REVALENCE OF SECONDARY TRAUMATIC STRESS, ITS PREDICTIVE FACTORS AND COPING STRATEGIES AMONG PSYCHOTHERAPISTS IN NAIROBI AND NAKURU COUNTIES OF KENYA

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A thesis Submitted to Board of Post Graduate Studies in fulfilment of the Requirement for the Award of the Degree of Doctor of Philosophy in Counseling Psychology of Egerton University

EGERTON UNIVERSITY

APRIL, 2015

DECLARATION AND RECOMMENDATION

Declaration

I declare that this thesis is my original work and has not been presented for award of degree in any other university.

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Recommendation

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DEDICATION

To my loving husband Patrick Ojijo and adorable children Ian Musa and Ryan Ochieng'. For your love, inspiration, support and endurance during this entire period and to all psychotherapists who carry out trauma work. Let's strive on!!

ACKNOWLEDGEMENT

The completion of this thesis is the realization of a dream that began several years ago. Along the way, there have been many people that have provided support and encouragement. Some have also inspired deeper levels of personal and professional growth. I am greatly indebted to all who have journeyed with me. First and foremost I would like to thank the almighty God for sufficient grace that enabled me to do this work. My special thanks to Egerton University for facilitating my studies. No words can express my gratitude to my brilliant and dedicated supervisors' Prof. Micah. C. Chepchieng and Dr. Teresia Njonge of the Department of Psychology, Counseling and Educational Foundations for their commitment, immeasurable insight, guidance and knowledge that helped shape and polish this thesis. My sincere thanks to my examiners Prof. Ezra Maritim and Prof. Paul Oburu of Maseno University whose academic brilliance I so much admired and whose observations were extremely useful in improving the quality and credibility of this thesis. Further, I wish to thank all the members of the Department of Psychology, Counseling and Educational Foundations and the Faculty of Education Foundation and Community Studies for their observations, suggestions and encouragement. I particularly single out Dr. Catherine Muimukha for editing this work. I am greatly indebted to Dr. Samson Chiaji, a trauma specialist working for the United States of America army for consistently reading this document and giving appropriate advice. Special thanks to my husband Patrick Musa who stood by me at each stage, prayed with me, supported me financially and gave words of encouragement to strive on especially when I felt like giving up. To my mighty sons Ian Musa and Ryan Ochieng, words cannot express my appreciation for your love and patient understanding as I spent countless evenings and weekends working on this thesis. To my friends and colleagues especially Janet Soy and Caroline Lelo who constantly set the projector and edited this work, I am immensely grateful for your unwavering support. Further, I also thank my parents Millicent Nyagaya and Jonah Nyagaya for their belief in me, encouragement, inspiration and for laying the foundation that enabled me go through this degree. I cannot forget my siblings Linet, Beth, Levi, Martha, Edith, Grace, Eve, Christine, Paul and Jeam for constantly reminding and encouraging me to strive on. Special thanks to Beth Wojnarski who introduced me to Dr Samson Chiaji who was very instrumental in this work.

ABSTRACT

Kenya has experienced many traumatic events in the recent past in which psychotherapists have been called upon to do trauma counseling. A review of Secondary Traumatic Stress (STS) literature indicates that engaging in therapeutic work with trauma victims can and does, impact on the therapists. Reactions may include avoidance, arousal, and numbing of trauma and may possibly lead to STS. The psychotherapist if secondarily traumatized may engage in behavior that impedes the therapeutic process and interventions crucial for client recovery. Most studies have however focused on the victims and not psychotherapists. The purpose of the study was to examine prevalence of STS, its predictive factors and coping strategies among psychotherapists in Nairobi and Nakuru counties of Kenya. The study was descriptive in approach. The population of study consisted of 752 practicing psychotherapists registered with Kenya Counseling and Psychological Association (KCPA). A sample size of 302 psychotherapists was selected using simple random sampling. Sixteen supervisors were purposively sampled too as key informants since they directly oversee the clinical work of psychotherapists. Data collection tools included a questionnaire and modified Secondary Traumatic Stress Scale (STSS) for psychotherapists that displayed internal consistency with Cronbach Alpha reported for STSS at 0.91 and an interview scheduled for supervisors. The collected data were analyzed using both descriptive and inferential statistics (t-test and chi -square) with the aid of Statistical Package for Social Sciences (SPSS) version 18.0. Findings of the study indicated high prevalence of STS among psychotherapists. Age, years of counseling experience, marital status, education level, and exposure to traumatic material were found to have a significant association with STS at 0.05 significant levels. History of trauma, personal life stressors, unresolved trauma, supervision, debriefing and empathy were found not to be predictive of STS. Further, the findings indicated that social, physical, emotional and professional coping strategies were a buffer to STS. However maladaptive and organizational strategies were not a buffer to STS. The conclusion made was that STS is prevalent among psychotherapists. The main recommendations were that strategies such as quality supervision and diffusion from qualified and experienced therapists, diversifying therapist's caseloads, limiting the number of trauma clients seen and hours spent with trauma clients to be put in place to address the high prevalence of STS among psychotherapists.

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LIST OF ABBREVIATIONS AND ACRONYMS

AIDS	:	Acquired Immune Deficiency Syndrome
APA	:	American Psychiatric Association
CF	:	Compassion Fatigue
CS	:	Compassion Stress
DSMIV	:	Diagnostic and Statistical Manual for Mental Disorders (4^{th} Edition)
HIV	:	Human Immunodefiency Virus
KCPA	:	Kenya Counselling and Psychological Association
NCSTI	:	National Commission for Science, Technology and Innovation
PTSD	:	Post Traumatic Stress Disorder
SPSS	:	Statistical Package for Social Sciences
STS	:	Secondary Traumatic Stress
ST	:	Secondary Traumatisation
STSD	:	Secondary Traumatic Stress Disorder
STSS	:	Secondary Traumatic Stress Scale
VT	:	Vicarious Trauma

