may also believe that their work can make a difference in the lives of others and society as a whole (Stamm, 2010). Other perceived benefits of trauma work may include a sense of satisfaction that comes from observing a client’s growth, deeper connections with others, improved personal and professional relationships, a greater appreciation for human resilience, and increased faith in humanity (Pearlman & Saakvitne, 1995a).

Despite the fact that compassion fatigue and compassion satisfaction are separate constructs, helpers may experience both phenomena concomitantly (Harr, 2013). Furthermore, researchers have suggested that compassion satisfaction is a protective mechanism that allows trauma workers to build resilience to compassion fatigue and maintain a sense of well-being (Phelps et al., 2009). For instance, Conrad and Kellar-Guenther (2006) investigated the relationship between compassion satisfaction and

compassion fatigue in a sample of 363 child protection workers. By comparing the average scores of compassion satisfaction, compassion fatigue, and burnout in this sample, the researchers determined that workers with higher rates of compassion satisfaction tended to score lower on compassion fatigue and burnout (Conrad & Kellar-Guenther, 2006). Conrad and Kellar-Guenther also discovered, although 50% of the participants presented a high risk of compassion fatigue, approximately 75% portrayed significant potential for compassion satisfaction. The results of Conrad and Kellar-Guenther's particular study offered support to Stamm's (2002, 2010) notion that compassion satisfaction may have the potential to mediate the effects of compassion fatigue and burnout. However, the exact relationship between the three constructs still remains unclear, and further research is required to determine whether or not compassion satisfaction indeed mitigates the risk of compassion fatigue and/or burnout.

**Factors contributing to compassion satisfaction in helpers.** Much of the existing literature on compassion satisfaction seems to stem from anecdotal reports and theoretical descriptions of how helpers may be positively impacted by their work (Zeidner & Hadar, 2014). Little research, if any, has sought to investigate the factors that may contribute to compassion satisfaction in helpers. The following is a summary of the existing literature on this particular topic.

While examining potential factors that promote compassion fatigue, Cicognani et al. (2009) discovered that social support may increase a helper's level of compassion satisfaction. Specifically, in their sample of 764 emergency workers, Cicognani et al. found a positive correlation between social support and compassion satisfaction rates ( $r = .137$ ). Similarly, in a study of 104 therapists, Killian (2008) observed a strong

positive correlation between the variable of social support and levels of compassion satisfaction ( $\beta = .46$ ). In fact, Killian stated that the “level of reported social support from friends, family, and community was the most significant predictor of compassion satisfaction” (p. 39). Overall, these findings indicated that the availability of social support may influence helpers’ compassion satisfaction rates.

Sprang et al. (2007), in their sample of 1,121 mental health workers, reported posthoc analyses that revealed a tendency for participants with specialized trauma training to score higher on compassion satisfaction than those participants who did not possess this training. This particular finding suggested specialized trauma training may play a role in the promotion of helpers’ compassion satisfaction rates.

Within their sample of 764 emergency workers, Cicognani et al. (2009) noticed that female workers appeared to score higher on compassion satisfaction than their male counterparts, and that the use of an active coping style was positively correlated with compassion satisfaction ( $r = .29$ ). Further research focused on validating this study is needed. Specifically, researchers need to investigate the variable of gender relative to participants’ levels of compassion satisfaction.

Based on the results of the above-mentioned studies, the themes surrounding compassion satisfaction appear to be quite limited. Through this project, I intend to present additional factors that may contribute to higher rates of compassion satisfaction in helpers.

### **Summary**

My focus in Chapter 3 was to provide the reader with a summary of current research and practice literature on compassion fatigue and compassion satisfaction. In

addition to highlighting several gaps in the literature, I described the need for researchers to focus more on compassion satisfaction, and thus provided additional support for my project. My next step is to offer a brief overview of some of the training and peer support that is available (or should be available) to victim support volunteers in the Province of Alberta. In the ensuing chapter, I provide the reader with further information on the target group for this project. Thereafter, in Chapter 5, I address the strengths and limitations of this project, as well as highlight areas for future research.

## **Chapter 4: Training and Peer Support in Victim Services**

My objective in this chapter is to provide the reader with background information on victim support services. First, the reader will be acquainted with the duties of a victim support volunteer, specifically in Alberta. Second, I will provide insight as to how training and peer support operate in the context of Victim Services in Alberta. In addition to describing the training, I will offer my critical analysis of the need to offer more attention towards compassion satisfaction. Integrated throughout this chapter will be my own experiences and observations as a victim support volunteer in the Province of Alberta.

### **The Role of Victim Services in Alberta**

Victim Services came into effect in Alberta in 1988, with a mandate to make a positive difference in the lives of people who have been affected by crime or tragedy (Government of Alberta, 2011). The fundamental role of Victim Services is to provide support, information, and referrals to survivors of criminal victimization. Services may be provided to victims either in person or via telephone. There are currently 126 Victim Service Units operating in Alberta (Alberta Justice and Solicitor General, 2013).

Although these units are housed and operated by the police, they are primarily staffed by volunteer civilian members.

I was a victim support volunteer for 2 years. Given my own experience in the role, the specific duties of a victim support volunteer often include the following:

- Initiating phone contact with victims of personal crime or tragedy in order to offer emotional support, information on the status of the police file, court

updates, and referrals to community agencies for counselling, bereavement, and other appropriate or necessary support services.

- Providing court preparation and court accompaniment services to victims and/or witnesses who are subpoenaed to testify in criminal matters.
- Arranging and/or attending on-scene support for victims of personal crime or tragedy who require face-to-face meetings with volunteers.
- Accurately documenting activities and adhering to police policy and procedures.
- Possessing adequate knowledge of the criminal justice system and various types of criminal offences.

In fulfilling these duties, volunteers are often exposed to a broad range of traumatic material, as the job requires listening to stories of domestic violence, sexual assault, robbery, suicide, and death. As outlined in Chapter 3, this is a process that may possibly result in an increased vulnerability to compassion fatigue. Thus, it seems important for volunteers to obtain training and resources that help them to effectively cope in the face of stress and retain a sense of gratification with the work they do. The following section describes the training that is currently provided to victim support volunteers in Alberta.

### **Victim Services Training**

In 2011, the Government of Alberta released a specialized training curriculum for victim support volunteers in order to prepare them for work with survivors of criminal victimization or personal tragedy. The training is split into two parts: an online component and a face-to-face component. In the following section, I briefly outline the

training provided to volunteers, and specifically indicate whether or not any material on compassion satisfaction is incorporated into this training.

**Online training.** All Alberta-based victim support workers are required to participate in a standardized, 70-hour online training program (Government of Alberta, 2011). Volunteers are provided with a copy of the training program's e-Learning workbook, which is a 913-page binder separated into 35 different modules plus a glossary of terms. Each online module covers a specific topic relevant to Victim Services, such as an introduction to the criminal justice system and information on how specific criminal offences may affect a victim.

Of these 35 online modules released in 2011, only one module is designed to educate volunteers on the effects of compassion fatigue—the self-care module. The objectives of this self-care module are to understand the impact that working with victims of crime (or trauma) has on victim support volunteers and others who take on a helping role, understand the importance of self-care, learn how to implement strategies that will foster and strengthen resiliency, recognize when an individual may be experiencing compassion fatigue symptoms, and learn when to request and/or provide support for fellow volunteers, as necessary (Government of Alberta, 2011).

Specific activities included in this module are a self-assessment of sources of stress and an evaluation of how stress impacts the volunteer, case examples accompanied by critical-thinking questions, and questions for self-reflection. From my perspective, and based on the information addressed in Chapter 2, it appears that the module focuses primarily on recognizing and preventing compassion fatigue, with an emphasis on developing self-care strategies to effectively cope with the symptoms of compassion

fatigue. No reference is made to compassion satisfaction or enhancing the sense of gratification that is obtained from victim support work.

**Classroom training.** The training program for victim support volunteers also includes some face-to-face sessions. I noticed these sessions are limited in terms of the time instructors spend on self-care and discussing the rewards of volunteering. As a volunteer, I was required to attend full-day classroom sessions that covered a number of topics, including safety, court procedures, crisis intervention and suicide prevention, grief support, and resiliency. I attended approximately 15 to 20 professional development sessions over the course of my tenure as a volunteer at Victim Services, with an average of eight to 10 per year. Of all these opportunities, only one classroom session on self-care was held. This was a half-day presentation delivered by an expert in the compassion fatigue field, which covered the concepts of compassion fatigue and vicarious trauma. Based upon my notes and from what I recall, the session focused primarily on the value of peer support and the need to adopt appropriate self-care strategies, and the instructor presented case examples of how compassion fatigue may affect victim support volunteers. I also recall that the instructor briefly mentioned compassion satisfaction and the importance of retaining a sense of gratification from the work. My sense from my professional development training is that compassion fatigue was continually referenced, with minimal reference being made to compassion satisfaction. Perhaps other trainers place different emphasis on self-care and compassion satisfaction, as I have gathered there is no uniform classroom curriculum like that of the online training component.

