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Secondary Traumatic Stress: The Hidden Trauma in Child and Youth Counsellors

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Secondary Traumatic Stress: The Hidden Trauma in Child and Youth Counsellors

By

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Abstract

The current research study was conducted to establish evidence based research identifying Secondary Traumatic Stress (STS) in Child and Youth Counsellors (CYCs). 161 CYCs participated in an online survey responding to both demographic questions and Bride's (1999) Secondary Traumatic Stress Scale (STSS). Data analysis included both descriptive and inferential testing. Scoring of the STSS revealed that 66.1% of the CYCs sampled experienced some level of STS. The overall mean score is 33.65 suggesting that CYCs experienced a mild level of STS. An independent group t-test indicated that CYC's who were exposed to children and youth's traumatic experience 1 to 3 times a week did not differ in the level of STS from CYC's who were exposed to children and Youth's traumatic experience over 4 times a week. A correlation analysis revealed a weak but positive relationship between the years of experience in the field of Child and Youth Care and the level of Secondary Traumatic Stress. Recommendations include educators incorporating this study in the teaching of STS to future CYCs; prevention and self care practices in the symptoms of STS. In addition, future research is needed to verify the current findings.

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I dedicate this research study to both Child and Youth Counsellors and Social Workers who have dedicated their work in supporting traumatized children and youth.

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Chapter 1: Introduction

Secondary Traumatic Stress in helping professionals has been explored in the literature for well over 10 years. To date I have been unsuccessful in locating any research on the experience of Secondary Traumatic Stress (STS) in Child and Youth Counsellors (CYCs). CYCs work with our most vulnerable population, traumatized children and youth. I personally have worked in the area of Child and Youth Care with traumatized young people for over 25 years. I have had my own experience of STS in the latter part of my career and had no idea at the time what I was experiencing. As a result, it is of utmost importance that STS, a potential occupational hazard be studied in this helping profession.

Writing this research thesis has been an ongoing learning process. As I was learning at the same time as I was conducting this study, some of the decisions I made around data analysis were developed based on my knowledge and skill level.

Organization of Thesis

In this introductory chapter, I provide the rationale including my social location for studying this research topic. In Chapter 2, I provide an in depth literature review of the construct Secondary Traumatic Stress. In chapter 3, I provide an overview of the methodology of the research study. In Chapter 4, I offer the findings. Finally in Chapter 5 , I offer a thorough discussion including the links between current findings and past literature; strengths and limitations of the study; application to practice and future research and my personal reflections.

Rationale

The purpose of this research was to identify the existence of Secondary Traumatic Stress (STS) in Child and Youth Counsellors (CYCs). Currently there is no literature reflecting any evidence as to the existence of secondary traumatic stress amongst these professionals. STS is defined by Figley (1999) "as the natural, consequent behaviours and emotions resulting from knowledge about a traumatizing event experienced by a significant other. It is the stress resulting from helping or wanting to help a traumatized or suffering person" (p.10). The literature suggests that those in other helping professions such as child protection workers, shelter workers, police, fire and ambulance personnel can experience STS (Conrad & Kellar, 2006; Stamm, 1997). CYCs nurture, care for and advocate for the needs of children and youth. Anglin (2002) shares:

> "children and youth" is the common phrase in North American for the full range of young people under the age of majority. There is not a negative connotation to the word "youth," and 14- to- 24- year-olds are generally comfortable being referred to as "youth." (p.1)

As Fewster & Garfat (2000) suggest, these young people can be described as behaviourally and/or emotionally challenged and some of their challenges can include mental illness, learning challenges, and chronic delinquency. Children and youth in the care of CYCs are commonly referred to as 'troubled' (pg.16). It is routine practice for CYCs to work with children and youth that have been victims of trauma. As such, caring, listening, being present and the display of empathy are essential components to the work of CYCs (Kreuger, 2003). Figley (1999) states that, "Empathy is a key factor in the induction of traumatic material from the primary to the secondary 'victim'." (p.20). The process of empathizing with a young person helps CYCs understand their traumatic

experience. Thus, as CYCs are indirectly exposed to the traumatic material of the children and youth that they support, powerful feelings can then be evoked for the practitioners themselves. Consequently, CYCs are then vulnerable to the experience of STS. In light of this, STS can be an occupational hazard with possible adverse outcomes for workers such as ineffectiveness on the job, extended sick leave, or simply withdrawing from the profession.

I questioned why the literature has given little attention to this subject area. I believe that CYCs are a marginalized population. This is a field where gaining professional identity has been difficult. Historically, there have been challenges within the discipline of CYC to gain professional recognition. The Ontario Association of Child and Youth Counsellors (OACYC) is the professional association representing CYCs in the province of Ontario, Canada. Currently there is no government mandatory licensing in the province of Ontario requiring CYC's to belong to the OACYC. The regulation of the profession would ensure that those using the title of CYC shared specific education qualifications to work in the field of Child and Youth Care. For example, social workers are required to be registered with the Ontario College of Social Workers and Social Service Workers in order to use the title of social worker. In August 2000, Ontario proclaimed the Social Worker and the Social Service Worker Act, 1998.

Everything from the name of these unique practitioners to the wide range of educational training adds to the marginalization of CYCs. How does this group of professionals gain professional identity when they themselves are unsure what name to refer to. The OACYC reported that this discipline has been referred to as Child Care Worker, Child and Youth Worker, Child and Youth Care Worker and Youth Worker.

The Association formally used the title of Child and Youth Counsellor after a formal vote in 1989.

The discipline of Child and Youth Counsellors remains unregulated in Ontario. There are approximately 8000 CYCs in the province (OACYC, 2009). CYCs are dispersed across the province, separated in small units across a wide range of practice settings. Practitioners work in community health, street work, recreation and outreach programs. They are employed in schools, special education programs, residential treatment programs and operate group homes. In addition, CYCs are employed in hospital and outpatient settings, in criminal justice and in custodial settings (Ferguson, Pence & Denham, 2000, p.6). In addition, CYC's employed by any board of education in Ontario are hired as educational assistants, teachers' assistants or child and youth workers. I find it is interesting to note that an educational assistant only requires a grade 12 high school diploma, thus adding to the displacement of the professional identity of CYCs.

Ontario provides training at the community college and university level, yet, there continues to be many practitioners who have unrelated training that are working with troubled young people. For example, a residential treatment centre may employ several CYCs with different educational qualifications working side by side, some of which may have completely unrelated qualifications. For this reason the professional association is just one way of providing some regulation where continuity in training is so desperately needed.

My Social Location

My social location has influenced my interest in this area of research. As a professional working in the field of Child and Youth Care for over 20 years, I have been an active participant in the ongoing development of the field. I graduated in 1984 with a community college diploma from Humber College as a Child Care Worker. A decade later, the profession changed the name to Child and Youth Work. More recently, I graduated with a B.A in Child and Youth Care from Ryerson University. Although I refer to myself as a Child and Youth Counsellor, my job has required me to go by the title of Child and Youth Worker. I have worked with traumatized young people in both children's mental health and child welfare and have been employed in both residential and day treatment centres, supporting both adolescents and young children.

My introduction to the construct of STS transpired during a class lecture in the Child and Youth Care Program at Ryerson. It was common practice among colleagues to discuss direct trauma (verbal and physical aggression) towards CYCs. However, discussing the impact of working with children and youth that have been traumatized was quite foreign. It was a relief to identify the idea of STS as it attributed to my own experience as a practitioner.

I recall an incident in 2001 while working in an adolescent residential treatment setting. A 17 year old female was gang raped by three males while taking a walk in the community. As it happened, I was working a stretch of shifts just after the assault. I provided this youth with continued one to one support for several days. As she disclosed descriptive details of the assault, the negative impact of this trauma was quite evident as she displayed difficulties eating, sleeping and experienced some suicidal ideation. She refused to speak of her trauma to any other staff with the exception of me. In turn, I felt

the enormous impact of hearing the details of this youth's experience. Consequently, my regular sleep patterns were interrupted; thoughts of her assault would linger into my mind; I became hyper vigilant around the physical safety of the residents in this group home as well as myself. In reflecting back, I realize that the quality of my work deteriorated. I now recognize my own experience as symptoms of STS. At that time the focus was supporting this young woman. There was no thought from my supervisor and colleagues as to the impact of this youth's traumatic experience on me.

So the question lies, is secondary traumatic stress experienced in the field of Child and Youth Care or was this experience an isolated one? One might draw the conclusion that if the literature presents empirical evidence of STS in other 'similar' type professions then it could be suggested that CYCs are then likely to share the same type of experiences. In the ongoing plight to gain professional recognition and more importantly, to minimize the negative impact that STS has on CYCs, evidence based research needs to occur.

Chapter 2: Literature Review

This review suggests that there is a gap in the literature identifying Secondary Traumatic Stress (STS) in the field of Child and Youth Care. While STS is a recognized phenomenon in other helping professions, it remains unknown in the growing profession of Child and Youth Counsellors. The following chapter represents in detail the current literature in the area of Secondary Traumatic Stress. This review will first explore the challenges that authors portray in formulating an understanding of this construct. This chapter will then identify the professional helpers stated in the literature. Finally, this chapter will end with an overview of the prevention and self care of Secondary Traumatic Stress. Unless specifically referenced in the literature, the term Secondary Traumatic Stress (STS) will be utilized.