CHAPTER ONE
INTRODUCTION

1.1 Background of the Study

Traumatic events occur worldwide, for instance bereavement, domestic violence, and sexual abuse, natural disasters such as landslides, floods, and fire tragedies among others. Some of these events are also common in Kenya. Because of the nature of these distressing events, victims often experience traumatic reactions that require swift and decisive interventions to help them heal and grow beyond these horrible experiences (Figley, 2002a). Psychotherapists are increasingly being called upon to intervene directly with trauma victims to protect them from further trauma and to help them recover from trauma that they are experiencing. In the course of providing trauma counselling to traumatized populations the psychotherapists bear witness to damaging and cruel past events, and acknowledge the existence of traumatic event in the world (Herman 1992; Kassam-Adams, 1999). Effective intervention with traumatic stress often involves assisting the individual in working through the traumatic experience, in a process in which the client slowly and vividly relives the events through vivid imagery. The impact of such exposure may lead to the emergence of secondary traumatic stress (STS) symptoms in psychotherapists (Zimering, Munroe, & Gulliver, 2003). Primary traumatic stress is the term used for individuals who respond with intense fear or helplessness after experiencing a traumatic event firsthand. STS occurs as a result of indirect exposure to trauma through a firsthand account or narrative of a traumatic event (Zimering et al., 2003).

The adverse psychological impact of working directly with trauma victims or survivors has been discussed in the STS literature and several variations and patterns are described. The picture that emerges is clear that exposure to traumatic material indirectly from clients is a potential occupational hazard of doing clinical work with traumatized populations (Figley, 1995a; Collins & Long, 2003; Bride, 2007; Deighton, Gurris & Traue, 2007). Whether it is disaster work in the field or clinical work in professional settings, the occupational hazards of such work may include episodes of intrusive, avoidance and arousal symptoms that appear to be linked to working with psychological trauma (Figley, 1995b). The concept that trauma can occur indirectly is consistent with the Diagnostic and Statistical Manual of Mental Disorders (4th ed.) criteria A for post

traumatic stress disorder (PTSD), which asserts that traumatisation is possible without being personally harmed or threatened with harm (APA, 2000).Traumatisation can occur through contact with narratives of primary traumatic stress. Psychotherapists come in close contact with such narratives of traumatic exposure. Chrestman (1995) in his study among therapists belonging to the International Society for Traumatic Studies and members of the Association of Marriage and Family Therapists, for instance found a significant relationship between secondary exposure to trauma and psychological distress of therapists. A study conducted by Creamer and Liddle (2005) on mental health workers responding to an attack on September 11, 2001 by terrorists' in New York City showed elevated levels of STS symptoms. Further, a study by Ennis and Sharon (2003) also indicated traumatic stress in sex offender's therapists. Bride (2007) concludes that, 15% of social workers engaged in direct clinical practice meet the diagnostic criteria for STS, conclusions that are consistent with an earlier report by the same author (Bride, 2004) that 19% of social workers in North Carolina meet study criteria for depression. Among lay trauma counsellors who had been trained to assist bank employees following bank robberies in South Africa, 10% reported STS symptoms in the high or extremely high range (Ortlepp & Friedman, 2002). Despite this knowledge, Figley (1995a; 2003) admits to the scanting attention therapists dealing with trauma have received in literature and the lack of studies that have been conducted with this sample (Figley, 1995a; Salston & Figley, 2003).

Literature on STS argues that hearing about trauma cannot alone cause STS. Researchers in the trauma field acknowledge that both predictive factors and coping strategies play a part in the development of STS (Dutton & Rubinstein, 1995; Ghahramanlou & Brodbeck, 2000; Stamm, 2002; Baird & Jenkins, 2002; Adams, Boscarino & Figley, 2004). Several predictive factors are responsible for the development of STS. Key among them is the trauma workers level of exposure to traumatic material (Dutton & Rubinstein, 1995; Figley, 1995a; Cornille & Meyers, 1999). A study done by Adams et al. (2004) among social workers in New York City following the September 11, 2001 terrorists' attacks indicate that the variables that predict STS include the degree of exposure, personal history, social support and environmental factors. In support of this, Kassam-Adams (1995) research found that workers who have experienced personal trauma are more likely to suffer from severe STS symptoms than workers who did not have a personal

trauma history. Figley (1995), a leading author in the field of STS, believes that empathy is a key personality characteristic in its development (Figley, 1995; 2003). His belief is widely held by other authors (Steed & Bicknell, 2001; Adams et al, 2004). The number of traumatized clients in the therapist's caseload and discussion of trauma work in one's own personal therapy are also predictive factors of STS (Creamer & Liddle, 1995). The psychotherapist's level of education was confirmed to be related to STS, that is those with less than a master's degree were more vulnerable (Arvay & Uhlemann, 1996). In a review of primary, non occupational traumatisation during disasters Norris, Byrne, and Diaz (2001) concluded that the following predictive factors cumulatively increase the risk of adverse outcomes in adults: Female gender; age in the middle years of 40 to 60; ethnic minority group membership; poverty or low socioeconomic status (SES); the presence of children in the home; psychiatric history; severe exposure to the disaster; living in a highly disrupted community. Insofar as psychotherapists work in hazardous conditions, they risk primary trauma exposure whose outcomes might follow the above predictive factors.