## Peer Support

Another source of training that is provided when one volunteers with Victim Services is learning to ask for and receive support from fellow volunteers. With respect to preventing the impact of compassion fatigue, half of the online training module on compassion fatigue is dedicated towards recognizing when traumatic stress is affecting yourself or another volunteer. The operating premise behind the need to connect with fellow volunteers states that those "who have responded to trauma, and been impacted by it, better understand and relate to individuals trying to deal with the effects of their work and are in a unique position to offer assistance" (Government of Alberta, 2011, p. 155). Similarly, the classroom training session I attended highlighted the importance of peer support as a preventative measure for compassion fatigue. Little attention, if any, appeared to focus on the use of peer support to enhance a volunteer's sense of compassion satisfaction.

Along with educating volunteers on the value of peer support, Victim Service Units also have the option of scheduling regular peer-support meetings in which volunteers are asked to get together with the coordinators and discuss how the work has been positively or negatively affecting them. These peer-support meetings may be subject to variability, because there seems to be no standardized method of conducting them. Instead, units may or may not choose to schedule meetings, and each unit may have its own system for running the meetings. In the unit I worked at, for instance, peer-support meetings were called case-management meetings and volunteer attendance was optional. Although my unit would schedule the meetings on a monthly basis, volunteers were given the choice of whether or not to attend. Given my understanding of Victim

Services, I am aware that this particular system may vary between units. For example, volunteers in other units have mentioned peer-support meetings are considered mandatory by the unit, and volunteers must attend these meetings on a regular basis.

### **Integrating Compassion Satisfaction into Victim Services Training**

Given the nature of their work, it could be argued that victim support volunteers are indeed susceptible to experiencing high levels of stress on the job, including that of compassion fatigue, which can be detrimental to their well-being. This inherent risk of compassion fatigue is likely to be balanced by the experience of compassion satisfaction. Thus, it becomes paramount for these volunteers to be aware of both the risks associated with compassion fatigue and the benefits of compassion satisfaction. The current approach of teaching victim support volunteers about compassion fatigue, with little to no emphasis on compassion satisfaction, may not be the most effective, as it potentially limits volunteers' abilities to capitalize on the benefits of their work. However, with the provision of increased knowledge and awareness of compassion satisfaction, I suspect that victim support volunteers may find it easier to experience enhanced levels of compassion satisfaction on the job, which in turn may also help them to maintain a healthier sense of well-being.

From an organizational perspective, victim support volunteers play a crucial role in Victim Services, as they aid the police in serving individuals who have been affected by crime and tragedy. Based on my own experience in the role, this type of work requires much time, patience, and empathy on part of the volunteers, which likely has implications for volunteer productivity and retention. As a former victim support volunteer, I noticed that my motivation for the work was primarily intrinsic. Rather than

on a promise of monetary compensation or other extrinsic rewards, I operated on the sense of fulfillment I experienced from being to help others. For me, the difficulty was in learning to maintain and enhance this sense of fulfillment, which I now identify as compassion satisfaction, and I eventually began to experience a decreased sense of motivation to stay. Whether or not other victim support volunteers have experienced a similar situation is yet to be investigated, but, for now, several researchers have hinted that compassion satisfaction may influence the productivity and retention of trauma workers (Bride & Kintzle, 2011; Conrad & Kellar-Guenther, 2006; Pearlman & Saakvitne, 1995b). Thus, it could be argued that the act of teaching victim support volunteers about compassion satisfaction may not only assist them in experiencing increased fulfillment in their work, but may also motivate them towards greater productivity with a decreased desire to leave Victim Services. For victims of crime and tragedy, this likely means the provision and maintenance of a higher quality of service, and, for Victim Services, this form of training may result in the possibility of increased volunteer retention.

### **Summary**

My experience as a victim support volunteer, coupled with a review of the research on compassion fatigue and compassion satisfaction, has ultimately resulted in the development of this project. In this chapter, I described how Victim Services and victim support volunteers operate in the Province of Alberta. I also described the training that is provided to these volunteers, highlighting the lack of time spent on compassion satisfaction.

## Chapter 5: Discussion

In general, I had three objectives while completing this project: (a) to provide a comprehensive review of the literature on compassion fatigue and compassion satisfaction and identify the need for more focus on compassion satisfaction; (b) to describe the current status of training that is provided to volunteer victim support workers in the Province of Alberta, with emphasis on what training is provided on compassion satisfaction; and (c) to make a case for greater emphasis on compassion satisfaction to be incorporated into this training. My aim in this chapter is to summarize how each objective was met. Thereafter, I speak to the strengths and limitations of this project, as well as describe several avenues for future research.

### Research Objectives

In this section, I seek to provide the reader with a summary of the three project objectives. I also provide an explanation of how each of these objectives was met.

**Objective one: Current literature on compassion fatigue and compassion satisfaction.** In this project, I devoted an entire chapter (see Chapter 3) towards the critical analysis of available research on compassion fatigue and compassion satisfaction. Within Chapter 3, I provided detailed explanations of the two concepts and highlighted several gaps in the research. As a result of this analysis, it became evident that researchers tend to place greater attention on the prevention of compassion fatigue as opposed to the enhancement of compassion satisfaction. Further research needs to be conducted on enhancing compassion satisfaction in order to fully understand the role that compassion satisfaction plays in the lives of trauma workers and other helpers.

**Objective two: Victim services training in the Province of Alberta.** In the previous chapter, I supplied my own account of the training that is provided to victim support volunteers in the Province of Alberta. Specifically, I described the material that was presented during my training and pointed out what I saw to be a lack of emphasis on compassion satisfaction.

**Objective three: Incorporating compassion satisfaction into victim services training.** Based on my own personal experiences as a victim support volunteer and the knowledge I have acquired while conducting the literature review in Chapter 3, I presented my rationalization for the integration of more material on compassion satisfaction into Victim Services training. I made reference to both personal and organizational implications, namely proposed connections between compassion satisfaction and the improved well-being, productivity, and retention of volunteers. Most importantly, I sought to fill this gap by designing a resource that Victim Services can use to teach volunteers how to enhance their experiences of compassion satisfaction. The creation of this resource is a vital element of this project, as it is one method by which more information on compassion satisfaction can be readily integrated into Victim Services training programs.

### **Project Limitations**

Despite some noteworthy strengths, which I describe in the following section, it is important to note that this project is not free of limitations. For instance, one significant limitation is the lack of available research on compassion satisfaction. Not only did this lack of information restrict the scope and generalizability of my work by resulting in potentially biased or unsupported conclusions, it also limited my ability to identify clear

examples of how compassion satisfaction can be integrated into Victim Services training. Given that there appears to be no concrete data to verify my conclusions, the reader is advised to interpret these conclusions with caution.

Another limitation to this project is my own bias in assessing Victim Services training. My participation in the training program took place several years ago, and thus there may be gaps in my memory with respect to the training provided. Additionally, there exists the possibility of changes being implemented to the program over the last 2 to 3 years that I may not be fully aware of, and hence cannot speak to in this project.

Last, but not least, my inexperience as a researcher is likely to have impacted this project. For example, although I completed a thorough scan of the available material on compassion fatigue and compassion satisfaction, it is possible that I may have overlooked information relevant to the topic. Also, as a novice researcher, many of my ideas are likely to differ from those of others in the field. For instance, I suspect that a survey of other researchers, victim support workers, or even therapists may generate perspectives that I have not contemplated.

### **Project Strengths**

Regardless of the limitations, the lack of research focus on compassion satisfaction is also a primary strength of this project, as it has enabled me to identify and pursue a gap in the literature. Pursuant to an in-depth review of the literature, not only was I surprised by the lack of focus on compassion satisfaction, but also by the even lesser amount of attention that appears to be placed on individuals who volunteer their time as trauma workers—such as on crisis lines and in Victim Services. In addition to being a practical application of current knowledge, the creation of a resource for victim

support volunteers to assist in boosting their levels of compassion satisfaction is a method by which this particular gap in the literature begins to be addressed.

Another significant strength of this project is the provision of an updated account of the literature on compassion fatigue and compassion satisfaction. The information presented in this project is supported by an in-depth search of the literature, as well as a transparent research process. The fact that I had the ideas vetted by two professors, in addition to my supervisor and an external reader, mitigated my novice research skills.

Finally, this project is also unique in that it is based on my own lived experience as a victim support volunteer. This qualitative element not only provides a richer feel to the information being presented, but also allows the reader to have a deeper sense of the material—one that statistics alone may not be able to provide. Furthermore, by sharing my own experience, I am likely enhancing the practicality and relatability of the information in the eyes of the reader.

### **Future Directions**

Although the term compassion satisfaction appears to be recognized in the literature, my review of available research on compassion fatigue and compassion satisfaction verifies the lack of focus on learning how to maximize compassion satisfaction in helpers. Studies that have measured levels of compassion satisfaction in helpers often centre more on reducing compassion fatigue. For example, Cicognani et al. (2009), Sprang et al. (2007), and Sprang, Craig, and Clark (2009) conducted studies that involved measuring helpers' levels of compassion fatigue, compassion satisfaction, and burnout. Nevertheless, a review of each study gives the impression that the researchers were more attentive to compassion fatigue, with little consideration being given to

compassion satisfaction. Within my project, I intended to step away from this particular trend by focusing on factors that may contribute to the enhancement of compassion satisfaction in helpers. In the future, I am hoping that researchers can build upon this work by verifying the ideas and critiques presented in this project, as well as determining whether or not these ideas and critiques are validated by other researchers and members of the Victim Services community. I would also like to see more research studies that utilize compassion satisfaction as primary focus. For instance, researchers may be able to obtain a deeper understanding of the role compassion satisfaction plays in the lives of helpers by conducting qualitative studies that directly examine helpers' experiences of it. It may even be useful to conduct further quantitative studies with specific focus on examining and validating noted factors that possibly contribute to compassion satisfaction or enhance helpers' experiences of it.