In the last number of years, there have been numerous studies investigating the negative impact of working with trauma survivors (Adams, Figley and Boscarino, 2008; Bride, 2007; Bride, Robinson, Yegidis and Figley, 2004; Chrestman, 1999; Kassam-Adams, 1999; Pearlman and MacIan, 1995). In addition, there have been a number of concepts developed in an attempt to understand how the impact of exposure to traumatic material has on the helping professional. A theme throughout the literature suggests that there is a lack of consensus in arriving at a common definition for this concept (Jenkins and Baird, 2002; Lerias and Byrne, 2003). The literature reflects similarities, overlaps and differences within these constructs (Jenkins and Baird, 2002; Salston and Figley, 2003; Sexton, 1999; Stamm, 1997; Trippany, Kress and Wilcoxon, 2004). Moreover, Stamm's (1997) review of the research suggests that not only do the constructs differ; the terms themselves are used interchangeably. A number of terms with an equal number of

definitions have been utilized (Figley, 1999). Phrases commonly used include vicarious trauma, secondary traumatic stress (STS), compassion fatigue, countertransference and burnout (Figley, 1999; Pearlman and Saakvitne, 1995: Sexton, 1999).

Figley (1999) defines STS "as the natural, consequent behaviors and emotions resulting from *knowledge about* a traumatizing event experienced by a significant other. It is the stress resulting from *helping or wanting to help* a traumatized or suffering person" (p.10). Salston and Figley (2003) report that (STS) parallels the symptoms of Post Traumatic Stress Disorder (PTSD). According to the *Diagnostic and Statistical Manual of Mental Disorder's (DSM-IV)* (American Psychiatric Association, 1994) PTSD is a type of anxiety disorder that:

> ....is the development of characteristic symptoms following exposure to an extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one's physical or witnessing an event that involves death, injury; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate. The person's response to the event must involve intense fear, helplessness, or horror. The characteristic symptoms resulting from the exposure to the extreme trauma include persistent reexperiencing of the traumatic event, persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness, and persistent symptoms of increased arousal(p. 435).

Figley (1999), states that the symptoms of secondary traumatic stress are virtually the same as PTSD with the exception that the exposure to a traumatic event experienced by

one individual becomes a traumatizing event for the second person. "Thus, the PTSD symptoms are directly connected to the person experiencing primary traumatic stress" (p.9). What this suggests is that helping professionals can experience these symptoms without actually experiencing the trauma directly. Furthermore, these symptoms can be experienced after one event and can appear suddenly without a lot of warning (Figley, 1999). Figley (1999) initially focused on family members and friends of individuals who were exposed to a traumatic event. He later acknowledged that mental health and other helpers were vulnerable to secondary traumatic stress. (p.10) Figley (1999) later incorporated the term compassion fatigue, seeing it as a normative occupational hazard for nurses and other various trauma and mental health professionals. It was suggested that this term was less stigmatizing for these practitioners as it better described the manifestations of their work related experiences. Figley did use the terms secondary traumatic stress and compassion fatigue interchangeably. Conrad and Kellar-Guenther (2006) using the Compassion Fatigue Test (Figley, C.R. and Stamm, 1996) studied the risk of compassion fatigue in child protection workers in Colorado. Their study showed that approximately 50% of this population experienced high to very high levels of compassion fatigue. The Secondary Traumatic Stress Test (Bride, 2007) was used to assess the frequency and severity with which PTSD symptoms were met in child protection workers. This study concluded that this population was highly likely to experience STS through their work with traumatized individuals.

The diagnosis of PTSD has come under great scrutiny (Herman, 1997; McQuaide, 1999). Herman (1997) notes how clinicians have had a tendency to blame the

victim by pathologizing the individuals' reactions as a response to the perpetrator's crimes.

> The tendency to blame the victim, however, has interfered with the psychological understanding and diagnosis of a posttraumatic syndrome. Instead of conceptualizing the psychopathology of the victim as a response to an abusive situation, mental health professionals have frequently attributed the abusive situation to the victim's presumed underlying psychopathology (p.116).

The challenge for clinicians is to then focus specifically on the response to the trauma.

Through the literature the notion of countertransference has been conceptualized by a number of clinicians (Herman, 1997: Pearlman and Saakvitne, 1995; Sexton, 1999). The idea of countertransference has its root in psychodynamic therapy (Sexton, 1999). Pearlman and Saakvitne (1995) define countertransference as:

> 1) the affective, ideational, and physical responses a therapist has to her client, is clinical material, transference, and reenactments, and 2) the therapist's conscious and unconscious defenses against the affects, intrapsychic conflicts, and associations aroused by the former. All of a client's responses and our responses to the client arise in the context of our role and professional identity as therapist, the unique nature of the therapeutic relationship, and our own personal histories (p. 23).

An important element of successful trauma therapy is the provision of a safe therapeutic environment and the development of a trusting relationship between the client and the therapist.

> The therapists' capacity for sustaining an empathic connection with the client is critical to achieving these goals…the intense nature of emotional reactions which may be elicited in the therapist, leading to strong countertransference reactions that can rapture the empathic stance of the therapist (Sexton, 1999, p. 394).

A distinctive difference between countertransference and STS is that the helping professional can experience a countertransference reaction to any response from the client. However, what makes STS distinguishable is that it is a specific reaction to a person's traumatic experience (Figley, 1999).

Vicarious traumatization refers to the transformation in the trauma worker's inner experience resulting from empathic engagement with a client's trauma material. The long-term empathic engagement with traumatized clients can shift the therapist's ways of experiencing the self, others and the world. These transformative effects are cumulative, permanent and will be evident in both the workers' professional and personal life (Pearlman & Saakvitne, 1995). Saakvitne and Pearlman (1996) state that vicarious trauma has its foundation in a conceptual model called constructivist self-development theory (CSDT).

> CSDT describes the aspects of the self that are affected by traumatic events. …CDST says that traumatic events impact a person in the context of her developing self. In the face of trauma, each person will adapt and cope given her current context(s) and early experiences: interpersonal, intrapsychic, familial, cultural, and social. Within these contexts, the theory outlines the impact of trauma on the self (p.27).

In contrast to Figley's ideas of STS, Saakvitne and Pearlman (1996) believe that vicarious trauma is cumulative process, not a response to a specific event. This process includes our intense feelings and our defenses against those feelings over time. Pearlman (1999) shares that,

> Because it is a process, it is not an event, a diagnosis, or even an experience. It's fluid, ever-changing, always shadowing us. As long as we are engaging empathically with trauma survivors and feeling responsible to help in some way, we are going to experience VT (p. xlix).

Vicarious trauma is our strong reactions to grief and rage, which grow as we continually hear about and see the client's pain and loss. It is equally our ability to put up a protective wall and numb ourselves from our wish not to know, which accompanies those reactions (p.41). Pearlman & Saakvitne (1995) share that there are two main contributing factors to vicarious trauma: aspects of the work environment and aspects that are individual to the therapist. Aspects of the work include the nature of the clientele, specific factors of the event, organizational factors, and social/ cultural issues. Aspects of the therapist include personality, personal history, current personal circumstances, and level of professional development. Pearlman & MacIan (1995) studied 188 trauma therapists with an extensive questionnaire including their Traumatic Stress Institute Belief Scale which measures disrupted cognitive schemas and the Impact of Event Scale which measures avoidance and intrusive symptoms. Their research found that therapists with a personal trauma history reported greater vicarious trauma than those without a personal history. As well, trauma therapists with their own trauma history were negatively affected by the length of time doing their work. It is interesting to note that

Schauben and Frazier (1995) report in their study of vicarious trauma in counsellors working with sexual violence survivors, that counsellors' personal trauma impact did not predict increased vicarious trauma.

There is ongoing discourse in the literature with dialogue linking the common threads and distinguishing the significant differences among these constructs. Both Figley, (1999) and Pearlman and Saakvitne (1995) contend that at the heart of both STS and vicarious trauma is empathic engagement with individuals and exposure to traumatic material. Jenkins and Baird (2002) note that both vicarious trauma and STS are related in that both stem from some form of contact with those that have experienced trauma. In addition, both constructs include a component of PTSD symptoms. Furthermore, these authors describe significant areas in which vicarious trauma and STS differ: 1) STS focuses on observable symptoms while vicarious trauma focuses on theory, and 2) the amount of exposure to traumatic material differ in the sense that Figley (1999) emphasizes the rapid onset of symptoms that can occur from exposure to a single event while Saakvitne and Pearlman (1996) emphasize the cumulative exposure to traumatic material. I concur with Jenkins and Baird (2002) that this is an important distinction.

Another construct that often gets misconstrued is burnout. Maslach, Schaufeli, Leiter, (2001) define burnout "as a prolonged response to chronic emotional and interpersonal stressors on the job, and is defined by the three dimensions of exhaustion, cynicism and inefficacy" (p. 397). Salston and Figley (2003) differentiate between burnout and STS. They suggest that burnout is experienced as an ongoing process rather then a specific event. These authors go on to state that:

.....Work-related burnout is not limited to persons working with the traumatized.

> Burnout can be caused by conflict between individual values and organizational goals and demands, an overload of responsibilities, a sense of having no control of the quality of services provided, awareness of little emotional or financial reward, a sense of a loss of community within the work setting, and the existence of inequity or lack of respect at the workplace (p. 168).

Salston and Figley (2003) continue on to list emotional responses that include emotional exhaustion, depression and anxiety. As well they note physiological responses that include physical exhaustion, hypertension and headaches. In another study Conrad and Kellar-Guenther (2006) attempt to understand the risk factors of both compassion fatigue and burnout in child protection workers. They were surprised that their findings concluded that the risk of burnout was far lower than the risk of compassion fatigue.

In addition, Trippany, Kress and Wilcoxon (2004) concur that there is a distinction between burnout and vicarious trauma in that construct of burnout is not population- specific while vicarious trauma is specific to those working with victims of trauma. These writers go on to share that both burnout and vicarious trauma may result in similar emotional and physical symptoms. Vicarious trauma can in fact lead to burnout.