Coping strategies appear to influence service providers' vulnerability to STS (Lerias & Byrne, 2003; Sabin-Ferrell & Turpin, 2003). To inoculate themselves from the worst STS, service providers often engage various strategies (Schauben & Frazier, 1995). For example, Bell (2003) found that domestic violence therapists who reported low levels of stress also reported greater feelings of competence about coping; having an objective motivation for work; resolving personal traumas; having early, positive role models of coping from which to draw; and possessing personal beliefs that buffered the effects of their exposure to trauma. Similarly, in a sample of highly skilled therapists, Harrison and Westwood (2009) identified coping strategies, including professional, personal and social support, mindfulness, acceptance of complexity, optimism, maintaining clear boundaries, professional satisfaction, and an ability to create meaning from clients' tragedies. Earlier work by Iliffe and Steed (2000) with a group of domestic violence service providers had identified effective coping strategies as a protective factor against STS. These coping strategies encompassed the work environment as well as personal time, and included strategies such as peer debriefing, team support, monitoring caseloads, focusing on clients' resilience, engaging in physical activity and pursuing pleasurable

activities (Iliffe & Steed, 2000). In support of this, Arnberg, Hultman, Michel and Lundin(2012) found social support a buffer in their study. Notably, Way, VanDeusen, Martin, Applegate and Jandle (2004) found that increased levels of both positive and negative coping were associated with higher levels of STS. Seeking supervision was found to be effective in Follette, Polusny and Milbeck (1994) study among law enforcement professionals providing services to sexual abuse survivors and in Pearlman and Mac Ian (1995) empirical study on effects of trauma work among trauma therapists . Dane (2000) found spiritual and religious beliefs important coping strategies. In addition to this, Lonne (2003) indicates that coping strategies targeting STS have traditionally focused on enhancing service providers' strategies for self-care. Typically, these interventions prescribe exercise, meditation, healthy eating, and seeking increased support and supervision.

In Africa, more specifically in post genocide Rwanda and even in Somali, Ethiopia, Sierra Leone, Sudan, and Congo which have experienced traumatic incidences, most reports have focused on victims and not therapists (Neugebauer, 2008). It is reported that only four studies have investigated post traumatic stress disorder in the aftermath of Rwandan genocide. One study indicates that women living in post genocide Rwanda report higher rates of PTSD symptoms than men do (Neugebauer, 2008). Research done in South Africa among prisoners indicates that counsellors working in a trauma unit with prisoners were especially vulnerable to compassion fatigue (Kaplan & Orlando, 1998). Musa and Hamid (2008) conducted a study of aid workers in Darfur and found 25% reported elevated levels of STS symptoms. In Kenya, limited studies have investigated the prevalence of STS, its predictive factors and coping strategies among psychotherapists. Yet Figley (2006) notes that psychotherapists who listen to reports of trauma, horror, human cruelty and extreme loss can become overwhelmed and may begin to experience feelings of fear, pain and suffering similar to that of their clients. Gitahi and Mwangi (2008) agree too that in the course of providing assistance to victims and survivors, psychotherapists are exposed to incidents and reports of life shattering pain, terror and loss. Pearlman and Saakvitne (1995a) add that the psychotherapists might therefore need assistance to cope with the effects of listening to traumatic experiences of others.

1.2 Statement of the Problem

In the recent past Kenya has experienced many traumatic events such as the West Gate Mall attack of 2014, Mathare slum land slide of 2014, Sinai village petrol tragedy of 2014, post 2007 election violence, Uhuru park prayer rally bombing, Sachagwan petrol fire tragedy, among others. In such situations, psychotherapists are called upon to provide trauma counseling. They share the emotional burden of trauma, hear tales of human suffering and observe emotions of fear, helplessness and horror registered by trauma victims. They are expected to be empathic, understanding and compassionate yet they must also control their emotional needs and responsiveness in dealing with their clients. Effective intervention with traumatic stress often involves assisting the individual in working through the traumatic experience, a process in which the client slowly and vividly relives the events through vivid imagery. Thus, as psychotherapists are indirectly exposed to the traumatic material of the trauma victims that they support, powerful reactions can then be evoked for the practitioners themselves, with such risk elevated by their personal experiences of stress before, during and following trauma work. Consequently, psychotherapists are then vulnerable to the experience of STS. In light of this, STS can be an occupational hazard with possible adverse outcomes for psychotherapists such as engaging in behaviours that impedes the therapeutic process and interventions crucial for client recovery, the psychotherapists may also implicitly convey a message to clients that they are unwilling to hear the details of the client's trauma, or be less likely to ask questions to facilitate dialogue related to the event. This can result in a revictimization of the trauma victims. Literature on STS has however given little attention to this subject area indicating a critical gap. Studies on trauma have focused on victims yet there are limited studies on psychotherapists. Hence the need for this study.

1.3 Purpose of the Study

The purpose of this study was to determine prevalence of secondary traumatic stress, its predictive factors and coping strategies among psychotherapists in Nairobi and Nakuru counties of Kenya.

1.4 Objectives of the Study

The objectives of the study were:

i) To determine the prevalence of STS among psychotherapists in the counties of Nairobi and Nakuru of Kenya.

ii) Compare the prevalence of STS among psychotherapists in the counties of Nairobi and Nakuru of Kenya.

iii) To establish how predictive factors contribute to STS among psychotherapists in Nairobi and Nakuru counties of Kenya:

iv) To establish how coping strategies employed by psychotherapists contribute to STS in the counties of Nairobi and Nakuru of Kenya.

1.5 Research Questions

The study answered the following questions:

i) What is the prevalence of STS among psychotherapists in the counties of Nairobi and Nakuru of Kenya?

ii) What is the difference in prevalence of STS among Psychotherapists in Nairobi and Nakuru counties of Kenya?

iii) How do selected predictive factors contribute to STS among psychotherapists in the counties of Nairobi and Nakuru of Kenya?

iv) How do coping strategies employed by the psychotherapists contribute to STS in the counties of Nairobi and Nakuru of Kenya?

1.6 Significance of the Study

A major significance of this study was its contribution in providing empirical evidence on the prevalence of STS among psychotherapists in Nairobi and Nakuru counties. This insight forms a

basis for advocating for personal therapy and quality supervision among psychotherapists. Information gathered from this study would also be useful in scaling up educational programmes/ training that could be of vital importance to all helping professionals at all levels of experience and training and for building a research base that may lead to effective programs for preventing and treating STS. The study also provided information on the predictive factors of STS and coping strategies employed by psychotherapists in the event of traumatisation. This information would help advance the understanding and development of STS among therapists and they would be more apt to seek assistance and collaborate with peers and supervisors when in distress, consequently the quality of care would be enhanced and the traumatized client population protected. The ethical imperative pertains to an obligation that psychotherapists have to provide appropriate and effective care and to 'do no harm' this study helps to recognize the distress of trauma therapist's work and the care that they give clients. Further, at the national level, the information generated could guide policy makers and /or implementers in developing effective policies that can promote the well being of therapists and clients. Professional organizations in counselling including Kenya Counselling and Psychological Association, Kenya Guidance, Counselling and Psychological Association, and Universities Counsellors Association would find the results of this study useful in sensitizing their members on the potential negative impact of working with trauma clients and the potential risks factors that may increase vulnerability to STS.