Finally, another interesting avenue to explore would be the formal evaluation of current education and training programs in terms of whether or not they include material on compassion satisfaction, including strategies for enhancing helpers' experiences of compassion satisfaction. Along with reviewing the information from training materials, researchers can design and administer surveys to individuals who have taken the training programs in order to determine whether or not information on compassion satisfaction has been provided, as well as understood. I believe this particular approach is the most powerful because it has the potential to enhance the applicability of the research on compassion satisfaction—in other words, it is a translation of theory into practice.

## **Conclusion**

My original intentions with this project included the promotion of a more positive perspective of trauma work, as well as to make a practical and significant contribution to traumatology literature. However, as I continued to piece the work together, I found that this project became more than just a professional endeavour. Instead, it became a part of my own personal journey to understand how individuals in helping professions—be it a paid position or a form of voluntary service—can continue to thrive and experience fulfillment despite being regularly exposed to trauma. Through my exploration of current literature on compassion fatigue and compassion satisfaction, I learned how important it is for helpers to not only understand how to prevent the negative effects of compassion fatigue, but also how to experience the benefits of compassion satisfaction. As I reminisce over my time as a victim support volunteer, I find myself wishing that I had a resource to consult when I was striving to experience greater fulfillment in my role as a helper. Nevertheless, I am grateful for that experience, as it has encouraged me to create a resource that I hope will be useful to the Victim Services community—and perhaps many others in helping roles.

## References

- Alberta Justice and Solicitor General. (2013). *Local victim service units*. Retrieved from [https://www.solgps.alberta.ca/programs\\_and\\_services/victim\\_services/Pages/VictimServiceUnits.aspx](https://www.solgps.alberta.ca/programs_and_services/victim_services/Pages/VictimServiceUnits.aspx)
- American Psychiatric Association. (2013). Trauma and stressor-related disorders. In *Diagnostic and statistical manual of mental disorders* (5th ed.). doi:10.1176/appi.books.9780890425596.991543
- American Psychological Association. (2010). *Publication manual of the American Psychological Association* (6th ed.). Washington, DC: Author.
- Baird, K., & Kracen, A. C. (2006). Vicarious traumatization and secondary traumatic stress: A research synthesis. *Counselling Psychology Quarterly, 19*, 181–188. doi:10.1080/09515070600811899
- Bell, H., Kulkarni, S., & Dalton, L. (2003). Organizational prevention of vicarious trauma. *Families in Society: The Journal of Contemporary Social Services, 84*, 463–470.
- Bober, T., & Regehr, C. (2006). Strategies for reducing secondary or vicarious trauma: Do they work? *Brief Treatment and Crisis Intervention, 6*, 1–9. doi:10.1093/brief-treatment/mhj001
- Birck, A. (2001). Secondary traumatization and burnout in professionals working with torture survivors. *Traumatology, 7*, 85–90. doi:10.1177/153476560100700203
- Bride, B. E. (2007). Prevalence of secondary traumatic stress in social workers. *Social Work, 52*, 63–70. doi:10.1093/sw/52.1.63

- Bride, B. E., Jones, J. L., & Macmaster, S. A. (2007). Correlates of secondary traumatic stress in child protective services workers. *Journal of Evidence-Based Social Work*, 4(3/4), 69–80. doi:10.1300/J394v04n03\_05
- Bride, B. E., & Kintzle, S. (2011). Secondary traumatic stress, job satisfaction, and occupational commitment in substance abuse counselors. *Traumatology*, 17(1), 22–28. doi:10.1177/1534765610395617
- Bride, B. E., Radey, M., & Figley, C. R. (2007). Measuring compassion fatigue. *Clinical Social Work Journal*, 35, 155–163. doi:10.1007/s10615-007-0091-7
- Brown, K. W., & Ryan, R. M. (2003). The benefits of being present: Mindfulness and its role in psychological well-being. *Journal of Personality and Social Psychology*, 84, 822–848. doi:10.1037/0022-3514.84.4.822
- Butt, R. L., & Retallick, J. (2002). Professional well-being and learning: A study of administrator-teacher workplace relationships. *Journal of Educational Enquiry*, 3(1), 17–34.
- Butt, R. L., & Retallick, J. (2004). Professional well-being and learning: A study of teacher-peer workplace relationships. *Journal of Educational Enquiry*, 5(1), 85–88.
- Canadian Psychological Association. (2000). *Canadian code of ethics for psychologists* (3rd ed.). Retrieved from <http://www.cpa.ca/cpasite/UserFiles/Documents/Canadian%20Code%20of%20Ethics%20for%20Psycho.pdf>
- Canadian Psychological Association. (2001). *Companion manual to the Canadian code of ethics for psychologists* (3rd ed.). Ottawa, ON, Canada: Author.

- Christopher, J. C., & Maris, J. A. (2010). Integrating mindfulness as self-care into counselling and psychotherapy training. *Counselling and Psychotherapy Research, 10*, 114–125. doi:10.1080/14733141003750285
- Cicognani, E., Pietrantonio, L., Palestini, L., & Prati, G. (2009). Emergency workers' quality of life: The protective role of sense of community, efficacy beliefs and coping strategies. *Social Indicators Research, 94*, 449–463. doi:10.1007/s11205-009-9441-x
- Collins, S., & Long, A. (2003). Working with the psychological effects of trauma: Consequences for mental health-care workers – a literature review. *Journal of Psychiatric and Mental Health Nursing, 10*, 417–424. doi:10.1046/j.1365-2850.2003.00620.x
- Conrad, D., & Kellar-Guenther, Y. (2006). Compassion fatigue, burnout, and compassion satisfaction among Colorado child protection workers. *Child Abuse & Neglect, 30*, 1071–1080. doi:10.1016/j.chiabu.2006.03.009
- Cummins, P. N., Massey, L., & Jones, A. (2007). Keeping ourselves well: Strategies for promoting and maintaining counselor wellness. *Journal of Humanistic Counseling, Education and Development, 46*, 35–49. doi:10.1002/j.2161-1939.2007.tb00024.x
- Cunningham, M. (2003). Impact of trauma work on social work clinicians: Empirical findings. *Social Work, 48*, 451–459. doi:10.1093/sw/48.4.451
- Cyr, C., & Dowrick, P. W. (1991). Burnout in crisisline volunteers. *Administration and Policy in Mental Health and Mental Health Services Research, 18*, 343–354. doi:10.1007/BF00707000

- Davis, M. H. (1983). Measuring individual differences in empathy: Evidence for a multi-dimensional approach. *Journal of Personality and Social Psychology*, *44*, 113–126. doi:10.1037/0022-3514.44.1.113
- Dorian, M., & Killebrew, J. E. (2014). A study of mindfulness and self-care: A path to self-compassion for female therapists in training. *Women & Therapy*, *37*, 155–163. doi:10.1080/02703149.2014.850345
- Dunkley, J., & Whelan, T. A. (2006). Vicarious traumatization in telephone counsellors: Internal and external influences. *British Journal of Guidance & Counselling*, *34*, 451–469. doi:10.1080/03069880600942574
- Eastwood, C. D., & Ecklund, K. (2008). Compassion fatigue risk and self-care practices among residential center childcare workers. *Residential Treatment for Children & Youth*, *25*, 103–122. doi:10.1080/08865710802309972
- Figley, C. R. (1995). Compassion fatigue as secondary traumatic stress disorder: An overview. In C. R. Figley (Ed.), *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized* (pp. 1–20). New York, NY: Brunner/Mazel.
- Gentry, J. E. (2002). Compassion fatigue: A crucible of transformation. *Journal of Trauma Practice*, *1*(3/4), 37–61. doi:10.1300/J189v01n03\_03
- Government of Alberta. (2011). *Victim services e-learning workbook*. Edmonton, AB, Canada: Queen's Printer.
- Hargrave, P. A., Scott, K. M., & McDowall, J. (2006). To resolve or not to resolve: Past trauma and secondary traumatic stress in volunteer crisis workers. *Journal of Trauma Practice*, *5*, 37–55. doi:10.1300/J189v05n02\_03