The literature reflects that CYCs suffer from job related burnout. (Savicki, 1993) Mann-Feder and Savicki (2003) discuss that burnout in CYCs has resulted in high turnover rates, and reduced quality of service to youth in therapeutic, educational and residential settings. I question whether STS has been one of the factors that have led to burnout.

While the literature does not reflect any research of STS in CYCs, it does however illustrate primary trauma in this population. In a pilot study of Canadian child and youth workers, Snow (1994) found that the majority of these professionals showed symptoms of psychological distress after attempted and actual physical and verbal assaults by residential treatment clients. 75% of these professionals met the diagnostic criteria of the DSM IV for re-experiencing the trauma, avoidance and arousal.

Current research focuses on the child welfare population (Anderson, 2000; Annscheutz, 1999; Conrad and Kellar-Guenther, 2006; Corovic, 2006; Dane, 2000; Regehr, Leslie, Howe, Chau, 2000). Figley's work on STS has focused on family members, police officers, nurses and trauma therapists. Pearlman and Saakvitne (1995) have focused primarily on mental health professionals who work with survivors of sexual assault. Stamm (1999) reviews the developed literature regarding emergency personnel and health care practitioners. She comments that other professions are lagging behind. Although this author is not specific, it can be suggested that the field of child and youth care is an area that could be further explored.

The consensus among the professionals is that the above constructs can be an occupational hazard. The cost of caring for helping professionals of victimized individuals can be high. As a result, the importance of prevention and self-care is critical (Figley, 1999; Sakkvitne and Pearlman, 1996; Savicki, 2003; Stamm, 1997).

The culture of a workplace structure can have both a positive and negative impact on its employees who work with trauma victims. Most organizations work within some kind of hierarchical structure. Those with healthy models provide collaborative communication and decision making through a participatory style (Richardson, 2001).

Staff will contribute in a meaningful way where they feel welcomed and supported. Furthermore, it is important for staff members to feel that the leadership of the organization is reliable and trustworthy. Some organizations have failed to work in a collaborative manner, which in turn has a negative impact on their employees. Employees in organizations that work within a rigid hierarchy and strict rules do not usually achieve autonomy, support or trust. Where as, a work environment that fosters an atmosphere that promotes autonomy, staff generally are more confident in the work they do (Richardson, 2001; Trippany, 2004).

Given the complexities of STS and vicarious trauma it is important for organizations to have strategies put in place to help in its prevention. Figley (1999) and Rosenbloom, Pratt and Pearlman (1999) argue that prevention of harmful effects from these constructs involves attention to concrete issues, such as individual supervision and adequate time off. These authors place great value on the supervision process, "a supervision atmosphere that fosters an atmosphere of respect, safety, and control for the therapist who will be exploring the difficult issues evoked by trauma therapy" (Rosenbloom, Pratt and Pearlman, p.77).

Saakvitne and Pearlman (1996) share their philosophy of self-care,

> "Work is a part of life, but not its totality. We need a balance between work and leisure, action and reflection, giving and taking. We must embrace and integrate all of the many aspects of our selves. We are serious, playful, careful, spontaneous, sexual, intellectual, intense, self-indulgent, and much, much more. We are complex as we are human. Our self-care must reflect our diversity and complexity" (p.61).

Moreover, Saakvitne and Pearlman (1996) sum up what they consider as central aspects of vicarious traumatization interventions as awareness, balance and connection. Awareness is having the ability to tune in to our own needs. This requires attention to all aspects of one's experience, including dreams, associations, and bodily sensations. This requires time and quiet reflection. Balance requires the ability to integrate work, play and rest activities into our lives. Connection is a vital intervention that supports workers to maintain connections with others and to ourselves. This in turn helps decrease the isolation that is a major symptom of vicarious trauma.

The research suggests that regardless of terminology utilized, the impact of shared exposure of traumatic material is potentially both a personal and an occupational threat for helping professionals. Moreover, the work which requires caring, understanding and most importantly empathy effects many helping professions. The literature continues to illustrate the gap in identifying Child and Youth Counsellors as an at risk profession for developing STS. My study has established evidence based research identifying STS in Child and Youth Counsellors. Identifying is the first step towards addressing this hidden trauma.

My research addressed this gap in knowledge by asking the following research question: Do Child and Youth Counsellors experience stress symptoms (secondary traumatic stress) resulting from exposure to working with children and youth who have experienced traumatic events? After establishing the existence of STS in the CYCs who participated in the study, I queried further questions based on the demographic information that I collected. The following additional questions are queried in this study:

- Does the level of STS in CYCs differ in those that are exposed to children and youth's traumatic experience 1 to 3 times a week versus CYCs that are exposed to children and youth's traumatic experience over 4 times a week?
- Is there a relationship between the years of experience in the field of Child and Youth Care and the level of Secondary Traumatic Stress?

Chapter 3: Methods

The following chapter outlines in detail the specific methodology utilized in this research study. This section begins with the description of the research orientation. It is then followed by the overall design which includes how the data was collected, how the participants were selected, procedures used and data analysis utilized. This chapter finishes with ethical considerations.

Research Orientation

In order to answer the research question, the methodological process informed by the heuristic school of thought was utilized. The heuristic paradigm (Westhues,Cadell, Kafabanow, Maxwell, Sanchez (1999) looks at understanding the specific phenomena and how this phenomenon shifts or reacts in an open system. This study has argued that an individual's view of reality changes according to ongoing interaction with others. This shift in perception occurs when people attempt to make sense of experiences especially those that are unexpected and confusing. The process of recognizing the meaning of the impact on child and youth counsellors when helping young people who have been traumatized is central to this study. When child and youth counsellors engage in a therapeutic process with clients they cultivate a meaningful connection which requires compassion and empathy. It is this dynamic that is crucial in supporting traumatized young people. This study has helped these professionals ascribe meaning to their consequent emotions and behaviours.

The heuristic approach allows for quantitative methods of data collection in testing theories of human behaviour (Westhues et el. 1999). This is generally done by forming predictions about relationships, measuring the variables and then analyzing the

relationships between the variables to see if the findings support or negate the predictions. The advantage to using to what Robson (2005) notes as a fixed design is that this approach lies in the ability to "transcend individual differences and identify patterns and processes which can be linked to social structures and group or organizational features" (p. 98). This study measured the stress symptoms in child and youth counsellors resulting from the exposure to hearing the disclosure of a specific traumatic event and the subsequent consequent emotions and behaviours.

Design/Data Collection

A cross-sectional design has focused on the relationship between all the variables that have been studied. I used a survey questionnaire (Appendix A) to gather information on characteristics of subjects (independent variable). In order to find out whether CYCs do experience STS as a result of indirect exposure to children and youth's traumatic material, I first had to establish whether in fact CYC's worked with a traumatized population. I asked a yes/no question specifically to identify whether CYCs were exposed to hearing traumatic content. A 'yes' answer prompted participants to the following question in the survey while a 'no' response required the participants to end the survey. Further information gathered provided the frequency of exposure to traumatic content (independent variable) and degree of psychological distress (dependent variable).

In order to answer the research question it was important to choose a scale that measured only STS. I considered several scales including the Compassion Satisfaction and Fatigue Test (Figley & Stamm, 1996), Impact of Event Scale Revised (Weiss, 2004; Weiss & Marmar, 1997), and the Trauma attachment and Belief Scale (Pearlman, 2003). I used Bride's (1999) Secondary Traumatic Stress Scale (STSS) to assess stress levels

associated with indirect exposure to traumatic events through working with children and youth. This particular assessment was chosen as the wording of the instructions and the questions posed were designed in such a way that the traumatic stressor is identified as clinical work with traumatized clients. This is done to minimize the possibility that participants will endorse items based on an experience of direct trauma (Bride, Radey, Figley, 2007). Participants were asked to answer 17 questions based on how they were impacted over the last seven days with respect to working with traumatized children and youth using a five-point response format (1=never, 2=rarely, 3=occasionally, 4=often and 5=very often). This scale target feelings related specifically to the event as opposed to general feelings of distress. The (STSS) is composed of three subscales (intrusion, avoidance and hyper arousal).

Bride, Robinson, Yegidis & Figley (2003) present evidence of reliability, and factorial validity of the STSS. Internal consistency estimates for the total STS score is .93. The alpha value for the intrusion subscale is .80. The alpha value for the avoidance subscale is .87 and the alpha value for the arousal subscale is .83. The STSS has demonstrated construct validity through factorial analyses (p.8).

Survey Monkey which is a web-based tool that allows individuals to create online surveys was utilized. Online surveys are a popular tool as it is an inexpensive alternative to mail surveys to reach a large sample of subjects. (Van Selm, Jankowski, 2006). This medium also allows the opportunity to reach a larger geographical area.

Participants

There were 161 participants who responded to the survey. There were 125 (77.6%) completed surveys. I was not able to determine the response rate as participants

were recruited from two different venues, formal from the Ontario Association of Child and Youth Counsellor data base and informal through snowball sampling.

Child and youth counsellors were approached through the Ontario Association of Child and Youth Counsellor (OACYC) data base. The participants were self-selected by responding to a written request for voluntary participation in the survey. The only sample criterion required was full membership. Full members are either Professional Certified, those that have a Child and Youth Worker diploma from a recognized community college or a Child and Youth Care degree from a recognized university; or Professional, those with a related diploma or degree and at least 4000 hours of employment in the Child and Youth Counsellor field. As well, both Professional Certified and Professional members require proof of education and employment. (OACYC, 2002). As of February 2007, there are a total of 1026 full members in the Association, 784 professional Certified and 242 professional members. Although there was a variance in educational background, all respondents worked in the field. This number significantly increased in 2008 with a total of 1819 full members as of February 2008.