1.7 Scope of the Study

The study was conducted in Nairobi and Nakuru counties of Kenya. The populations of focus for this study were the psychotherapists who were primarily engaged in therapy with clients and the supervisors who helped the psychotherapists cope with trauma. The study sought to determine prevalence of STS among psychotherapists in Nairobi and Nakuru counties, to compare prevalence of STS among psychotherapists in Nairobi and Nakuru counties and to establish how predictive factors contribute to STS. The study also established the various coping strategies employed by the psychotherapists in the event of STS. Indicators for prevalence rate included PTSD symptoms of re-experiencing, arousal and numbing as defined by DSM-IV. Predictive factors were drawn from the Dutton and Rubinstein (1995) and Figley (2002b) studies on STS

and included: empathy, exposure, demographic characteristics, personal trauma history, and history of psychiatric symptoms, unresolved trauma, personal life stressors and social support. Coping strategies included: physical strategies, professional strategies, organizational strategies, social support, emotional support and maladaptive strategies.

1.8 Limitation of the Study

The results of this study were limited to the study areas and generalization to be done with caution. This is because the implementation of therapy may not be similar in all regions, there may be other aspects unique to different parts of the country for example culture. The sample were primarily female, the experiences of male psychotherapists when exposed to indirect traumatic material are not indicated therefore generalization should be limited due to homogenous nature of the study. This however reflects the much higher percentage of females in mental health field. Current study was also self reported thus introducing the possibility of self report bias. Data may have been influenced by desire on part of the psychotherapists to present themselves in a certain light. Study somewhat limiting in its focus as it only looks at the negative aspects of being a trauma worker, while failing to explore the positive side such as role satisfaction, heightened sensitivity to other vulnerabilities and continued dedication to comply with the responsibilities inherent in the work of trauma workers. Another study limitation was that psychotherapists not registered by KCPA were omitted from the sample.

1.9 Assumptions of the Study

The study was conducted with the following assumptions.

i. That the respondents would cooperate and provide honest responses that reflect the information stipulated in the questionnaires.
ii. That the office bearers of KCPA would offer co-operation to the researcher by providing lists of registered psychotherapists and supervisors.

1.10 Operational definitions of terms

Coping strategies : Coping in relation to trauma refers to the thoughts and actions we use to deal with a threatening situation (Regehr, Goldberg & Hughes, 2002; Tedeschi & Calhoun, 1996). The ultimate aim is to make sense of the event, which involves a cognitive process of ascertaining meaning in relation to the experience.

Within the current study, coping strategies was operationally defined as all methods, personal, professional, organizational and maladaptive or otherwise used by the psychotherapists in Nairobi and Nakuru to normalize their STS.

Empathy : Empathy, defined as the action of understanding, being aware of, being sensitive to, and vicariously experiencing the feelings, thoughts, and experience of another (Figley, 1995).

Operationally defined as the psychotherapists recognition of clients pain, identification with or vicarious experiencing of the feelings, thoughts, or attitudes of trauma victim.

Exposure : The DSM-IV-TR (2000) defines direct exposure to trauma as: A situation in which the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others. The person's response (to the event) involved intense fear, helplessness or horror (APA, 2000).

Exposure was operationally defined as a therapists witnessing and handling of client traumatic material and was conceptualized as number of hours per week spent doing trauma work, number of clients seen per week, monthly case load that include trauma clients and type of trauma dealt with in the past three months.

History of trauma : Historical trauma in STS refers to cumulative emotional and psychological wounding, exceeding over an individual lifespan and across generations, caused by traumatic experiences (Meyers & Cornille, 2002).

It was operationally defined in this study as the traumas experienced by the psychotherapists in Nairobi and Nakuru counties prior to trauma work.

Personal life stressors : The unexpected changes in schedule, routine, and meaning of life, responsibilities that demand attention for instance illness, changes in life style, professional or personal obligations (APA, 2000).

Operationally defined as the traumatic stressors experienced by psychotherapists in Nairobi and Nakuru counties before, during and after trauma work with clients.

Predictive factors : Refers to those individual characteristics and environmental characteristics surrounding the practitioners that make them vulnerable (Dutton & Rubinstein, 1995).

Predictive factors are operationally defined in this study as those factors that made the psychotherapists vulnerable to STS such as empathy and exposure, social support, professional experience, history of trauma, and demographic characteristics.

Prevalence : Prevalence refers to the total number of individuals in a population who have a disease or health condition at a specific period of time, usually expressed as a percentage of the population (Jekel, 2001).

In the study prevalence refers to the extent to which psychotherapist's in

Nairobi and Nakuru exhibited PTSD symptoms of arousal, avoidance, and intrusion.

Psychotherapists : Refers to a professionally trained helper, who offers psychological support to the client (Corey, 2001).

In the case of this study it referred to counselors and psychologists, in Nairobi and Nakuru Counties primarily engaged in therapy with Clients and are Registered with KCPA.

Secondary traumatic stress : Figley (2003) defines STS 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. STS parallels the symptoms of Post Traumatic Stress Disorder (PTSD).

Operationally defined as the intrusive symptoms, avoidance symptoms, and arousal symptoms experienced by psychotherapists as result of Helping trauma victims.

Social support : Social support is defined as a "condition resource" that can increase a helper's sense of competency and control (Stamm, 2002), provide a secure and respectful environment (Rosenbloom, Pratt, & Pearlman, 1995), offer emotional and instrumental support (Catherall, 1995), and help individuals to feel understood and accepted (Wee & Myers, 2002).