- Harr, C. (2013). Promoting workplace health by diminishing the negative impact of compassion fatigue and increasing compassion satisfaction. *Social Work & Christianity, 40*(1), 71–88.
- Horowitz, M., Wilner, N., & Alvarez, W. (1979). Impact of Event Scale: A measure of subjective stress. *Psychological Medicine, 41*, 209–218.
- Jaffe, P. G., Crooks, C. V., Dunford-Jackson, B. L., & Town, J. M. (2003). Vicarious trauma in judges: The personal challenge of dispensing justice. *Juvenile and Family Court Journal, 54*(4), 1–9. doi:10.1111/j.1755-6988.2003.tb00083.x
- Jenkins, S. R., & Baird, S. (2002). Secondary traumatic stress and vicarious trauma: A validation study. *Journal of Traumatic Stress, 15*, 423–432.  
doi:10.1023/A:1020193526843
- Joseph, S., Andrews, B., Williams, R., & Yule, W. (1992). Crisis support and psychiatric symptomology in adult survivors of the Jupiter cruise ship disaster. *British Journal of Clinical Psychology, 31*(Pt. 1), 63–73.
- Kadambi, M. A., & Ennis, L. (2004). Reconsidering vicarious trauma: A review of the literature and its' limitations. *Journal of Trauma Practice, 3*(2), 1–21.  
doi:10.1300/J189v03n02\_01
- Kalliath, T. J., O'Driscoll, M. P., Gillespie, D. F., & Bluedorn, A. C. (2000). A test of the Maslach burnout inventory in three samples of healthcare professionals. *Work & Stress: An International Journal of Work, Health & Organisations, 14*, 35–50.  
doi:10.1080/026783700417212

- Killian, K. D. (2008). Helping till it hurts? A multimethod study of compassion fatigue, burnout, and self-care in clinicians working with trauma survivors. *Traumatology, 14*(2), 32–44. doi:10.1177/1534765608319083
- Kinzel, A., & Nanson, J. (2000). Education and de-briefing: Strategies for preventing crises in crisis-line volunteers. *Crisis, 21*, 126–134. doi:10.1027//0227-5910.21.3.126
- Krippner, S., Pitchford, D. B., & Davies, J. A. (2012). *Post-traumatic stress disorder (biographies of disease)*. Santa Barbara, CA: Greenwood/ABC-CLIO.
- Lawson, G., & Myers, J. E. (2011). Wellness, professional quality of life, and career-sustaining behaviors: What keeps us well? *Journal of Counseling & Development, 89*, 163–171. doi:10.1002/j.1556-6678.2011.tb00074.x
- Lee, R. T., & Ashforth, B. E. (1990). On the meaning of Maslach's three dimensions of burnout. *Journal of Applied Psychology, 75*, 743–747.
- Lerias, D., & Byrne, M. K. (2003). Vicarious traumatization: Symptoms and predictors. *Stress and Health, 19*, 129–138. doi:10.1002/smi.969
- MacRitchie, V., & Leibowitz, S. (2010). Secondary traumatic stress, level of exposure, empathy and social support in trauma workers. *South African Journal of Psychology, 40*, 149–158. doi:10.1177/008124631004000204
- Maslach, C., & Jackson, S. E. (1981). The measurement of experienced burnout. *Journal of Occupational Behaviour, 2*, 99–113. doi:10.1002/job.4030020205
- McCann, I. L., & Pearlman, L. A. (1990). Vicarious traumatization: A framework for understanding the psychological effects of working with victims. *Journal of Traumatic Stress, 3*, 131–149. doi:10.1007/BF00975140

- McKim, L. L., & Smith-Adcock, S. (2014). Trauma counsellors' quality of life. *International Journal for the Advancement of Counselling, 36*, 58–69. doi:10.1007/s10447-013-9190-z
- Newell, J. M., & MacNeil, G. A. (2010). Professional burnout, vicarious trauma, secondary traumatic stress, and compassion fatigue: A review of theoretical terms, risk factors, and preventive methods for clinicians and researchers. *Best Practice in Mental Health, 6*(2), 57–69.
- O'Sullivan, J., & Whelan, T. A. (2011). Adversarial growth in telephone counsellors: Psychological and environmental influences. *British Journal of Guidance & Counselling, 39*, 307–323. doi:10.1080/03069885.2011.567326
- Pearlman, L. A. (1996). Psychometric review of TSI belief scale revision L. In B. H. Stamm (Ed.), *Measurement of stress, trauma and adaptation* (pp. 415–417). Lutherville, MD: Sidran Press.
- Pearlman, L. A., & Mac Ian, P. S. (1995). Vicarious traumatization: An empirical study of the effects of trauma work on trauma therapists. *Professional Psychology: Research and Practice, 26*, 558–565. doi:10.1037/0735-7028.26.6.558
- Pearlman, L. A., & Saakvitne, K. W. (1995a). *Trauma and the therapist: Countertransference and vicarious traumatization in psychotherapy with incest survivors*. New York, NY: W. W. Norton.
- Pearlman, L. A., & Saakvitne, K. W. (1995b). Treating therapists with vicarious traumatization and secondary traumatic stress disorders. In C. R. Figley (Ed.), *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized* (pp. 150–179). New York, NY: Brunner/Mazel.

- Phelps, A., Lloyd, D., Creamer, M., & Forbes, D. (2009). Caring for carers in the aftermath of trauma. *Journal of Aggression, Maltreatment & Trauma, 18*, 313–330. doi:10.1080/10926770902835899
- Potter, P., Deshields, T., Berger, J. A., Clarke, M., Olsen, S., & Chen, L. (2013). Evaluation of a compassion fatigue resiliency program for oncology nurses. *Oncology Nursing Forum, 40*, 180–187. doi:10.1188/13.ONF.180-187
- Radey, M., & Figley, C. R. (2007). The social psychology of compassion. *Clinical Social Work Journal, 35*, 207–214. doi:10.1007/s10615-007-0087-3
- Saakvitne, K. W., Gamble, S., Pearlman, L. A., & Lev, B. T. (2000). *Risking connection: A training curriculum for working with survivors of childhood abuse*. Baltimore, MD: The Sidran Press.
- Saakvitne, K. W., & Pearlman, L. A. (1996). *Transforming the pain: A workbook on vicarious traumatization*. New York, NY: W. W. Norton.
- Salston, M., & Figley, C. R. (2003). Secondary traumatic stress effects of working with survivors of criminal victimization. *Journal of Traumatic Stress, 16*, 167–174. doi:10.1023/A:1022899207206
- Schauben, L. J., & Frazier, P. A. (1995). Vicarious trauma: The effects on female counselors of working with sexual violence survivors. *Psychology of Women Quarterly, 19*, 49–64. doi:10.1111/j.1471-6402.1995.tb00278.x
- Sprang, G., Clark, J. J., & Whitt-Woosley, A. (2007). Compassion fatigue, compassion satisfaction, and burnout: Factors impacting a professional's quality of life. *Journal of Loss and Trauma, 12*, 259–280. doi:10.1080/15325020701238093

- Sprang, G., Craig, C., & Clark, J. (2009). Secondary traumatic stress and burnout in child welfare workers: A comparative analysis of occupational distress across professional groups. *Child Welfare, 90*(6), 149–169.
- Stamm, B. H. (2002). Measuring compassion satisfaction as well as fatigue: Developmental history of the compassion satisfaction and fatigue test. In C. R. Figley (Ed.), *Treating compassion fatigue* (pp. 107–119). New York, NY: Brunner-Routledge.
- Stamm, B. H. (2005). *The Professional Quality of Life Scale: Compassion satisfaction, burnout & compassion fatigue/secondary trauma scales*. Lutherville, MD: Sidran Press.
- Stamm, B. H. (2010). *The concise ProQOL manual* (2nd ed.). Retrieved from [http://www.proqol.org/uploads/ProQOL\\_Concise\\_2ndEd\\_12-2010.pdf](http://www.proqol.org/uploads/ProQOL_Concise_2ndEd_12-2010.pdf)
- Stamm, B. H., & Figley, C. R. (1996). *Compassion satisfaction and fatigue test*. Retrieved from [http://www.practicenotes.org/vol10\\_n3/Stamm.pdf](http://www.practicenotes.org/vol10_n3/Stamm.pdf)
- Thieleman, K., & Cacciatore, J. (2014). Witness to suffering: Mindfulness and compassion fatigue among traumatic bereavement volunteers and professionals. *Social Work, 59*, 34–41. doi:10.1093/sw/swt044
- Thomas, J. T., & Otis, M. D. (2010). Intrapsychic correlates of professional quality of life: Mindfulness, empathy, and emotional separation. *Journal of the Society for Social Work and Research, 1*, 83–98. doi:10.5243/jsswr.2010.7

- Varra, E. M., Pearlman, L. A., Brock, K. J., & Hodgson, S. T. (2008). Factor analysis of the trauma and attachment belief scale: A measure of cognitive schema disruption related to traumatic stress. *Journal of Psychological Trauma, 7*(3), 186–196. doi:10.1080/19322880802266813
- Zeidner, M., & Hadar, D. (2014). Some individual difference predictors of professional well-being and satisfaction of health professionals. *Personality and Individual Differences, 65*, 91–95. doi:10.1016/j.paid.2014.01.032
- Zilberg, N. J., Weiss, D. S., & Horowitz, M. J. (1982). Impact of event scale: A cross-validation study and some empirical evidence supporting a conceptual model of stress response syndromes. *Journal of Consulting and Clinical Psychology, 50*, 407–414. doi:10.1037/0022-006X.50.3.407

**Appendix A**

**FROM TRAUMATIZED TO ENERGIZED: HELPING VICTIM SUPPORT  
VOLUNTEERS CULTIVATE COMPASSION SATISFACTION IN THE FACE  
OF CRISIS**

## Preamble

### Purpose

The following is the applied element of this project—a manuscript prepared for submission to *Crisis: The Journal of Crisis Intervention and Suicide Prevention* (<http://www.hogrefe.com/periodicals/crisis-the-journal-of-crisis-intervention-and-suicide-prevention/>). This manuscript will be provided to the editor of the journal by no later than February 2016, following receipt of the project's approval by the University of Lethbridge. I, Alisha M. Shivji, am the primary author of the article, and the secondary author is my project supervisor, Dawn L. McBride.<sup>1</sup>

In conjunction with underscoring a concept that requires further attention and research in the traumatology field, our purpose with this manuscript is to supply a practical and valuable resource to the Victim Services community. In this manuscript we call attention to the general lack of focus on compassion satisfaction, as well as propose several strategies by which individuals who volunteer their time as victim support workers may learn to enhance their experience of compassion satisfaction on the job.