Child and Youth Counsellors were also recruited via a snowball effect. Several Child and Youth Counsellors who responded to the survey questionnaire forwarded the *Survey Monkey* web link via email to other Child and Youth Counsellors. It is unclear how many participants responded to the survey from either venue.

Procedure

A survey questionnaire was administered through the online web-based tool, *Survey Monkey.* A small advertisement (Appendix C) was placed in the actual Association's bi-monthly newsletter requesting participants' voluntary participation. The

advertisement directed participants to a specific web link on *Survey Monkey.* 1819 newsletters were sent in February 2008 and 1817 newsletters were sent in April 2008. Advertisements were placed in both newsletters for the purpose of increasing the response rate.

Participants of this survey opened the site directly to a consent statement (Appendix B) that required a 'yes' answer to the question, 'Do you agree to take this survey?', indicating that they have read and understood the consent form and that they are participating voluntarily. Respondents were prompted to the next question. A 'no' response advanced the participant to the last page thanking them for their time. With regards to confidentiality, there is no identifying information recorded at any time. Any information that participants supplied cannot be associated to any participant. The data is stored on a secure server by an ID number and will be deleted once the data analysis is completed. This survey took no more than ½ an hour to complete.

Data Analysis

I used statistical methods to clean and analyze the data with the help of *Survey Monkey* and the computer program SPSS. I applied both descriptive and inferential statistical analyses to the data collected. The information collected for analysis was derived from both demographic questions and responses to the Secondary Traumatic Stress Scale (STSS) (Bride, 1999). Scoring of the STSS consisted of adding the 1s, 2s, 3s, 4s and 5s for each of the three subscales. Bride (1999) identified specific questions from his STSS for each of the subscales. For Intrusion I added questions 2, 3,6,10 and 13. For Avoidance I added questions 1,5,7,9,12,14 and 17 and for Arousal I added 4,8,11,15 and 16. Once I computed the subscales I then added the subscales together for a

total STS score. I then presented the data using Bride's (2007) categorical approach which classifies the scores into levels of STS. In this approach Bride suggests taking a participant's score and classifying individuals into categories. Those that score less than 28 are interpreted as little or no STS. Scores 28-37 are interpreted as mild STS. Scores at 38-43 are interpreted as moderate STS; scores at 44-48 are interpreted as high STS and scores 49 and above are interpreted as severe STS.

I employed a second measure of scoring of the STSS (Bride, 2007) to analyze whether an STS symptom was endorsed or not. A symptom was thought to be endorsed if the CYC indicated that the symptom was experienced 'occasionally', 'often' or 'very often' in the proceeding seven days of responding to the survey.

I conducted an independent—samples t-test to explore the sub question do the levels of STS differ in those that are exposed to children and youth's traumatic experience 1-3 times a week versus CYCs that are exposed to children and youth's traumatic experience over 4 times a week. For this test, recoding of the original data needed to be adjusted to carry out the independent group t-test. Child and Youth Counsellors who in the course of a week heard children and youth share their traumatic experiences 1-3 times a week was coded as 1.00. Those that heard 4-6 and 6 or more times a week is now recoded as 4 or more times in a week. This is documented as 2.00.

I conducted a correlation analysis was conducted to determine whether there is a relationship between the years of experience in the field of Child and Youth Care and the level of STS.

Ethical Considerations

There was a risk of potential discomfort responding to questions of a personal or troubling nature. Participants could have been troubled recalling incidents of exposure to client's traumatic experiences. I provided participants with my contact information and the Wilfrid Laurier Ethical Review Board. Participants were encouraged to contact their local community supports if needed.

Chapter 4: Results

The following chapter outlines the results of both the descriptive and inferential statistical analysis tested. The information collected for analysis was derived from both demographic questions and responses to the Secondary Traumatic Stress Scale (STSS) (Bride et al., 2004). Not all of the independent variables (age, gender, and education) gathered in the demographics were tested beyond the basic descriptive analysis. These variables will be further explored in chapter 5 of this study. The focus of the descriptive testing centered on the analysis of the scoring of STS. Inferential testing was conducted to query the sub questions of this research. I conducted an independent group t-test to analyze the difference of the means of the between the independent variable, exposure to children and youth's traumatic material and the dependent variable, the level of the STS scores. Pearson correlation was conducted to examine the relationship between the years of experience (independent variable) and the scores representing the levels of STS (dependent variable).

Analysis of the demographic information collected from those who participated in the survey indicated that respondents were on the average between 31 to 40 years of age and were for the most part female (81.5%) (Table 1). The majority of Child and Youth Counsellors had a college diploma (57.6%) while 22.2 percent of the respondents held an undergraduate degree in Child and Youth Care. 6.3 percent held a Masters degree while 1.4 percent held a PhD. The 'other' category (8.3%) held certificates in youth development, undergraduate degrees in criminology and psychology. Continued analysis of the demographic information revealed that the mean of the number of years working in the field of Child and Youth Care was 12.30.

One hundred and sixty one participants began the survey questionnaire. Of these, 125 participants (77.6 %) completed the demographic questionnaire. The numbers do vary somewhat in the completion of the actual questions. Participants responded to the questions that described the characteristics of the respondents (independent variables) as follows: 151 (93.7%) completed both the gender and the age question. One hundred and forty four (89.4 %) CYC responded to the question of education background while 149 (92.5 percent) responded to how many years of experience they have achieved. One hundred and forty eight (91.9%) responded to the question asking in what work setting participants were employed. One hundred and forty two (88.1%) participants responded to the question regarding of exposure to traumatic content (independent variable) while 127 (78.9 %) responded to the questions regarding degree of stress symptoms (table 1).

Table 1: Demographic and Professional Characteristics of Child and Youth Counsellors responding to Secondary Traumatic Stress Survey

	N	M	%
Age Range	**151**		93.7
20-25	33		21.9
26-30	27		17.9
31-35	31		20.5
36-40	22		14.6
41-45	15		9.9
46-50	9		6.0
51-55	8		5.3
56-60	6		4.0
Gender	**151**		93.7
Female	123		81.5
Male	28		18.5
Education	**144**		89.4
Certificate	5		3.5
Diploma	83		57.6
B.A. CYC	33		22.9
Masters	9		6.3
PhD	2		1.4
Other	12		8.3
Years of Experiences	**149**	12.3	92.5
Work Settings	**148**		91.9
Residential Treatment Centres	37		25
Group Home	19		12.8
School Board	29		19.6
Day Treatment	9		6.1
Hospital	21		14.2
Heard Traumatic experience	**145**		
Yes	143		98
No	2		2
How often traumatic experiences heard in a week	**142**		88.1
1-3	60.2		68.3
4-6	19.3		21.8
6 or more	14		9.9

Research Question

The essence of my research was testing the question, *Do child and Youth Counsellors experience Secondary Traumatic Stress resulting from exposure to working with children and youth who have experienced traumatic events.* Once it was confirmed in the demographic responses that CYCs did in fact work with

traumatized children and youth, it was then necessary to analyze the data from the Secondary Traumatic Stress Scale (STSS) (Bride et al., 2004) (see Appendix A). The STSS is made up of 3 subscales, intrusion, avoidance and arousal. Scoring of the STSS was conducted 2 different ways. The first method required summing up the scores on each item. Scoring of the STSS consisted of adding the 1s, 2s, 3s, 4s and 5s for each of the three subscales. Bride (1999) identified specific questions from his STSS for each of the subscales. For Intrusion I added questions 2, 3,6,10 and 13. For Avoidance I added questions 1,5,7,9,12,14 and 17 and for Arousal I added 4,8,11,15 and 16. Once I computed the subscales I then added the subscales together for a total STS score. I then presented the data using Bride's (2007) categorical approach which classifies the scores into levels of STS.

I employed a second measure of scoring of the STSS (Bride, 2007) to analyze whether an STS symptom was endorsed or not. A symptom was thought to be endorsed if the CYC indicated that the symptom was experienced 'occasionally', 'often' or 'very often' in the proceeding seven days of responding to the survey.

Levels of Secondary Traumatic Stress

Of the several approaches Bride (2007) recommends to presenting the scores of the Secondary Traumatic Stress Scale (STSS), I employed the categorical approach. In this approach Bride suggests taking a participant's score and classifying individuals into categories. Out of 161 respondents that started the survey127 participants completed the STSS. 84 (66.1%) of CYC's experienced some level of STS. The overall mean score is 33.65 suggesting that CYCs experienced mild level of STS with a standard deviation of 11.51. 43 (33.9 %) of the CY Cs that responded to the STSS had a score of less than 28,

suggesting that participants experienced little to no STS. 42 (33.0 %) of the respondents experienced mild STS while 19 (15.0 %) experienced moderate STS. 9 (7.1%) of CYCs experienced high STS with 14 (11.0%) of these professionals experiencing severe STS (Figure 1). Figure 2 illustrates that the STS scores are in actuality, slightly positively skewed indicating an approximately normal distribution.