This definition was adapted and used as it in this study. Social support encompassed what all the four authors have indicated.

Supervisor : Is defined as a teacher, coach, trainer, facilitator, mentor, or one who has superior knowledge, evaluator of therapeutic process, supporter and gate keeper (Gachutha, 2012)

Operationally defined in this study as the psychologists and counsellors trained to assist or directly oversee the professional clinical work of psychotherapists.

Trauma : Any horrifying event or material that the psychotherapists experienced as a result of helping that was disturbing and outside the range of usual human experience (APA, 2000).
The same definition was used in this study.

Unresolved personal trauma: : Previous trauma experienced by psychotherapists before, during and after trauma work but were not dealt with (Adams, Matto & Harrington, 2001).
This study used the same definition.

CHAPTER TWO
LITERATURE REVIEW

2.1 Introduction

This chapter reviewed related literature from various sources according to the objectives of the study. The following chapter represents in detail the current literature in the area of Secondary Traumatic Stress. This review first explored the challenges that authors portray in formulating an understanding of this construct, the prevalence and predictive factors of STS and reviewed literature on coping strategies in the event of STS. It also looked at the relevant theories to the study and the conceptual framework. This review suggests that there is a gap in the literature identifying STS among psychotherapists.

2.2 The Conceptualization of Secondary Traumatic Stress

Review of STS literature indicates challenges that authors portray in formulating an understanding of STS. There has been lack of conceptual clarity about what constitutes as STS and how it differs from other adverse work (Adams et al, 2004). A theme throughout the literature suggests that there is a lack of consensus in arriving at a common definition for this concept (Jenkins & Baird, 2002; Lerias & Byrne, 2003). The literature reflects similarities, overlaps and differences within constructs (Stamm, 1997; Baird & Jenkins, 2002; Salston & Figley, 2003; Trippany, Kress & 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 (VT), secondary traumatic stress (STS), compassion fatigue (CF), counter transference and burnout (Figley, 1999; Pearlman & Saakvitne, 1995).

Figley (1995a) defines STS as the natural consequent behaviours resulting from knowledge about a traumatizing event experienced by a significant other and the stress results from wanting to help or helping a traumatized person. Salston and Figley (2003) report that STS parallels the symptoms of PTSD. Pearlman and Saakvitne (1995a) described STS as the presence of post-

traumatic stress disorder symptoms in caregivers, which are probably connected to the victims experience rather than the caregivers'. Figley (1999), states that the symptoms of STS 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. What this suggests is that psychotherapists 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 or after a single exposure to traumatic material (Figley, 1999). Psychotherapists are considered especially vulnerable to the development of STS due to the empathic engagement and level of exposure that they have with their clients.

Figley (2002b) stated that people can be traumatised without actually being physically harmed or threatened with harm. Both the vivid re-counting of the trauma experienced by the victims and the trauma workers' subsequent cognitive or emotional interpretation of that event may result in symptoms similar to or associated with PTSD such as hyper arousal, intrusive and avoidance symptoms (Zimering et al, 2003; Bride, 2007). If enough symptoms are present and reach a level of clinical distress, the individual may have secondary traumatic stress disorder (STSD) which is conceptualized by American Psychiatric Association (2002) to be identical to PTSD a part from the source of trauma exposure. Whereas PTSD is a result of direct personal experience with a traumatic event or learning about the trauma of a personally close individual, STSD results solely from exposure to a traumatizing event experienced by another person with whom one has a close empathic relationship. The exposure to the event must result in a response of fear, helplessness, or horror and symptoms must last for at least one month and cause clinically significant distress for it to be considered STSD (APA, 2002). It is because of these responses that Creamer and Liddle (2005) state that it is often misunderstood and labelled as pathological. It is often asked why the term STS is employed rather than simply referring to indirect traumatisation or PTSD. Figley (1995a) adopted the term 'Secondary Traumatic Stress' to replace indirect trauma as it more accurately represented the reactions of helpers of those experiencing PTSD. Stamm (1997) after an extensive review of literature on STS stated that the great controversy about STS is not, can it happen, but what shall we call it? Stamm concluded

that there is no consistently used term regarding the impact of being exposed to traumatic material as a consequence of being a therapist (Steed & Bicknell, 2001). Current literature reflects the use of various terms that are or are nearly synonymous with STS. These include: compassion fatigue (Figley, 1995); counter transference (Pearlman & McCann, 1990); burnout (Maslach & Jackson, 2001); and vicarious traumatisation (Pearlman &McCann, 1990; Pearlman & Saakvitne, 1995a; Stamm, 1997). It is evident throughout the literature that these terms have been used interchangeably. The term STS was used in the current study as it is argued that perhaps it is the most inclusive (Stamm, 1997), and extends beyond the context of therapy to occur in all caring situations (Figley, 1995a).

Two terms that fall under STS that are more specific to trauma workers are compassion fatigue / compassion stress and vicarious traumatisation. The following paragraphs will underline the similarities and differences between these two main constituents of STS. The concepts compassion fatigue (CF) and compassion stress (CS) are suggested as appropriate substitutes for STS. Most often these names are associated with the "cost of caring" for others in emotional pain. Figley (1995c) argued that compassion fatigue is a natural consequence of working with people who have experienced extremely stressful events. Compassion fatigue is defined as the state of exhaustion and dysfunction that results from prolonged exposure to compassion stress. CF can challenge the helpers' ability to provide effective services and maintain personal and professional therapeutic relationships. The severity of CS is determined by how long the individual is exposed to the various compassion stress influences. It is through this process of empathic engagement and exposure that the individual experiences emotions and symptoms which are similar to those of the victim. Thus, Figley (1995b) has suggested that the term Compassion Fatigue be used as a friendlier alternative to the term STS. It does nevertheless reflect a particular focus on the impact of counselling or working with trauma survivors. Hence it specifically elaborates on the notion of STS in relation to counsellors.