### Journal's Instructions to Authors

The guidelines for preparation and submission of a manuscript to *Crisis: The Journal of Crisis Intervention and Suicide Prevention* are set out in Appendix D of this project. It should be noted that the journal sets a maximum limit of 4,000 words for manuscript submissions to their "Clinical Insights and Research Trends" sections, and 1,500 words for submissions to their "Short Reports" section.

---

<sup>1</sup> The format and structure of this preamble has been adapted from *The dual role of psychologist-researcher: Using psychological assessments for research purposes* (Masters of Counselling project), by E. Kewley, 2013, AB, Canada: University of Lethbridge. Copyright 2013 by E. Kewley.

### **Formatting Style Requirement**

In line with the journal's specifications, this manuscript has been structured as per the standards set out in the 6th edition of the *Publication Manual of the American Psychological Association* (American Psychological Association, 2010).

### **Statement of Copyright**

The contents of this work are subject to copyright. Permission from me, as the author, or my supervisor (Professor Dawn McBride) should be obtained prior to the utilization of any material from this project and draft manuscript. To seek permission, please contact my supervisor via email at dawn.mcbride@uleth.ca. The reader may use ideas from this work provided they are referenced as follows:

*In-text:*

(Shivji, 2015)

*Full reference:*

Shivji, A. M. (2015). *Compassion satisfaction in victim services: Focusing on the rewards of trauma work* (Unpublished master's project). University of Lethbridge, Lethbridge, Alberta.

## Title Page

**Article Title:** From Traumatized to Energized: Helping Victim Support Volunteers Cultivate Compassion Satisfaction in the Face of Crisis

**Journal Name:** *Crisis: The Journal of Crisis Intervention and Suicide Prevention*

**Full name and details of corresponding author:**

(To be inserted when manuscript is submitted for publication)

**Full name and details of co-author:**

(To be inserted when manuscript is submitted for publication)

**Acknowledgements:**

(To be inserted when manuscript is submitted for publication)

### **Abstract**

Victim support volunteers are often a first line of intervention for individuals affected by crime or tragedy. In their efforts to provide support to survivors of criminal victimization, these volunteers are exposed to an intense array of traumatic events. Although this process increases volunteers' risks of experiencing traumatic stress and falling into crisis themselves, it is possible for them to counter this negative impact and experience fulfillment in witnessing victims transform into survivors (Radey & Figley, 2007). Compassion satisfaction (CS) denotes the positive feelings and energy derived from helping others to recover from crisis and trauma (Stamm, 2002). CS plays an important role in the lives of victim support volunteers, as it functions to strengthen resiliency and sustain well-being. However, there is insufficient research focus on CS and even less attention is placed on teaching victim support volunteers how to develop CS. In this article, we propose strategies that victim support volunteers (and other crisis workers) may use to cultivate greater CS in their work. We hope this information can be integrated into Victim Services training to promote a more optimistic perspective of victim support work and shift the focus from being traumatized by the work to being energized.

*Keywords:* compassion satisfaction, victim services, volunteers, training

## **From Traumatized to Energized: Helping Victim Support Volunteers Cultivate Compassion Satisfaction in the Face of Crisis**

Volunteers play a crucial role in Victim Services, as they assist police in supporting individuals affected by crime and tragedy. The nature of this work involves exposure to a considerable amount of traumatic material—numerous accounts of domestic violence, sexual assault, kidnapping, robbery, suicide, and even death. Researchers indicated that continuous exposure to the traumatic experiences of others has both positive and negative implications (Harr, 2013; McKim & Smith-Adcock, 2014; Radey & Figley, 2007; Stamm, 2002). Compassion fatigue (CF), vicarious trauma, and burnout are constructs used to describe the psychological and emotional costs of aiding individuals who have experienced some form of crisis or trauma (Collins & Long, 2003; Figley, 1995; Newell & MacNeil, 2010; Salston & Figley, 2003). In bearing witness to the pain of others, it is not uncommon to experience stressful reactions (Figley, 2002) and significant changes in cognitive, emotional, or behavioral functioning (Bride, Radey, & Figley, 2007). Although researchers have regularly emphasized the negative impact that stems from helping others in crisis, insufficient attention is placed on the unique rewards of the work (Radey & Figley, 2007). This contrast to CF is termed compassion satisfaction, and it is described as being “often overlooked” (Lawson & Meyers, 2011, p. 164).

Within this article, we present the current status of compassion satisfaction (CS) in literature and practice—particularly in the context of training provided to victim support volunteers in Alberta. Along with highlighting what seems to be inadequate focus on CS, we propose eight strategies that victim support volunteers can adopt to

cultivate CS in their work. We hope the information presented in this article can be integrated into Victim Services training to teach volunteers how to capitalize on the more energizing aspects of their work and sustain gratification in helping others to recover from crisis.

### **Compassion Satisfaction: In Research and Practice**

CS is defined as a feeling of pleasure acquired from the ability to effectively help others and make a positive mark in society (Stamm, 2010). Researchers stressed the importance of CS by identifying it as a contributing factor to career longevity and sustained well-being (Radey & Figley, 2007), as well as a protective mechanism that mitigates the effects of CF (Conrad & Kellar-Guenther, 2006; Phelps, Lloyd, Creamer, & Forbes, 2009; Samios, Abel, & Rodzik, 2013). Stamm (2010) alleged that trauma workers who experience increased CS may feel energized by their work and believe they can continue to make a difference in the world. However, little research has utilized CS as a focal point (Lawson & Meyers, 2011; Radey & Figley, 2007) and the majority of studies in this area have examined CS secondarily to CF.

A similar trend appears to be evident in Alberta Victim Services training—in which too often is the focus on being traumatized rather than energized. For instance, of the 35 standardized training modules released in 2011, only one is dedicated towards educating victim support volunteers on the traumatic implications of the work and how to prevent the effects of CF—no mention of CS is ever made (Shivji, 2015). Hence, it seems victim support volunteers are being informed about the risks of the job with minimal instruction on the unique benefits of the position. Unlike trauma specialists and professionals in the field, these volunteers may have limited access to educational

materials and resources that can assist them in becoming cognizant of CS and how it applies to their work. Therefore, it is imperative they be taught not only how to detract from the trauma of CF, but also how to thoroughly experience the energy of CS.

In the next section, we offer eight general recommendations for sustaining CS in Victim Services (and possibly other forms of work with survivors of crisis and trauma). However, it should be noted that these recommendations are based on the work and ideas of a limited group of researchers, primarily because the literature on CS is sparse and there is simply not enough material to consult in terms of how CS can be actively enhanced and maintained.

### **Recommended Strategies for Cultivating Compassion Satisfaction**

Radey and Figley (2007) contended that certain steps could be taken to enhance CS; they recommended increasing positive affect, resources, and self-care to create a higher ratio of positive to negative experiences, and thus provide an ideal environment for CS to grow. The advent of CS may be compounded by witnessing growth and resilience in clients, bonding with colleagues who share a commitment to bring about positive change, and understanding the true value of the work being done (Harr, 2013). Building on the recommendations proposed above, the following are several preliminary strategies by which victim support volunteers (and other populations of crisis or trauma workers) may be able to cultivate greater CS in their work. These strategies are informed by an in-depth review of current literature on CF and CS, in addition to one author's personal experiences as a victim support volunteer in Alberta (Shivji, 2015).

**Adopt an active coping style.** An active coping style entails use of positive strategies for stress management (i.e., support seeking, leisure, and relaxation techniques)

and an increased focus on problem-solving, as opposed to the enactment of negative coping strategies (i.e., alcohol and drug use, avoidance) and denial or ignorance of the problem (Kinzel & Nanson, 2000). The shift into a problem-solving mindset is considered by researchers to be a plausible tactic for dealing with symptoms of CF (Cicognani, Pietrantonio, Palestini, & Prati, 2009; Dunkley & Whelan, 2006; Kinzel & Nanson, 2000). In fact, Dunkley and Whelan (2006) insinuated that use of an active coping style involves development of a keen capability to generate solutions, which increases the likelihood of success in countering the effects of CF. This resolution of CF is significant, as it opens the door for increased CS. By actively taking steps to reduce CF, victim support volunteers allow greater opportunity for CS to occur. Furthermore, the practice of actively constructing solutions to deal with stress may translate into an application of actively constructing ideas to enhance the positive and energizing feelings that arise from being able to help others recover from crisis or trauma.