Figure 1: Level of Secondary Traumatic Stress Scores

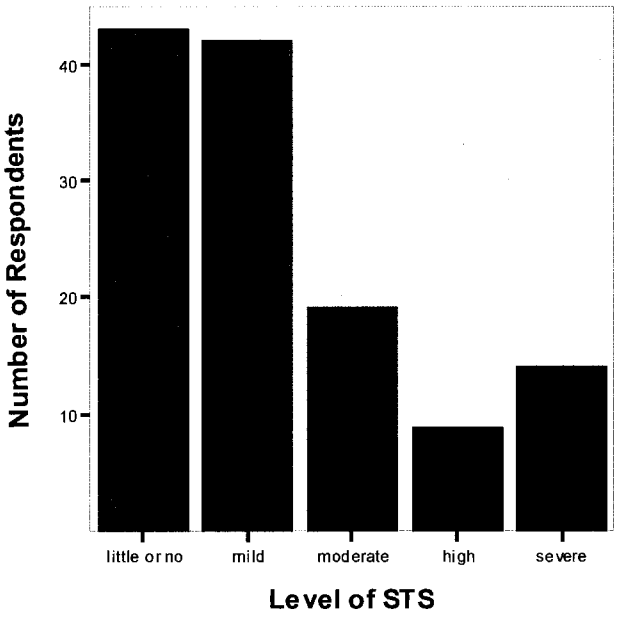
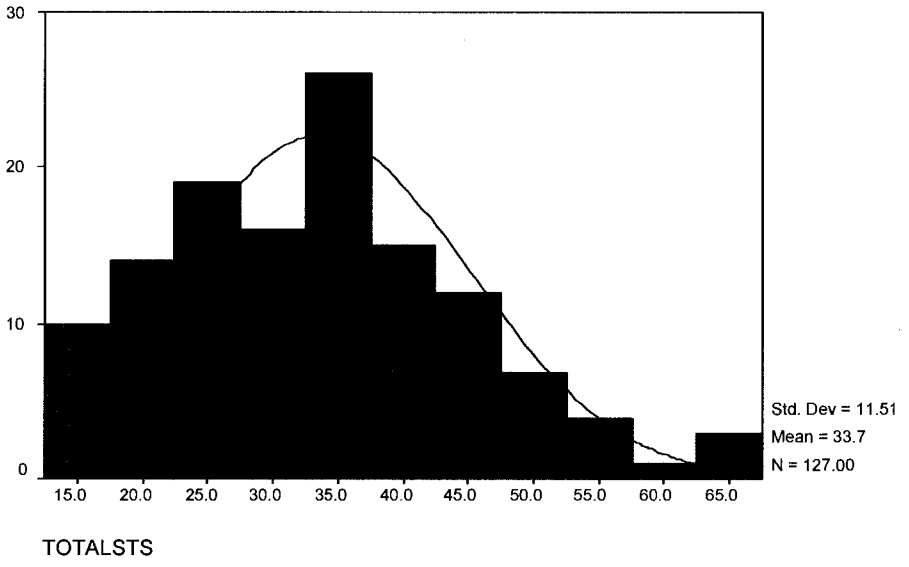


Figure 2: Histogram: Distribution of STS Scores



Results of Individual Symptoms

I endorsed an individual symptom of STS as Bride (2007) suggested, if a CYC participant indicated that the symptom was experienced 'occasionally,' 'often,' or 'very often' in the previous seven days. The intrusion subgroup included the most frequently reported symptom experienced by child and youth counsellors. 68.5% of respondents thought about their work with traumatized children or youth without intending to (Table 2). The least reported symptom was in the avoidance subscale with 81.5 % of CYC's noticing gaps in their memory about children and youth sessions. Experiencing physiological reactions, i.e. heart pounding when thinking about work with children (41 %) and youth and being upset when reminded of children and youth (28.4 %) were the next frequently reported symptoms in the intrusion subscale. The two remaining symptoms in the intrusion subscale were reported less frequently with 26 % of

respondents reporting having disturbing dreams about children and youth and 20.4 % of CYC's reliving the trauma(s) experienced by children and youth.

Continuing interpreting individual symptoms looked at how the remaining symptoms in both the avoidance and arousal subscales were endorsed. Avoided working with some children and youth (43.8% n=32) followed by feeling emotionally numb (41%) were the most frequently endorsed symptoms in the arousal subscale. 29% of CYCs reported less activity and feelings of discouragement while 26 percent reported they had little interest in being around others and 24.4% of CYCs avoided people, places or things that reminded them of their work with children and youth. The three most frequently reported symptoms in the arousal subscale with 43.2 %, 39.3 % and 36.9 % respectively are feeling easily annoyed, had trouble concentrating and trouble sleeping. The remaining two symptoms endorsed were those that expected something bad to happen with 26.8% and respondents that felt jumpy with 22.1 %.

Table 2 : Frequency of Secondary Traumatic Stress Symptoms as Reported by Child and Youth Counsellors *(N= 127)*

Criterion (Item No.)	*Never n(%)*	*Rarely n(%)*	*Occas. n(%)*	*Often n(%)*	*Very Often n(%)*	*M*
Criterion B- Intrusion symptoms						
Intrusive thoughts about clients (10)*	14(11.0)	26(20.5)	48(37.8)	29(22.8)	10(7.9)	*2.96*
Disturbing dreams about Clients (13)*	65(51.2)	29(22.8)	22(17.3)	11(8.7)	----	*1.83*
Sense of reliving clients' trauma (3)	54(42.5)	47(37.0)	22(17.3)	4(3.1)	----	*1.81*
Cued psychological distress (6)	50(39.4)	41(32.3)	26(20.5)	10(7.9)	----	*1.97*
Cued physiological reaction (2)	37(29.1)	38(29.9)	39(30.7)	11(8.7)	1(.8)	*2.24*
Criterion C- Avoidance symptoms						
Avoidance of clients (14) (N=32)*	7(21.9)	11(34.4)	12(37.5)	2(6.3)	----	*2.28*
Avoidance of people, places, things (12)	64(50.4)	32(25.2)	26(20.5)	4(3.1)	1(.8)	*1.79*
Inability to recall client information (17)*	59(46.5)	27.6(35)	24(18.9)	7(5.5)	2(1.6)	*1.86*
Diminished activity level (9)	46(36.2)	43(33.9)	29(22.8)	8(6.3)	1(.8)	*1.88*
Detachment from others (7)	60(47.2)	34(26.8)	25(19.7)	7(5.5)	1(.8)	*2.02*
Emotional numbing (1)	37(29.1)	38(29.9)	41(32.3)	10(7.9)	1(.8)	*2.21*
Foreshortened future (5)	48(37.8)	41(32.3)	25(19.7)	9(7.1)	4(3.1)	*2.06*
Criterion D- Arousal symptoms						
Difficulty sleeping (4)	36(28.3)	44(34.6)	28(22.0)	15(11.8)	4(3.1)	*2.27*
Irritability (15)	32(25.2)	40(31.5)	36(28.3)	14(11.0)	5(3.9)	*2.37*
Difficulty concentrating (11)	34(26.8)	43(33.9)	31(24.4)	15(11.8)	4(3.1)	*2.31*
Hypervigilance (16)	53(41.7)	40(31.5)	26(20.5)	7(5.5)	1(.8)	*1.92*
Easily startled (8)	64(50.4)	35(27.6)	18(14.2)	9(7.1)	1(.8)	*1.8*

Sub Question 1

An independent –samples t-test was conducted to evaluate the question: Does the level of STS in CYCs differ in those that are exposed to children and youth's traumatic experience 1 to 3 times a week versus CYCs that are exposed to children and youth's traumatic experience over 4 times a week? The test was non-significant, t (124) = -1.21, p = 22. CYC's who were exposed to children and youth's traumatic experience 1 to 3 times a week (M = *32.89, SD= 11.19)* did not differ in the level of STS from CYC's who were exposed to children and Youth's traumatic experience over 4 times a week (M = *35.60, SD = 12.22)* (Table 3)

Table 3: Results of Independent Samples t test

Group Statistics

	# of times in	N	Mean	Std. Deviation	Std. Error Mean
TOTALSTS	1.00	88	32.8977	11.1912	1.1930
	2.00	38	35.6053	12.2288	1.9838

Independent Samples Test

		Levene's Test for Equality of Variances		t-test for Equality of Means						
									95% Confidence Interval of the Mean	
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	Lower	Upper
TOTALSTS	Equal variances assumed	.147	.703	-1.212	124	.228	-2.7075	2.2343	-7.1299	1.7148
	Equal variances not assumed			-1.170	64.986	.246	-2.7075	2.3149	-7.3306	1.9156

Sub Question 2

A correlation analysis was computed to determine whether there is a relationship between the years of experience in the field of Child and Youth Care (independent variable) and the level of Secondary Traumatic Stress (dependent variable). There was a weak correlation between the two variables, r =.126, n =127, p = .079 (Table 4).

Table 4

Descriptive Statistics

	Mean	Std. Deviation	N
experience	12.3087	8.6725	149
TOTALSTS	33.6535	11.5066	127

Correlations

		experience	TOTALSTS
Pearson Correlation	experience	1.000	.126
	TOTALSTS	.126	1.000
Sig. (1-tailed)	experience	.	.079
	TOTALSTS	.079	.
N	experience	149	127
	TOTALSTS	127	127

Chapter 5: Discussion

My study has established evidence based- research that has identified levels of STS in the sample of CYCs studied. 66.1% of CYCs in this study experienced some level of STS. The literature has suggested that professionals in other helping careers such as social workers, child protection workers, nurses, police, fire and ambulance personnel do experience Secondary Traumatic Stress (Bride, 2007; Conrad & Kellar, 2006; Stamm, 1997). The following sections will discuss the links between current findings and the past literature, describe the strengths and limitations of the study, application to practice and highlight opportunities for future research. This discussion will also include my personal reflections about my journey as a researcher.

The decision to name the construct discussed in this study has been a struggle of mine from the onset of this research. The term Vicarious Trauma was the first phrase that was introduced to me in my undergraduate degree in 2004. This phrase was loosely defined as stress symptoms as a result of being exposed to the traumatic material of the children and youth. This is the term that has stuck with me and have been drawn to for no other reason. When I began my research the title of my study was *Vicarious Trauma: The Hidden Trauma in Child and Youth Counsellors.* Vicarious Trauma was the chosen term used throughout the study. Through the writing of my data analysis I could not ignore that my own research reflected that I needed to move towards the use of the terminology Secondary Traumatic Stress. I had incorporated Charles Figley's (1999) definition of Secondary Traumatic Stress and used Brian Bride's (2004) Secondary Traumatic Stress Scale. It was important that I allow the research to direct the terminology used and not let my personal sentiment impact this decision. My own

struggle with the choice of terminology continues to reflect the differences in the language used in the literature (Stamm, 1997). Figley (1999) himself uses the terms Secondary Traumatic Stress and Compassion Fatigue interchangeably.