Vicarious trauma on the other hand refers to a transformation in the therapist's inner experience resulting from empathic engagement with client's trauma material (Pearlman & McCann, 1990). Collins and Long (2003) added that it is through exposure to clients graphic accounts of

traumatic experiences and to the realities of people's intentional cruelty to one another, and through the inevitable participation in traumatic re-enactments in the therapy relationship that people suffer VT. According to Arvay (2002) VT and STS refer to the same phenomenon. It can have a profound psychological effect on the therapist, causing painful disruptions to his or her sense of meaning, connection, identity, beliefs, psychological needs, and interpersonal relationships. These effects are viewed as cumulative and permanent, resulting from continued involvement with multiple survivors of trauma (Pearlman & Saakvitne, 1995a). V T can impact therapists either from direct exposure to trauma clients and their descriptions of trauma, supervision of trauma cases, or via readings and professional presentations related to trauma (Rosenbloom et al., 1995). Therapists may internalize the memories of their clients, which may alter their own memory systems, causing disruptions to the therapists' psychological and interpersonal functioning. In summary, no matter the name or theoretical constructs used, this study agrees with Figley (1995); Stamm (1999); Arvay et al (2001a) and Bell (2003) that all these terms refer to similar reactions that may occur when professionals, family members, or friends care for someone who is suffering from a traumatic experience.

Disruptions in imagery are considered a hallmark symptom of VT. Therapists may experience the clients' traumatic imagery as flashbacks, disturbing dreams, or intrusive thoughts. This imagery is most often fragmented without context or apparent meaning (Pearlman &McCann, 1990a). These disruptions are often associated with strong emotional reactions such as sadness, anxiety, and anger and can parallel the feelings experienced by the trauma survivor (Pearlman & Saakvitne, 1995b). These feeling states may be triggered within conscious awareness or they may be repressed and out of the therapist's conscious awareness (Pearlman &McCann, 1990b). One of the main conceptual distinctions between STS and VT is their theoretical origin. VT and STS focus on different symptoms as a result of traumatisation. STS focuses predominantly on observable symptoms that mirror PTS responses of intrusion, avoidant, and arousal symptoms while VT focuses on inner cognitive changes related to five main psychological needs areas: safety, trust, esteem, control, and intimacy (Baird & Jenkins, 2002). VT is also inclusive of avoidant, intrusive, and arousal symptoms, but views them within the context of cognitive schema changes (Pearlman & Saakvitne, 1995a). Perceived on-set and duration of symptoms is

another distinction among these concepts. STS symptoms are conceptualized as acute, sudden, and can occur after exposure to a single traumatized person (Figley, 1995b). While VT reactions have been conceptualized to be long term in duration and reflect a permanent transformation of a therapist's inner experience. Changes occur as a result of cumulative exposure to many clients, and across various types of trauma contact (Pearlman &McCann, 1990a; Pearlman & Saakvtine, 1995b). Despite the clear distinction between vicarious traumatisation and STS these terms are often used interchangeably which creates a great deal of confusion. It is important that this study conceptualizes the two concepts in order to clarify further what each stands for.

Counter transference and burnout are the concepts that parallel compassion fatigue most. The term counter transference comes from psychodynamic psychotherapy and was originally defined by Sigmund Freud. Freud viewed counter-transference as the inappropriate reaction of the therapist to the client (Corey, Corey & Callanan, 2007). Counter-transference is further defined as any projections by therapists that distort the way they perceive and react to a client (Corey & Callanan, 2007). Herman (1992) used the term traumatic counter transference to describe STS but Figley (1995a) distinguished it from STS in the following way: STS includes, but is not limited to counter-transference, which occurs within the context of psychotherapy and is a result of reactions to the transference on the part of the client. Stamm (1999) states that counter transference can occur outside the context of exposure to traumatic material while STS always arises as a result of exposure to a client's traumatic material. That means that it can be as a result of chronic attachment associated with family of origin issues and much less to do with empathy toward the client that causes trauma. Wilson and Lindy (1994) identified two types of defensive counter transference reaction by trauma therapists: avoidance reactions and over-identification reactions. Avoidance counter transference reactions are characterized by denial, minimization, distortion, counter phobic reactions, detachment and disengagement from an empathic stance. In contrast, over-identification involves idealization, enmeshment, and excessive advocacy for the client, as well as guilt due to the therapist's perceived failure to provide adequate assistance. These defensive therapist reactions can compromise a trauma victim's recovery. This is in tandem with Figleys 2003) STS theory that informs this study. Therapeutic interaction with trauma victims may reactivate early conflicts, socializations, experiences, and memories. These

reactivations are what this study conceptualizes as predictive factors. Literatures on STS have continued to give conflicting information on predictive factors and therefore this remains a key area for study in this research. Burnout has been defined as a collection of symptoms associated with emotional exhaustion, depersonalization, and reduced personal accomplishment (Maslach, Schaufeli & Leiter, 2001). Burnout is conceptualized as a defensive response that occurs when an individual experiences prolonged exposure to demanding interpersonal situations in an organization or work environment that lacks adequate support (Baird & Jenkins, 2002). Research supports burnout as a distinct construct from STS and VT (Schauben & Frazier, 1995) and finds job Burnout and STS to be separate contributors to psychological distress (Figley & Roop, 2006). Burnout can be caused by conflict between individual values and organizational goals. It demands an overload of responsibilities, a sense of having no control over the quality of services provided, an awareness of little emotional or financial reward, a sense of loss of community within the work setting, and the existence of inequity or lack of respect at the work place (Sulston & Figley, 2003). The etiology of burnout generally indicates workload, co-worker conflict, organizational stress and chronic tediousness in the workplace as precipitating factors, not targeted exposure to client trauma. The symptoms also emerge gradually (Maslach, Schaufeli & Leiter, 2001). In contrast, certain STS symptoms can emerge suddenly with little warning and also include a sense of helplessness, confusion, and isolation from support systems (Figley, 2005). Although burnout has many of the same causes and symptoms of ST, burnout results from long term non-supportive work environments. It differs from ST in that exposure to clients' trauma is not the precipitating factor (Siegfried, 2008).