**Balance your life and your workload.** Maintenance of a work–life balance is considered an important factor in promoting effective functioning and positivity in crisis and trauma work (Lawson & Meyers, 2011). Hence, volunteers who take time to develop healthy personal relationships and engage in fun or meaningful activities likely experience greater CS than volunteers who focus primarily on their work. Indeed the provision of support and services to victims is a valuable effort, but in this process of helping others it becomes easy to neglect the wholeness of life and subsequently slip into a downward spiral of stress. However, by preserving a balance between personal and professional life, victim support volunteers can experience opportunities to remove

themselves from the helping role and recharge (Harr, 2013). This not only cultivates positive energy within volunteers, but may also raise their capacities for CS.

In addition to managing a balance between work and life, volunteers may find it helpful to maintain a diversified workload. For instance, Radey and Figley (2007) asserted that caseload variety enhances CS through provision of increased chances for work-related success—conceivably when volunteers take on simple tasks and cases, along with the more challenging ones. Specific strategies for diversifying the workload in Victim Services may include taking on a variety of cases and equally dividing the number of hours spent on various tasks or sites (i.e., court support, call center, site of the crime or tragic incident, home of the victim, etc.).

**Be positive.** A strong sense of optimism appears to be the key to enhancing CS. With respect to the amount of patience and emotional energy required to effectively support victims of crime and tragedy, it is necessary for volunteers to have an “ongoing input” (Harr, 2013, p. 83) of positive energy to sustain the ability to help—especially in the face of crisis or stress. Although it is easy to fall prey to the negativity that encompasses the position, victim support volunteers do hold the power to invoke positivity in their work. Keeping a journal of successes, reviewing progress made with victims, and remembering words of appreciation are all methods by which volunteers can boost optimism and discover CS (Radey & Figley, 2007).

Radey and Figley (2007) referenced the idea of positivity opening a wider array of thoughts and actions, thereby provoking additional approaches for working with clients—or, in the case of Victim Services, survivors of criminal victimization. In adopting a positive outlook, volunteers not only learn to develop new strategies for

helping, but may also experience increased success in doing so. This improved capability to succeed in the helping role is likely to promote potential for CS. Samios et al. (2013) suggested that positive emotions ultimately build CS via positive reframing. Positive reframing refers to broadening of the mindset to search for positive meaning, which allows events to be reinterpreted in a positive light (Samios et al., 2013). In Victim Services, positive reframing may direct volunteers to uncover greater value in their work and thus maximize the experience of CS.

**Consistently evaluate your levels of CS and CF.** Newell and MacNeil (2010) highlighted the need to regularly evaluate CS and CF experienced by helpers. Through simple quantification and regular monitoring of their CS and CF levels, victim support volunteers can easily recognize when energy is depleting and traumatic stress is increasing. This will in turn prompt action to reduce CF and enhance CS. Volunteers may also experience increased optimism in seeing their levels of CS rise—a process that is likely to instill greater motivation for continuing to serve in a helping role.

One method by which volunteers can evaluate their levels of CS and CF is the Professional Quality of Life Scale (ProQOL). The ProQOL is a self-report tool specifically designed to measure both positive and negative effects of trauma work (Stamm, 2010). In addition to being the most preferred measure of CS and CF, the ProQOL is determined by researchers to be a highly valid and reliable test for individual experiences of CS, CF, and burnout (Adams, Boscarino, & Figley, 2006; Bride et al., 2007; Jenkins & Baird, 2002; O'Sullivan & Whelan, 2011; Stamm, 2010). For ease of access, a copy of Stamm's (2002, 2010) ProQOL is attached as Appendix B. The scoring guide for the ProQOL is attached as Appendix C (Stamm, 2010).

**Embrace self-care.** Lack of self-care is hardly conducive to CS. Instead, researchers emphasized the regular practice of self-care to reduce CF and improve chances of CS (Radey & Figley, 2007). For instance, victim support volunteers who neglect their own needs may observe a diminished capacity to function both personally and professionally, as their energy is drained and they may find it difficult to provide quality service and keep up with the demands of the position and everyday life (Radey & Figley, 2007). Thus, it is important to identify the need for personal rejuvenation and preserve a sense of well-being (Harr, 2013), as doing so increases room for CS.

Specific self-care strategies that volunteers may use to build CS include actively maintaining good mental and physical health (i.e. establishing a healthy diet, exercising, regular medical checkups), spending time with loved ones, incorporating leisure time into their schedules, facilitating hope through spirituality or positive thinking, and maintaining boundaries to limit emotional involvement with victims (Harr, 2013). Enrolment in personal therapy is also a viable method for self-care, as it enhances resiliency and CS through the deeper processes of reflection and insight (Cummins, Massey, & Jones, 2007).

**Practice mindfulness.** Kabat-Zinn (1990) characterized mindfulness as “paying attention, in a particular way: on purpose, in the present manner, and nonjudgmentally” (p. 14). This process involves deliberate attendance to thoughts, emotions, and sensations associated with crisis and trauma work, and researchers have generally supported the use of mindfulness to reduce CF and promote well-being (Christopher & Maris, 2010; Figley, 2002). It is through mindfulness that victim support volunteers can learn to become

aware of their experiences of CF and CS, thereby enabling them to shift from feeling traumatized and depleted by the work to being resilient and energized in the helping role.

**Pursue knowledge.** Another favorable medium for cultivating CS is the pursuit of intellectual resources through continuing education and training (Radey & Figley, 2007). While lack of competence in specific skills or knowledge may contribute to CF, efforts to gain experience and competence likely provide fresh perspectives that make handling the challenges of the job a smoother process (Harr, 2013). Improvements in skills and knowledge can lead victim support volunteers to experience greater success in their work, which may result in increased CS. Furthermore, Victim Services can assist volunteers in developing awareness of CS through provision of specialized training on the unique rewards of helping.

**Seek social support.** One of the most consistent ideas in the literature to date is the link between social support and CS (Cicognani et al., 2009; Conrad & Kellar-Guenther, 2006; Killian, 2008; Radey & Figley, 2007; Stamm, 2002). Harr (2013) described social support from family and friends as a method for finding “refuge from the emotional intensity of the work” (p. 83). This disengagement from the stress of the job presumably strengthens the potential for CS.

In addition to seeking support from family and friends, victim support volunteers may benefit from mentoring and peer support meetings. Mentoring programs allow more experienced and resilient volunteers, who know how to actively counter CF and build CS, to share their knowledge and support less experienced peers to make the shift from traumatized to energized (Kulkarni, Bell, Hartman, & Herman-Smith, 2013). Similarly, peer support meetings supply an outlet for volunteers to share techniques to improve their

work with victims and increase their rates of success, which further augments CS. In this line of work, volunteers may also develop a tendency to diminish successes and accentuate more problematic cases (Radey & Figley, 2007). This persistent focus on the negative is grounds for heightened CF. Nevertheless, peer support meetings can provide volunteers with opportunities to share successes (Radey & Figley, 2007) and receive positive feedback on their work, which boosts optimism and increases capacity for CS.

### **Conclusion**

CS induces purpose, meaning, and hope in the face of challenges (Harr, 2013). It is a powerful capacity to feel energized and optimistic about the ability to make a difference in the lives of others and change the world. Jones (as cited in Harr, 2013) stated that perceiving positive change in another's quality of life results in fulfillment and motivation to continue in the helping role. Given the profound impact CS can have on victim support volunteers, it becomes paramount for them to be aware of how they can become energized by their work. The current approach of emphasizing the prevention of CF and minimizing the enhancement of CS does little to improve volunteers' abilities to capitalize on the rewards of helping. However, with increased knowledge and training on CS, victim support volunteers (and other populations of crisis and trauma workers) can effectively learn to cultivate greater CS in their work, which in turn may help them to sustain well-being and stay out of crisis as they help others to recover from trauma.

## References

- Adams, R. E., Boscarino, J. A., & Figley, C. R. (2006). Compassion fatigue and psychological distress among social workers: A validation study. *American Journal of Orthopsychiatry*, *76*, 103–108. doi:10.1037/0002-9432.76.1.103
- American Psychological Association. (2010). *Publication manual of the American Psychological Association* (6th ed.). Washington, DC: Author.
- Bride, B. E., Radey, M., & Figley, C. R. (2007). Measuring compassion fatigue. *Clinical Social Work Journal*, *35*, 155–163. doi:10.1007/s10615-007-0091-7
- Christopher, J. C., & Maris, J. A. (2010). Integrating mindfulness as self-care into counselling and psychotherapy training. *Counselling and Psychotherapy Research*, *10*, 114–125. doi:10.1080/14733141003750285
- Cicognani, E., Pietrantoni, L., Palestini, L., & Prati, G. (2009). Emergency workers' quality of life: The protective role of sense of community, efficacy beliefs and coping strategies. *Social Indicators Research*, *94*, 449–463. doi:10.1007/s11205-009-9441-x
- Collins, S., & Long, A. (2003). Working with the psychological effects of trauma: Consequences for mental health-care workers – a literature review. *Journal of Psychiatric and Mental Health Nursing*, *10*, 417–424. doi:10.1046/j.1365-2850.2003.00620.x
- Conrad, D., & Kellar-Guenther, Y. (2006). Compassion fatigue, burnout, and compassion satisfaction among Colorado child protection workers. *Child Abuse & Neglect*, *30*, 1071–1080. doi:10.1016/j.chiabu.2006.03.009