The current study has incorporated both descriptive and inferential statistical data analysis in examining the data collected. Inferential testing was able to explore the underpinnings in the literature questioning the link between the amount of exposure of indirect trauma to STS. In addition, I questioned the relationship between the years of experience in the field of Child and Youth Care and STS.

The demographic information collected indicated that the respondents were on the average between 31 and 40 years of age. Although not specifically tested in the current study, it is remarkable to note that in her study Kassam-Adams (1999) found that age was not related to therapist's level of stress symptoms. The majority of respondents were female (81.5 percent). This was not a surprising finding. Bride's (2007) study of the prevalence of secondary traumatic stress among social workers also received a larger sample from female respondents (81.9 percent). Bride does not give any reasons for this. However, one thought is that the social service field has attracted a larger female contingent. Another idea to consider is that female clinicians are more likely to report trauma symptoms than their male counterparts. In her study Kassam-Adams (1999) suggested the influence the role of gender has had on the reporting of indirect exposure of trauma symptoms. She found that the gender of the clinician was a variable in vicarious trauma. This is not to suggest that males do not experience vicarious trauma, it simply suggests that they are not reporting the symptoms. It would be interesting to sample

strictly male CYCs to obtain a more clear understanding of their responses to indirect exposure to the traumatic experiences of children and youth.

This study indicates that CYCs that had been employed in the field of Child and Youth Care for a number of years had responded to the survey. The mean value of the years in the field of Child and Youth Care is 12.3 indicating that experienced CYC's responded to this survey. It is worthy of note that 80.5 percent of CYCs reported having a college diploma in Child and Youth Work with 22.9 percent of these respondents having a Bachelor of Art in Child and Youth Care. It is interesting that even though it is difficult to ascertain whether the sample of CYCs were members of the Ontario Association of Child and Youth Counsellors, the sample did suggest a high percentage of CYC's with college diplomas in Child and Youth Work.

Research Question

The heart of my research is testing the question, *Do Child and Youth Counsellors experience Secondary Traumatic Stress resulting from exposure to working with children and youth who have experienced traumatic events.* In order to analyze this question, my research study first had to establish whether in fact CYC's worked with a traumatized population. 98 percent of CYCs responded in the affirmative indicting the extent that respondents worked with young people that have experienced traumatic events. Only 2 percent declined having that experience. This in itself is noteworthy as it acknowledges that a significant aspect of the CYC's job is working with traumatized clients. Stuart and Sanders (2008) illustrate in their recent study that CYCs who work in residential group care help children and youth deal with historical traumatic events.

It is interesting to note the difference between the number of participants who responded to the question regarding indirect exposure to traumatic content and the questions concerning degree of stress symptoms. 142 (88.1 percent) participants stated that they had experienced indirect exposure to traumatic content in their work environment while only 127 (78.9 percent) responded to the questions regarding degree of stress symptoms. These particular CYC's chose not to complete the Secondary Traumatic Stress Scale (Bride et al, 2004). I queried what stopped CYCs from completing the survey at this point. Bride (2007) suggests that although he had a fairly respectable response rate that social workers in his study were less likely to respond fearing the act of completing the survey would increase their distress. With this said, one thought is that CYC's could be triggered by the content of the instrument. The hope is that the content would have a meaningful connection for those filling it out thus giving a language to their experience. Undoubtedly, this meaning could be negatively influenced.

Interpretation of the STS results is the core of my research study. Overall, results indicated that CYC's engaged in direct practice with children and youth who have had traumatic experiences are likely to experience some level of STS. It was important to maintain continuity in the scoring with Bride's Secondary Traumatic Stress Scale (Bride, Robinson, Yegidis, & Figley, 2004) to ensure the integrity of the results. Total STS scores ranged from 13, meaning no symptoms to 64 suggesting severe symptoms (Table 2). STS scores were slightly positively skewed indicating an approximate normal distribution (Figure 1) and that many CYCs had low level symptoms. Conversely, a smaller number (11 percent) of CYCs were experiencing more severe symptoms of STS while 33 percent of these professionals experienced mild stress symptoms Bride (2007)

experienced similar results in his research study. His study stated that total STS scores ranged from 17 to 74. It is encouraging to note that 33.9 percent did not endorse any symptoms of STS.

A decision was made to interpret the individual symptoms of STS as an alternative method of calculating the scoring of the Secondary Traumatic Stress Scale. Bride (2007) uses this measure of scoring in his study of STS in social workers. A symptom was endorsed if the respondent indicated that the symptom was experienced 'occasionally', 'often', or 'very often' in the previous week. The results of the current study were somewhat consistent with Bride's (2007) study. The five intrusion symptoms contained both the most and the least frequently reported symptoms. This was true for both the current study and Bride's. In fact, the most frequently reported symptom, intrusive thoughts related to work with clients was endorsed by 40.5 percent of respondents in Bride's study where 68.5 percent of CYC's from the current study reported endorsing the same symptom.

Sub Question 1

I raised the sub question: *Does the level of STS in CYCs differ in those that are exposed to children and youth's traumatic experience(s) 1 to 3 times a week versus CYCs that are exposed to children and youth's traumatic experience(s) over 4 times a week* My results indicated that there was no significant difference. CYC's that are exposed to children and Youth's traumatic experience(s) 1 to 3 times a week did not differ in the level of STS from CYC's who were exposed to children and Youth's traumatic experience over 4 times a week.

The literature does suggest differing theories. Saakvitne and Pearlman (1996) emphasize the cumulative exposure to traumatic material. They contend that in their work with survivors of sexual trauma, professionals who work for longer periods of time with continued exposure to their client's traumatic material are more at risk for vicarious trauma. In their study, Woodard Meyers and Cornille (2002) contended those child protection workers who worked for longer periods of time in the field of child protection and as a result exposed to longer duration of traumatic material, experienced more severe STS symptoms than those who were in the field for a few years. Figley (1999) emphasizes the rapid onset of symptoms that can occur from exposure to a single event. Chrestman (1999) reported that in her study with therapists who treat traumatized clients, stress from secondary exposure to trauma presented as acute and were able to recover after a short time rather than chronic. I do acknowledge a personal bias in this area. My own personal experience with STS occurred after a single event of being exposed to a youth's traumatic experience. I am not suggesting that STS cannot occur as a result of cumulative exposure to children and youth's traumatic content. However, I am suggesting as Figley (1999) contends, that levels of STS can occur from exposure to a single event.

Although my current study does not suggest a strong relationship between STS symptoms and the amount of exposure to indirect trauma, it does further query the relationship between these two variables. Exposure to client's traumatic material was not qualified in my study other than asking how many times in a week did the CYC hear a child or youth share a traumatic event. Data was not collected on client workload per se, specifically how many clients seen over a course of a week. As CYC's work in a

variety of settings client workload is more difficult to assess. For example, those that work in residential setting are likely to work with same young person for a period of time i.e. same child or youth for a 5 day stretch versus a CYC in child protection is likely to have a different caseload on a daily basis. So the question asks how the amount of indirect exposure is defined.

Sub Question 2

The third sub question I queried in this study was: *Is there is a relationship between the years of experience in the field of Child and Youth Care and the level of Secondary Traumatic Stress?* My results indicated that there is a weak positive relationship between years of experience and levels of STS. The literature is conflicting in this area. In her study with therapists who treat trauma stressed clients, Chrestman (1999), reports that increased professional experience was associated with a decrease in stress symptoms. In her study of STS in therapists who treat sexually traumatized clients, Kassam-Adams (1999) reported that years of clinical experience was not related to therapists stress symptoms to secondary exposure. I would be interested in knowing if the weak positive relationship between years of professional experience and the level of STS is related to a knowledge base of STS. Would there be a difference in levels of STS between new CYC graduates and experienced CYCs who are knowledgeable in STS versus CYC graduates and experienced CYCs who lack the knowledge about STS?

Limitations/Strengths

This study presented both strengths and limitations that are relevant to note. The Secondary Traumatic Stress Scale (STSS) was chosen for its ability to offer a brief self administered format. This took into account respecting the time it takes to respond to

surveys while appreciating the importance of the intended research. The STSS differs from other questionnaires as the stressor indicated in the wording of the instructions is identified as clinical work with traumatized clients in order to minimize the possibility that CYCs will endorse items based on direct trauma (Bride, Radey, Figley, 2007). The STSS required that respondents answer questions based on their experience 7 days prior to completing the survey. It would have been interesting to examine CYC's experience of STS over the course of a career. Examining STS over a course of a career could suggest a either cumulative effect or conversely it could suggest that STS could be experienced after a specific event that occurred sometime in their career. I did investigate the use of alternate scales. Other scales were considered with a time line but were ruled out as the scales measured more than one construct. For example, The Compassion Fatigue Self Test, although had no time frame indicated, measured both Compassion Fatigue and Burnout (Figley, 1995). It was essential that the current study measure specifically only one construct, Secondary Traumatic Stress.

Limitations of this design include the tendency for low level response rates for online surveys. A second advertisement was placed two months after the first notification to increase response rate. The data gathered is obtained retrospectively and it is quite likely that respondents' memories and perceptions of incidents become distorted over time. In addition, as there are approximately 8000 CYCs in Ontario the scope of this study did not reach the entire CYC population in Ontario as not all CYCs are members of the association. Another possible limitation is that those who take the time to respond may be motivated to do so while the unmotivated participants may be adversely impacted

by Secondary Traumatic Stress. In some ways these CYCs, the ones that may be affected by STS are the ones that need the study the most.