While conceptualized differently from one another, CF, STS, VT and burnout do share similar characteristics. Each may result in physical, emotional, and behavioural symptoms, work related issues, and interpersonal problems (Salston & Figley, 2003). The overlap and similarities among the concepts have led many researchers to suggest that the terms STS and VT actually refer to a single core phenomena, and that the respective concepts just distinguish those struggling primarily with cognitive disruptions from those struggling with PTSD symptomology (Arvay, 2002; Baird & Jenkins, 2002; Bride, 2004; Kadambi & Truscott, 2004; Deighton et al, 2007;

Linley & Joseph, 2007) . Ultimately, the terms VT, SST and CF attempt to explain the various emotional, physical, and interpersonal reactions that an individual can have as a result of contact with traumatized persons and their traumatic material (Bride, 2007). Stamm (1997) states that STS is a better term to use as it is broader and VT and CF are actually specific types of STS (Ortlepp & Friedman, 2001). After thoroughly reviewing the literature, the conclusion made is that VT is the appropriate term to use when examining the cognitive changes that may occur in a mental health professional as a result of providing trauma therapy, whereas compassion fatigue is the optimal term to use when exploring the broader psychological effects that may occur when an individual engages in an empathic, helping relationship with a traumatized person. Compassion fatigue may describe events that occur within the context of a therapeutic relationship, but may also be applied to caretakers and other professionals outside of the mental health field (Figley, 2002a). As such, in the current study, STS was used as it is argued that perhaps it is the most inclusive (Stamm, 1997), and extends beyond the context of therapy to occur in all caring situations (Figley, 1995a). Secondly, the state of knowledge surrounding STS is in its infancy and has received scant attention in comparison to PTSD. STS has largely been a theoretical issue, while studies supporting this theory are severely lacking (Macliam, 2003). Finally, there are also several scales which are used to measure STS; however they consist of many dissimilar items and therefore provide a poor evaluation of the concept (Adams et al, 2004). Nonetheless, because the terms have frequently been conflated in the literature, it is crucial to take account of VT, CF, counter transference and burnout studies when reviewing the existing research on STS (Baird & Jenkins, 2002; Sprang et aI. 2007). In addition to this, literature on STS 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 affects many helping professions.

2.3 Prevalence of Secondary Traumatic Stress

Prevalence of STS was reviewed and synthesized according to symptom domains as suggested by other researcher's. The symptom domains focused predominantly on assessing for PTSD

related symptomology such intrusion, avoidance, and arousal symptoms and indicators of psychological distress or dysfunction, relational disturbances and cognitive shifts (Collins & Long, 2003; Dutton & Rubinstein, 1995; Sabin-Farrell & Turpin, 2003). The current state of empirical studies on STS prevalence is limited. Theorists such as Figley (1995b), McCann and Pearlman (1990), and Stamm (1995) have written extensively on the phenomena of STS, the level of corroborative data is however not commensurate with the sophistication of the existing theories. Indicating a gap on prevalence of STS , and purpose for this research.

2.3 Secondary Traumatic Stress Symptoms

The symptoms of STS are similar to those of PTSD, only instead of the symptoms being based upon a trauma that is directly experienced; it is due to the trauma that client(s) have experienced. Following a traumatic event, almost everyone experiences at least some of the symptoms of PTS. But for most people these are short lived. They may last for several days or even weeks, but gradually subside. If one has PTSD, however the symptoms do not decrease in fact one gets worse. PTSD does not always develop in hours or days following a traumatic event, although this is most common, for some people, the symptoms take weeks, months, or even years to develop. The symptoms of STS can arise suddenly, gradually, or come and go overtime. Sometimes symptoms appear seemingly out of nowhere. At other times, they are triggered by something that reminds one of the original traumatic events, such as noise, image, certain words, or smell (APA, 2002). Symptoms under one month duration are considered normal. Those not manifesting symptoms until six months or more following the event are delayed STSD.

These symptoms are clustered into three criteria: intrusions, avoidance, and hyper arousal (APA, 2002).The first criteria for STS are intrusions. It involve re-experiencing of the traumatic event and occur in different ways. Traumatic events and feelings recur in the form of illusions, hallucinations, flashback, physiological reactivity and psychological distress when exposed to internal and external cues or reminders of the event. Remembrance and intrusion of the trauma is expressed on many different levels, ranging from flashbacks; the individual thinks he or she is actually experiencing the trauma or seeing it unfold before his/her eyes. Affective states making the individual to act or feel as if the traumatic event were recurring. Intense physical reactions to

reminders of the event include pounding heart, rapid breathing, nausea, muscle tension and sweating. Interpersonal re-enactments including transference repetitions, character styles, and pervasive life themes. When working with trauma victim's psychotherapists experience intrusions, avoidance and hyper arousal symptoms. For example with regard to intrusions Figley's (1995c) research suggests that similar to PTSD the individual re-experiences, in fantasy, the traumatic event that occurred to the victim. Figley's research further supports that of Munroe (1991) who studied male veterans' administration therapists in Boston and found they suffered from intrusion and withdrawal symptoms similar to their combat PTSD clients.. When working with trauma victims psychotherapists often experience strong reactions to hearing traumatic and vivid narratives. Thus as a result of trauma work Cerney (1995) states that they experience a change in their interaction with the world, themselves and their families. They may begin to have intrusive thoughts, nightmares and generalised anxiety (Cerney,1995). The state of knowledge on intrusive symptoms of STS is largely theoretical, while studies supporting this theory are severely lacking (Macliam, 2003). Additional evidence based research identifying intrusive symptoms STS among psychotherapists is required.