- Cummins, P. N., Massey, L., & Jones, A. (2007). Keeping ourselves well: Strategies for promoting and maintaining counselor wellness. *Journal of Humanistic Counseling, Education and Development, 46*, 35–49. doi:10.1002/j.2161-1939.2007.tb00024.x
- Dunkley, J., & Whelan, T. A. (2006). Vicarious traumatization in telephone counsellors: Internal and external influences. *British Journal of Guidance & Counselling, 34*, 451–469. doi:10.1080/03069880600942574
- Figley, C. R. (1995). Compassion fatigue as secondary traumatic stress disorder: an overview. In C. R. Figley (Ed.), *Compassion fatigue: coping with secondary traumatic stress disorder in those who treat the traumatized* (pp. 1–20). New York: Brunner/Mazel.
- Figley, C. R. (2002). Compassion fatigue: Psychotherapists' chronic lack of self care. *Journal of Clinical Psychology/In Session: Psychotherapy in Practice, 58*, 1433–1441. doi:10.1002./jclp.10090
- Harr, C. (2013). Promoting workplace health by diminishing the negative impact of compassion fatigue and increasing compassion satisfaction. *Social Work & Christianity, 40*(1), 71–88.
- Jenkins, S. R., & Baird, S. (2002). Secondary traumatic stress and vicarious trauma: A validation study. *Journal of Traumatic Stress, 15*, 423–432. doi:10.1023/A:1020193526843
- Kabat-Zinn, J. (1990). *Full catastrophe living: Using the wisdom of your body and mind to face stress, pain, and illness*. New York, NY: Bantam Doubleday Dell.

- Killian, K. D. (2008). Helping till it hurts? A multimethod study of compassion fatigue, burnout, and self-care in clinicians working with trauma survivors. *Traumatology, 14*(2), 32–44. doi:10.1177/1534765608319083
- Kinzel, A., & Nanson, J. (2000). Education and de-briefing: Strategies for preventing crises in crisis-line volunteers. *Crisis, 21*, 126–134. doi:10.1027//0227-5910.21.3.126
- Kulkarni, S., Bell, H., Hartman, J. L., & Herman-Smith, R. L. (2013). Exploring individual and organizational factors contributing to compassion satisfaction, secondary traumatic stress, and burnout in domestic violence service providers. *Journal of the Society for Social Work and Research, 4*, 114–130. doi:10.5243/jsswr.2013.8
- Lawson, G., & Myers, J. E. (2011). Wellness, professional quality of life, and career-sustaining behaviors: What keeps us well? *Journal of Counseling & Development, 89*, 163–172. doi:10.1002/j.1556-6678.2011.tb00074.x
- McKim, L. L., & Smith-Adcock, S. (2014). Trauma counsellors' quality of life. *International Journal for the Advancement of Counselling, 36*, 58–69. doi:10.1007/s10447-013-9190-z
- Newell, J. M., & MacNeil, G. A. (2010). Professional burnout, vicarious trauma, secondary traumatic stress, and compassion fatigue: A review of theoretical terms, risk factors, and preventive methods for clinicians and researchers. *Best Practices in Mental Health, 6*(2), 57–69.

- O'Sullivan, J., & Whelan, T. A. (2011). Adversarial growth in telephone counsellors: Psychological and environmental influences. *British Journal of Guidance & Counselling, 39*, 307–323. doi:10.1080/03069885.2011.567326
- Phelps, A., Lloyd, D., Creamer, M., & Forbes, D. (2009). Caring for carers in the aftermath of trauma. *Journal of Aggression, Maltreatment & Trauma, 18*, 313–330. doi:10.1080/10926770902835899
- Radey, M., & Figley, C. R. (2007). The social psychology of compassion. *Clinical Social Work Journal, 35*(3), 207–214. doi:10.1007/s10615-007-0087-3
- Samios, C., Abel, L. M., & Rodzik, A. K. (2013). The protective role of compassion satisfaction for therapists who work with sexual violence survivors: An application of the broaden-and-build theory of positive emotions. *Anxiety, Stress, & Coping, 26*, 610–623. doi:10.1080/10615806.2013.784278
- Salston, M., & Figley, C. R. (2003). Secondary traumatic stress effects of working with survivors of criminal victimization. *Journal of Traumatic Stress, 16*, 167–174. doi:10.1023/A:1022899207206
- Shivji, A. M. (2015). *Compassion satisfaction in Victim Services: Focusing on the rewards of trauma work* (Unpublished master's project). University of Lethbridge, Lethbridge, Alberta.
- Stamm, B. H. (2002). Measuring compassion satisfaction as well as fatigue: Developmental history of the compassion satisfaction and fatigue test. In C. R. Figley (Ed.), *Treating compassion fatigue* (pp. 107-119). New York, NY: Brunner-Routledge.

Stamm, B. H. (2010). *The concise ProQOL manual* (2nd ed.). Retrieved from  
[http://www.proqol.org/uploads/ProQOL\\_Concise\\_2ndEd\\_12-2010.pdf](http://www.proqol.org/uploads/ProQOL_Concise_2ndEd_12-2010.pdf)

## Appendix B

### Professional Quality of Life Scale (ProQOL)<sup>2</sup>

*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 situation as a victim support volunteer. 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.

---

<sup>2</sup> This test is a direct copy from the following source: Stamm, B. H. (2010). *The concise ProQOL manual* (2nd ed.). Retrieved from [http://www.proqol.org/uploads/ProQOL\\_Concise\\_2ndEd\\_12-2010.pdf](http://www.proqol.org/uploads/ProQOL_Concise_2ndEd_12-2010.pdf)

- \_\_\_ 13. I feel depressed because of the traumatic experiences of the people I 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 caseload 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

### Scoring Guide for ProQOL<sup>3</sup>

In this section, you will score your test so you understand the interpretation for you. To find your score on **each section**, total the questions listed on the left and then find your score in the table on the right of the section.

#### Compassion Satisfaction Scale

3. \_\_\_\_\_  
 6. \_\_\_\_\_  
 12. \_\_\_\_\_  
 16. \_\_\_\_\_  
 18. \_\_\_\_\_  
 20. \_\_\_\_\_  
 22. \_\_\_\_\_  
 24. \_\_\_\_\_  
 27. \_\_\_\_\_  
 30. \_\_\_\_\_

Total: \_\_\_\_\_

The sum of my Compassion Satisfaction questions	So my score equals	My level of compassion
22 or less	43 or less	Low
Between 23 and 41	Around 50	Average
42 or more	57 or more	High

#### Burnout Scale

- \*1. \_\_\_\_\_  
 \*4. \_\_\_\_\_  
 8. \_\_\_\_\_  
 10. \_\_\_\_\_  
 \*15. \_\_\_\_\_  
 \*17. \_\_\_\_\_  
 19. \_\_\_\_\_  
 21. \_\_\_\_\_  
 26. \_\_\_\_\_  
 29. \_\_\_\_\_

Reverse the scores for those that are starred.

0 = 0, 1=5, 2=4, 3=3, 4=2, 5=1

Total: \_\_\_\_\_

The sum of my Burnout questions	So my score equals	My level of compassion
22 or less	43 or less	Low
Between 23 and 41	Around 50	Average
42 or more	57 or more	High

<sup>3</sup> This scoring guide has been obtained from the following source: Stamm, B. H. (2010). *The concise ProQOL manual* (2nd ed.). Retrieved from [http://www.proqol.org/uploads/ProQOL\\_Concise\\_2ndEd\\_12-2010.pdf](http://www.proqol.org/uploads/ProQOL_Concise_2ndEd_12-2010.pdf)

## Secondary Traumatic Stress Scale

2. \_\_\_\_\_  
 5. \_\_\_\_\_  
 7. \_\_\_\_\_  
 9. \_\_\_\_\_  
 11. \_\_\_\_\_  
 13. \_\_\_\_\_  
 14. \_\_\_\_\_  
 23. \_\_\_\_\_  
 25. \_\_\_\_\_  
 28. \_\_\_\_\_

The sum of my Secondary Traumatic Stress questions	So my score equals	My level of compassion
22 or less	43 or less	Low
Between 23 and 41	Around 50	Average
42 or more	57 or more	High

**Total:** \_\_\_\_\_

Based on your responses, place your personal scores below. If you have any concerns, you should discuss them with physical or mental health care professional.

### Compassion Satisfaction \_\_\_\_\_

Compassion satisfaction is about the pleasure you derive from being able to do your work well. For example, you may feel like it is a pleasure to help others through your work. You may feel positively about your colleagues or your ability to contribute to the work setting or even the greater good of society. Higher scores on this scale represent a greater satisfaction related to your ability to be an effective caregiver in your job.

The average score is 50 (SD 10; alpha scale reliability .88). About 25% of people score higher than 57 and about 25% of people score below 43. If you are in the higher range, you probably derive a good deal of professional satisfaction from your position. If your scores are below 40, you may either find problems with your job, or there may be some other reason—for example, you might derive your satisfaction from activities other than your job.

### Burnout \_\_\_\_\_

Most people have an intuitive idea of what burnout is. From the research perspective, burnout is one of the elements of Compassion Fatigue (CF). It is associated with feelings of hopelessness and difficulties in dealing with work or in doing your job effectively. These negative feelings usually have a gradual onset. They can reflect the feeling that your efforts make no difference or they can be associated with a very high workload or a non-supportive work environment. Higher scores on this scale mean that you are at higher risk for burnout.