I have no way of being able to differentiate what the response rate was as some of the original methodology shifted. What is known is that 1819 newsletters were sent out in February 2008 and a follow up newsletter (1817) was sent in April 2008. If this was the only guiding influence then the response rate would be considered quite low as there were a total of 161participants (8 percent). A considerable strength of this survey is that Child and Youth Counsellors that responded to this survey appreciated the depth and importance that this study had for CYCs. As a result, they felt the need to inform their colleagues resulting in a snowball effect. At the same time this strength is a limitation of this study. CYC's were also recruited from other CYC's who responded to the original survey. Several CYC's who responded to the survey forwarded the *Survey Monkey* web link to other CYC's. What is not known is how many emails were sent and then how many responses were directly from that source. It would be useful for future surveys to simply ask the question of how respondents heard about the survey.

The other consideration with regards to the shift in methodology is that there was no way to identify in the questionnaire who in fact is a certified member of the Ontario Association of Child and Youth Counsellors. The original sample criterion was to be full certified members of the association thus requiring minimum a child and Youth Worker diploma from a recognized community college. The bias in this did not account for other methods of recruitment. On the other hand, if in fact only members of the OACYC were the only participants this could have impacted the response even further thus not taking into account other CYC experiences.

One of the limitations of my study is that although 81.5 percent of the respondents were female the results do not indicate the experience of male CYCs when exposed to indirect traumatic material. The question becomes how does the male CYC experience get recognized? In addition, what keeps this gender from responding to the research study?

It is necessary to note that question 14, 'I wanted to avoid working with some children and youth', of the Secondary Traumatic Stressed Scale (STSS) was omitted by error from the survey on *Survey Monkey*. This error was corrected by adding the question to the questionnaire. There were 32 respondents to this question out of 127 possible responses to the STSS. It is interesting to note that 43.8 percent of the respondents endorsed this symptom of avoidance. This error could indeed have impacted the categorical scoring of the STSS. The impact of including this question could have had a substantial positive effect on the outcome of the results.

A strength of my study is that this is the first study that I am aware of that has established levels of STS in the sample of CYC's studied. With that said, my study being the initial study of STS in CYCs does present somewhat of a limitation. I was not able to query whether my results could be generalized to the larger population of CYCs.

Applications to Social Work Practice

There has been a growing influence in the literature on STS within a number of the helping professionals including social workers. There has been an influx of research on STS within the social work community (Adams, Figley & Boscarino, 2008; Bride, 2007). Without this preliminary research I could not have conducted the current study with CYCs. Previous research in this area has given breadth to my current study.

I have known CYCs who have been known to leave the profession of Child and Youth Care and enter other helping type professions in the hope of attaining career advancement including higher paid positions. The profession of social work has long attracted Child and Youth Counsellors. One of the reasons is that currently in Ontario there is only one Bachelor of Art Degree program in Child and Youth Care and no Masters or PhD programs. These graduate programs do exist but are limited in numbers and are located outside the province of Ontario (Stewart & Hare,2004). This makes access to higher education in Child and Youth Care more of a challenge and hence choosing social work, a rewarding program in the helping profession that much more appealing.

CYCs are able to transition into the field of social work quite naturally. We bring with us an enormous amount of skill and expertise when we begin our academic journey in social work. Historically, I believe that some CYCs have entered the field of social work without the knowledge and understanding of what STS is and the impact that STS has. In addition, some CYCs may themselves have experienced some level of STS. It is unknown how many CYCs have entered the field of social work. My study has offered CYCs entering the field of social work an added knowledge base of STS.

What my study has brought to light is a possible shared understanding between helping professionals, which now can include CYCs. Many CYCs work on multi disciplinary teams which include social workers. As stated in the literature, Bride (2007), social workers experience levels of STS. My hope is that this study will add to the pool of knowledge that will only add to the working relationship between CYCs and social workers.

Applications to Child and Youth Care

My study has provided evidentiary substance to current literature that STS exists in CYC's. This recognition has incredible meaning as this new found knowledge brings relevance not only to CYCs as individual practitioners, but to the profession of Child and Youth Care as a whole. Looking back to the rationale of my research it is important to be reminded of the challenges within the discipline of Child and Youth Care to gain professional recognition. CYCs with various education backgrounds are dispersed through the province of Ontario. In an effort to promote this profession it is important to engage those in a position to inform and teach when there is new research added to the field of Child and Youth Care. It will be important for educators in the community college and university arena to utilize this study in the teaching of STS to future CYCs. It is vital that an understanding and an increase awareness of CYCs' experience STS be passed on to students entering the field.

Until the field of Child and Youth Care becomes a regulated profession where all CYCs are mandated to have minimum educational requirements and be a certified member of the Ontario Association of Child and Youth Counsellors, it remains a challenge for those working with traumatized young people to access the knowledge in the area of STS. The responsibility then becomes each individual CYC to pass on their knowledge of STS. Figley (1999), states that practicing professionals have a special obligation to train other workers on this occupational hazard (p.22).

The hope is that this new knowledge of STS in CYCs will help in both the prevention and self care practices in the symptoms of STS. STS is a normal reaction to

an abnormal event. It is the silent trauma that has affected CYC's in their day to day work with traumatized young people. The literature does contend that prevention and self care is of utmost importance as the cost of caring can be high for helping professionals that work with victimized young people (Figley, 1999; Sakkvitne and Pearlman, 1996; Savicki, 2003; Stamm, 1997). While no one disagrees around the importance of self care, this is easier said than done. In order for prevention and self care to be effective, I believe it is necessary for it to be a collaborative approach between the organizations and the CYCs that they employ. Richardson (2001) discusses the importance of a healthy organizational model that provides collaborative communication and decision making through a participatory style. When management makes prevention of STS and self care a priority CYCs in turn will respond in a meaningful way. (Figley, 1999; Sakkvitne and Pearlman, 1996; Savicki, 2003; Stamm, 1997).

Reflections

I remember thinking back to my undergraduate degree in Child and Youth Care that 'someone should do some research in Vicarious Trauma in Child and Youth Counsellors'. I was quite surprised to learn that research had never been done in this area. Little did I realize that I would in fact be the 'someone' to take on the challenge of this much needed research. As the old saying goes, 'be careful what you wish for'. It has been my passion for the field of Child and Youth Care and my need to challenge myself in new aspects of learning that has guided me through this journey.

Research was an area in academia that I always had found intimidating. Personally, I struggled with the knowledge and skill level that research required (or that I believed it required). Professionally, I admired those that put themselves out for the

professions that they were attached to. The research thesis for the Masters of Social Work (MSW) was an option. I actively made the choice to do this research. I chose the thesis stream for two reasons. One, I wanted to challenge my own insecurities and learn how to do research. I wanted to say that I did a research thesis in my academic career. The second reason was appreciating that I could make a difference as a Social Worker in the field of Child and Youth Care. Research plays such an important role in validating a profession. Child and Youth Care is longing for research especially in the area of identifying the experiences of the practitioners that work with children and youth. I wanted to make a difference. I felt quite privileged that the MSW program allowed me to honour both myself and Child and Youth professionals by doing this research.

It is humbling being in the position of 'not knowing'. It can be both scary and exciting at the same time. I came into this learning journey with passion, enthusiasm and some trepidation. Learning to be comfortable with 'not knowing' was my first learning challenge. As soon I settled into the rhythm of the learning process, I was able to engage with the new knowledge that I acquired. I believe that I have had the most personal growth in this area. There were times I was ready to give up. Truly embracing a position of 'not knowing' is a skill has guided me for the last 3 ½ years. This has even transferred to other areas of my life. i.e. new working situations. I find myself feeling much more humbled and welcoming of new learning. I believe that this has made me much more approachable as an individual.

Through this process as a new researcher I learned to understand just how much my social location influences how the study unfolds. I chose the heuristic school of thought as I entered this research thesis already situated with a personal stake in the

results. I wanted to see of other CYCs had similar experiences to the one that I had. I used quantitative methodology which typically is from a positivist approach more as a tool and less as a research orientation. My focus was simply that I wanted to identify STS in CYCs. While I am not minimizing the importance of this study I have recognized that utilizing some qualitative methodology would have added the voice of CYCs in a way that quantitative data collection does not capture.

I look back at my own rationale for doing this research study and realize how much my journey into the field of social work has mirrored my own struggle with professional identity. I believe I am a CYC who has always advocated for the profession of Child and Youth Care. I have been in the field of Child and Youth Care since 1981 and have and still do quite proudly call myself a CYC. When I began the Master in Social Work (MSW) program here at Wilfird Laurier University I entered each course sharing my experience as a CYC with my professors and colleagues. I wanted my new colleagues to know what my professional roots were. I really struggled with the loyalty bind that I had created for myself. How did I remain true to the profession of CYC, a profession that struggles with its own professional recognition and enter the field of social work. I have friends that are CYCs that jokingly referred to me as a 'traitor' for being in social work. I was clear about why I shifted professions. I wanted to increase my clinical knowledge in the hopes of working in a hospital setting and open a private practice in individual and family counseling. The MSW program offered me an opportunity to pursue my career ambitions. I had to acknowledge that unless I wanted to travel out of province I was not able to continue my academic career in Child and Youth Care.

I thought that I had the perfect answer. I would teach as a part time instructor in the B.A. program in Child and Youth Care at Ryerson University. This way I had the opportunity to give back to the profession.