The average score on the burnout scale is 50 (SD 10; alpha scale reliability .75). About 25% of people score above 57 and about 25% of people score below 43. If your score is below 43, this probably reflects positive feelings about your ability to be effective in your work. If you score above 57 you may wish to think about what at work makes you feel like you are not effective in your position. Your score may reflect your mood; perhaps you were having a “bad day” or are in need of some time off. If the high score persists or if it is reflective of other worries, it may be a cause for concern.

### **Secondary Traumatic Stress \_\_\_\_\_**

The second component of Compassion Fatigue (CF) is secondary traumatic stress (STS). It is about your work related secondary exposure to extremely or traumatically stressful events. Developing problems due to exposure to others’ trauma is somewhat rare but does happen to many people who care for those who have experienced extremely or traumatically stressful events. For example, you may repeatedly hear stories about the traumatic things that happen to other people, commonly called Vicarious Traumatization. If your work puts you directly in the path of danger, for example, field work in a war or area of civil violence, this is not secondary exposure; your exposure is primary. However, if you are exposed to others’ traumatic events as a result of your work, for example, as a therapist or an emergency worker, this is secondary exposure. The symptoms of STS are usually rapid in onset and associated with a particular event. They may include being afraid, having difficulty sleeping, having images of the upsetting event pop into your mind, or avoiding things that remind you of the event.

The average score on this scale is 50 (SD 10; alpha reliability .81). About 25 % of people score below 43 and about 25% of people score above 57. If your score is above 57, you may want to take some time to think about what at work may be frightening to you or if there is some other reason for the elevated score. While higher scores do not mean that you do have a problem, they are an indication that you may want to examine how you feel about your work and your work environment. You may wish to discuss this with your supervisor, a colleague, or a health care professional.

## Appendix D

### **Instructions for Authors from *Crisis: The Journal of Crisis Intervention and Suicide Prevention***

The journal in which the proposed manuscript (see Appendix A) is to be submitted for review details specific instructions for authors of manuscripts to follow.

Below is a direct copy of relevant information taken from the following sources:

- Hogrefe Publishing. (2015). *Crisis: The Journal of Crisis Intervention and Suicide Prevention – About the journal & the editors*. Retrieved from <http://www.hogrefe.com/periodicals/crisis-the-journal-of-crisis-intervention-and-suicide-prevention/about-the-journal-the-editors/>. Used with permission from Hogrefe Publishing. Copyright © 2015 by Hogrefe Publishing.
- Hogrefe Publishing. (2012). *Instructions to authors – Crisis: The Journal of Crisis Intervention and Suicide Prevention* [PDF file]. Retrieved from [http://www.hogrefe.com/fileadmin/redakteure/hogrefe\\_com/Periodicals/Crisis/cri\\_authors.pdf](http://www.hogrefe.com/fileadmin/redakteure/hogrefe_com/Periodicals/Crisis/cri_authors.pdf). Used with permission from Hogrefe Publishing. June 1, 2012. Copyright © 2012 by Hogrefe Publishing.

#### **About the Journal**

A must for all who need to keep up on the latest findings from both basic research and practical experience in the fields of suicide and crisis intervention! This well-established periodical's reputation for publishing important articles on suicidology and crisis intervention from around the world has been further enhanced with the increase of content by 20% in 2013. But over and above its scientific reputation, *Crisis* also publishes potentially life-saving information for all those involved in crisis intervention

and suicide prevention, making it important reading for clinicians, counselors, hotlines, and crisis intervention centers.

**Instructions to Authors—*Crisis: The Journal of Crisis Intervention and Suicide Prevention***

Manuscripts for publication in *Crisis: The Journal of Crisis Intervention and Suicide Prevention* should be prepared in the manner outlined below. **Submissions are only accepted online** at <http://www.editorialmanager.com/cri>. Please follow the online instructions for submission.

**Originality.** Authors should only submit manuscripts that have not been published elsewhere and are not under review by another publication.

**Types of papers.** *Crisis: The Journal of Crisis Intervention and Suicide Prevention* publishes three types of original scientific papers: Papers for the **Research Trends** section may be up to 4,000 words (excluding references). **Short Reports** may be up to 1,500 words (excluding references). **Clinical Insights** are clinically oriented papers and may be up to 4,000 words (excluding references).

**Manuscript preparation.** Manuscripts should be prepared according to the *Publication Manual of the American Psychological Association* (6th ed.). In particular, statistical and mathematical copy and styling of references and their text citation should conform to the *Publication Manual*.

**Abstract and keywords.** Each manuscript must be submitted with keywords (maximum 5) and a structured abstract (maximum 200 words) divided into the following sections: Background, Aims, Methods, Results, Conclusions.

**Affiliations, addresses, and biographies.** Each manuscript must include the following: (a) Corresponding Author: Name and complete address, including E-mail and telephone and telefax numbers of the corresponding author; (b) Names and affiliations of all authors; (c) A brief biography (up to 50 words) for each author.

**Figures and tables.** Figures and tables should be numbered using Arabic numerals. The number of figures and tables should be kept to a minimum and only be included to facilitate understanding of the text. The same information should not appear in both a figure and a table. Each table and figure must be cited in the text and should be accompanied by a legend on a separate sheet. Please note that online submission via the Editorial Manager allows text, figures, and tables to be submitted as separate files. Figures must be supplied in a form suitable for reproduction: preferably high-resolution bitmaps (e.g., jpg, 300 dpi) or as vector graphics files. Figures will normally be reproduced in black and white only. While it is possible to reproduce color illustrations, authors are reminded that they will be invoiced for the extra costs involved.

**Reviews and decisions.** Manuscripts are all subject to anonymous peer review. Based on the title and abstract, two or more reviewers will be requested to review the manuscript. Upon receipt of the reviews, the editor in chief will make his editorial decision and notify the corresponding author of the result. There are four kinds of decisions: accept, accept conditionally (on minor changes), resubmit after major revision, and reject. Rejected manuscripts cannot be resubmitted. The entire review process is completely reliant on electronic communication in order to ensure speedy processing. A request by the editor for revision of a manuscript does not constitute a decision to publish.

All revised manuscripts will be reevaluated, and the editors reserve the right to reject a paper at any point during the revision process.

**Submission procedure and conditions.** All manuscripts should be submitted online at <http://www.editorialmanager.com/cri>. Please follow the online instructions for submission.

During the submission procedure the authors will have to answer the following:

1. Has the manuscript or any component of it already been published or is currently under consideration by another journal?
2. Has this manuscript or another version of it been submitted to this journal or another journal in the past? (Please specify which journal/s)
3. If the paper has been written by more than one person, can the corresponding author attest that each author has studied the manuscript in the form submitted, agreed to be cited as a coauthor, and has accepted the order of authorship?
4. Have I disclosed any conflicts of interest in the manuscript?

**Copyright agreement.** By submitting an article, the author confirms and guarantees on behalf of him-/herself and any coauthors that he or she holds all copyright in and title to the submitted contribution, including any figures, photographs, line drawings, plans, maps, sketches and tables, and that the article and its contents do not infringe in any way on the rights of third parties. The author indemnifies and holds harmless the publisher from any third-party claims. The author agrees, upon acceptance of the article for publication, to transfer to the publisher on behalf of him-/herself and any coauthors the exclusive right to reproduce and distribute the article and its contents, both physically and in nonphysical, electronic, and other form, in the journal to which it has

been submitted and in other independent publications with no limits on the number of copies or on the form or the extent of the distribution. These rights are transferred for the duration of copyright as defined by international law. Furthermore, the author transfers to the publisher the following exclusive rights to the article and its contents:

1. The rights to produce advance copies, reprints, or offprints of the article, in full or in part, to undertake or allow translations into other languages, to distribute other forms or modified versions of the article, and to produce and distribute summaries or abstracts.
2. The rights to microfilm and microfiche editions or similar, to the use of the article and its contents in videotext, teletext, and similar systems, to recordings or reproduction using other media, digital or analog, including electronic, magnetic, and optical media, and in multimedia form, as well as for public broadcasting in radio, television, or other forms of broadcast.
3. The rights to store the article and its content in machine-readable or electronic form on all media (such as computer disks, compact disks, magnetic tape), to store the article and its contents in online databases belonging to the publisher or third parties for viewing or downloading by third parties, and to present or reproduce the article or its contents on visual display screens, monitors, and similar devices, either directly or via data transmission.
4. The rights to reproduce and distribute the article and its contents by all other means, including photomechanical and similar processes (such as photocopying or facsimile), and as part of so-called document delivery services.

5. The right to transfer any or all rights mentioned in this agreement, as well as rights retained by the relevant copyrights clearing centers, including royalty rights to third parties.

**Online rights for journal articles.** Hogrefe will send the corresponding author of each accepted paper free of charge an e-offprint (PDF) of the published version of the paper when it is first released online. This e-offprint is provided for the author's personal use, including for sharing with coauthors.

**e-Offprint/published version of record.** The e-offprint is provided exclusively for the authors' personal use. Other uses of the e-offprint/published version of record, including but not limited to the following, are not permitted except with express written permission of the publisher: posting the e-offprint/published version of record to a personal or institutional website or to an institutional or disciplinary repository; changing or modifying the digital file; reproducing, distributing, or licensing the article in whole or in part for commercial use.