What guided my shift in perception was my final practicum in the MSW program. I worked in the Child and Family Program at Credit Valley Hospital. One of my goals was to integrate my experience as a CYC into my new role as a social worker. I was quite honest with my supervisor that I was having a lot of difficulty transitioning to my new role. I even had a hard time referring to myself as a social work student. I had (and still have) the opportunity to work with a wonderful group of social workers who embraced my skills and experience as a CYC. My supervisor who coincidentally had a background in CYC, gave me some advice one day. He suggested letting the work guide me. He continued on by directing me to focus on my clinical practice and less on what I call myself. Somehow my shift in thinking became less about what I was losing and more about what I was gaining. Social work became an addition to Child and Youth Care rather than a replacement of Child and Youth Care. Being able to distinguish this was fundamental in the integration of both honorable careers.

I plan on expanding my new found knowledge in the area of research in my current position at Credit Valley Hospital. I participate in a running group for youth who suffer with depression and anxiety. This group has recently expanded to include both parents and youth. I have taken on the task of conducting evidence based research in the evaluation of this program. I would not be able to accomplish this daunting task if not for the extensive learning process of my research thesis.

Future Research

Additional research is necessary to validate these original findings. It would be necessary to explore other methods of data collection in order to capture the voices of CYCs . Mailed questionnaires to organizations and agencies may increase the response rate. In addition, future research may include qualitative methods i.e., interviewing individual CYCs. It would be important that future research include assessing both personal risk and protective factors. This would answer the question, why do so some CYC's experience STS and other's do not. According to Briere (1997), individuals who have been exposed to many traumatic events are prone to more severe trauma responses especially if they have not appropriately dealt with previous traumatic events. It can be suggested that CYC's with a previous history of personal trauma are more likely to experience stress symptoms associated with indirect exposure to young people's traumatic material. This would be important demographic information to collect in the future, This study did not investigate the impact of STS on the effectiveness of clinical practice of CYC's.

Appendix A

DATE_____

Please fill in the following information:

1) Male ☐ Female ☐

2) AGE:

20-25 ☐	31-35 ☐	41-45 ☐	51-55 ☐
26-30 ☐	36-40 ☐	46-50 ☐	56-60 ☐

3) EDUCATION:

Certificate	Date graduated_____
Diploma- Child and Youth Work	Date graduated_____
B.A.-Child and Youth Care	Date graduated_____
M.A.	Date graduated_____
Ph.D.	Date graduated_____
Other	Date graduated_____

4) EXPERIENCE:

How many years of experience do you have working in the field of Child and Youth Care? _____

5) Please check off the following setting where you are currently employed.

Residential Treatment Centre	☐	Hospital	☐
Group Home	☐	Detention	☐
School Board	☐	Street Outreach	☐
Day Treatment	☐	Other (please specify	
		_____	

The following questions refer to your exposure to working with traumatized children and youth in the course of your career. A traumatic experience is defined as " an event that involves actual or threatened death or serious injury, or other threat to one's physical or witnessing an event that involves death, injury; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate (DSM. "IV", 1994). If you answer no in question 6 please discontinue this survey. Thank you for your time.

6) Have you ever heard a child or youth share their traumatic experience?

a. No ☐ b. Yes ☐

7) In the course of a work week, how many times do you hear children and youth share their traumatic experience?

a. 1-3 □ b. 4-6 □ c. 6 or more □

The following is a list of statements made by persons who have been impacted by their work with traumatized children and youth. Read each statement then indicate how frequently the statement was true for you in the past 7 days and at any other time during the course of your career.

	Never	Rarely	Occasionally	Often	Very Often
8. I felt emotionally numb	1	2	3	4	5
9. My heart started pounding when I thought about my work with children and youth	1	2	3	4	5
10. It seemed as if I was reliving the trauma(s) experienced by children and youth	1	2	3	4	5
11. I had trouble sleeping	1	2	3	4	5
12. I felt discouraged about my future	1	2	3	4	5
13. Reminders of my work with children and youth upset me	1	2	3	4	5
14. I had little interest in being around others	1	2	3	4	5
15. I felt jumpy	1	2	3	4	5
I6. I was less active then usual	1	2	3	4	5
17. I thought about my work with children and youth when I didn't intend to	1	2	3	4	5
18. I had trouble concentrating	1	2	3	4	5
19. I avoided people, places, or things that reminded me of my work with children and youth	1	2	3	4	5
20. I had disturbing dreams about my work with children and youth	1	2	3	4	5
21. I wanted to avoid working with					

some children and youth

1 2 3 4 5

22. I was easily annoyed

1 2 3 4 5

23. I expected something bad to happen

1 2 3 4 5

24. I noticed gaps in my memory about children and youth sessions

1 2 3 4 5

THANK YOU FOR YOUR TIME!

Appendix B

Wilfrid Laurier University
Informed Consent Statement / Information Letter
Vicarious Truama: The Hidden Trauma in Child and Youth Counsellors
Principle Investigator: Michelle Bloom
Advisor: Martha Kuwee Kumsa

You are invited to participate in a research study. The purpose of this study is to identify the existence of vicarious trauma in Child and Youth Counsellors. Vicarious trauma or sometimes referred to as secondary traumatic stress is defined by Figley (1999) "as the natural, consequent behaviours and emotions resulting from *knowledge about* a traumatizing event experienced by a significant other. It is the stress resulting from *helping* or *wanting to help* a traumatized or suffering person" The research suggests that those in helping professions such as social workers, child protection workers, police, fire, and ambulance personnel all experience vicarious trauma. It is common place for Child and Youth Counsellors to work with children and youth that have been victims of trauma. There is a gap in the literature of an evidentiary nature as to the existence of vicarious trauma in Child and Youth Counsellors.

The principal investigator is a 3rd year part time study Masters of Social Work student at Wilfrid Laurier University of Kitchener, Waterloo.

INFORMATION

You are required to have access to a computer and the internet during this study. You will need to read the content of this consent statement and agree to it by choosing "I agree" in order to proceed to the next screen.

This study should take less then one hour to complete.

This study requires you to answer some yes or no questions and short one word descriptors. You will also be asked to report if you have experienced symptoms of psychological stress as a result of working with traumatized children and youth within the last 7 days. You will then be asked to report if you have experienced symptoms of psychological stress as a result of working with traumatized children and youth in the course of your career (Bride, 1999).

RISKS

Although minimal, there are several risks to this research. The first risk is of potential discomfort responding to questions of a personal or troubling nature. It is possible that the questions may trigger the recall of traumatic events. You are reminded that you are free at any time to discontinue participating, and you can do so simply by closing your

Web browser. If needed, you are encouraged to access your local community supports.

The second risk relates to the impossibility of providing full assurance as to the security of online data. *Survey Monkey* does use standard security protocols. No identifying information is requested. Once this researcher has obtained the data for analysis, the questionnaires are removed from *Survey Monkeys'* servers permanently.

BENEFITS

There are no direct benefits for participating in this research. The results of this research may be useful to the profession in the future for helping to understand the experiences of Child and Youth Counsellors and to create and support healthier workplace environments.

CONFIDENTIALITY

There is no identifying information recorded at any time. Information that you supply cannot be associated to your person. All of the data will be stored on a secure server by ID number. Data will be deleted once data analysis is completed. No identifying information will be identified in any publication. Data will be seen only by the Wilfrid Laurier faculty advisor and the principal investigator.

COMPENSATION

For participation in this study, you will receive no compensation.

CONTACT

If you have questions at any time about the study or the procedures, (or you experience adverse effects as a result of participating in this study) you may contact the researcher, Michelle Bloom at bloo2134@wlu.ca. This project has been reviewed and approved by the University Research Ethics Board at Wilfrid Laurier University. If you feel you have not been treated according to the descriptions in this form, or your rights as a participant in research have been violated during the course of this project, you may contact Dr. Bill Marr, Chair, University Research Ethics Board, Wilfrid Laurier University, (519) 884-0710, extension 2468.

PARTICIPATION

Your participation in this study is voluntary; you may decline to participate without penalty. If you decide to participate, you may withdraw from the study at any time without penalty and without loss of benefits to which you are otherwise entitled. If you withdraw from the study before data collection is completed your data will be returned to you or destroyed. You have the right to omit any questions you choose.

FEEDBACK AND PUBLICATION

Feedback regarding the study's findings will be provided to the participants through the Ontario Association of Child and Youth Counsellors newsletter.

CONSENT

I have read and understand the above information. I agree to participate in this study.

By proceeding into the questionnaire by checking the "Yes, I agree to the terms" you indicate that you have read and understand the above information and agree to participate in this research.

Appendix C

ATTENTION ALL PROFESSIONAL CERTIFIED AND PROFESSIONAL CHILD AND YOUTH COUNSELLORS!

You are invited to participate in a research study. This study's investigator is Michelle Bloom CYC, B.A. (cert), a 3rd year part time Master of Social Work student at Wilfrid Laurier University of Kitchener, Waterloo. The research is being supervised by Dr. Martha Kuwee Kumsa an Associate Professor in the Faculty of Social Work at Wilfrid Laurier University. The purpose of this study is to identify the existence of vicarious trauma in Child and Youth Counsellors. Vicarious trauma or sometimes referred to as secondary traumatic stress is defined by Figley (1999) "as the natural, consequent behaviours and emotions resulting from *Knowledge about* a traumatizing event experienced by a significant other. It is the stress resulting from *helping* or *wanting to help* a traumatized or suffering person." The research suggests that those in the helping professions such as social workers, child protection workers, police, fire, and ambulance personal all experience vicarious trauma. Child and Youth Counsellors work in a variety of settings with children and youth that have been victims of trauma. There is a gap in the literature of an evidentiary nature as to the existence of vicarious trauma in Child and Youth Counsellors.

Please take a moment of your time to fill out the survey questionnaire which can be accessed at the following web site. _____

Thank you in advance for your time.

Michelle Bloom CYC B.A. (CERT)

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