The second criteria for STS are symptoms of avoidance. Avoidance occurs as victims make an unconscious effort to avoid thoughts or feelings that remind them of the trauma. The avoidance is both physical as well as psychological. This includes persistent avoidance of activities and places that might be similar to the place or activity where the trauma happened, Inability to recall important aspects of the entire traumatic event, detachment from people/diminished interests in relationships and work, restricted affect such as having hard time expressing their feelings of laughter, hugging among others and foreshortened future-one does not expect to live along life or have a normal life span for instance get married or even have a career (APA, 2002). Salston and Figley (2003) indicate that psychotherapists who often experience strong reactions to hearing traumatic narratives protect themselves by dissociate to some degree, distance themselves from others, become overwhelmed with helplessness or become emotionally numb. Smith, (2011) in the study on juvenile justice education, trauma workers endorsed sense of foreshortened future as the highest (53.4%) followed by detachment from others (50.9) and emotional numbing (38.1%). Just like in intrusive symptoms the state of knowledge on

avoidance symptoms of STS are also largely theoretical, while studies supporting this theory are severely lacking , besides, several scales have been used to measure avoidance symptoms of STS. However these scales consist of many dissimilar items and therefore provide a poor evaluation of avoidance symptoms (Adams et al, 2004). Further evidence based research identifying avoidance symptoms of STS among psychotherapists is required.

The last criterion for PTSD is hyper arousal. Symptoms include anxiety, insomnia, irritability or outbursts of anger, difficulty concentrating, hyper vigilance for traumatic person/event, exaggerated startle response and physiological reactivity to cues. Other symptoms of PTSD include depression, grief and loss, helplessness and guilt. Individuals often experience a number of these symptoms together. Research findings of primary and secondary PTSD related to the World Trade Center terrorist attacks illustrate this point. Galea et al (2002) showed that in the first five to six weeks following the September 11, 2001, terrorist attacks in New York City, 20% of residents living close to the World Trade Center met criteria for probable PTSD. The same research showed a similar prevalence pattern in mental health care professionals who treated survivors of the World Trade Centre. On standardized clinical interviews many providers endorsed symptoms of PTSD linked to their exposure to survivor narratives, but most did not meet diagnostic criteria for PTSD. However, a minority of professionals met full diagnostic criteria for PTSD in the months following their exposure to survivor narratives.In similar findings Meldrum, King, and Spooner (2002) found that in a sample of 300 trauma case managers working with psychiatric inpatient and outpatient clients, 17.7% met symptom criteria for STS. Among other helping professionals, the prevalence of compassion fatigue has been shown to vary widely. In Meadors, Lamson, Swanson, White, and Sira's (2009) study of 167 trauma workers, only 7.3% of the total sample was observed to be at high risk of developing compassion fatigue. A similar finding was uncovered by Sprang, Clark, and Whitt-Woosley (2007) in their study of traumatic stress responses among 1,121 rural mental health providers 13% of the total sample was found to be at high risk of compassion fatigue. High rates of compassion fatigue have also been detected among crisis counselors following the Oklahoma City Bombing (Wee & Myers, 2002). The literature on STS presents limited research on prevalence of STS illustrating a gap. Additional research is required to identifying STS among

psychotherapists in Nairobi and Nakuru counties of Kenya. A particular issue that will be addressed in the current study is the prevalence of STS among this group.Other symptoms of STS include cognitive shifts and relational disturbance. Cognitive shifts as an STS reaction refer to shifts in the therapist's beliefs, expectations and assumptions (Pearlman & McCann, 1990b). These cognitive shifts can affect one's level of trust that results in chronic suspicion of others. One can go from feeling safe to having a heightened sense of vulnerability. One can move from a sense of independence to feeling a loss of personal control and freedom (Dutton & Rubinstein, 1995). Herman (1992) speaks of the notion of 'witness guilt', which sometimes plagues trauma workers who have not been directly traumatized. Trauma workers feel guilty for enjoying life while they observe victims/ survivors struggling. It is important, therefore that trauma therapists be able to distinguish between reasonable therapeutic efforts towards healing and the retraumatisation that may occur in their work with victims /survivors. Moreover, Herman (1992) advances his argument by describing a type of victim-blaming that sometimes occurred in trauma workers because they themselves began to feel victimized by their clients whom they perceived to be threatening, manipulative, or exploitative. Clearly, this would have devastating effects on the therapeutic process. Therapists must take responsibilities by setting appropriate limits for client's unwelcome actions towards them.

Indicators of psychological distress include distressing emotions like sadness or grief, horror or dread (Figley, 1995a). In addition, nightmares and images of the client's traumatic material can occur. Somatic complaints including sleep difficulty, gastric distress and headaches. Addictive behaviours or compulsive behaviours including substance abuse or work holism, impairment of the therapist's day to day functioning in social and personal roles, such as missed or cancelled appointments, decreased use of supervision, chronic lateness, and feelings of isolation can also be indicators of psychological distress (Dutton & Rubinstein, 1995). Trauma research demonstrates that secondary exposure to trauma may have an impact on the relationships, both personal and professional, of trauma therapists. According to Lairel and Figley (2012) for instance, personal relationships can suffer as a result of increased stress or difficulties related to trust and intimacy. The professional relationship between the therapists and the client may be

affected when the workers experience STS and respond to their clients by either the relationship dynamics of detachment or over identification (Dutton & Rubinstein, 1995). Detachment or distancing oneself emotionally from trauma survivors is used consciously or unconsciously to enable trauma therapists to deal with their feelings of being overwhelmed or rendered vulnerable by the traumatic material, hence blocking out such emotional reactions. However, the use of these defence mechanisms may leave clients feeling isolated emotionally and detached once again, even from those people who are aspiring to help them. The use of dynamics of detachment or distancing by trauma therapists as a secondary response to trauma may also take the form of withdrawal from family, friends or colleagues, perhaps out of the belief that no-one understands their distressed response to their work . Trauma therapists may feel isolated emotionally in their working environment as they may perceive that they are the only ones who feel traumatized by such difficult and painful work and this contributes further to their problems (Corey, 2001). Trauma therapists sometimes use the relationship dynamic of over identification with the client, either consciously or unconsciously, to the point that they may react with 'paralysis' or numbness to the clients' traumatic experiences. Alternatively, they might take on excessive responsibility for the clients' life, perhaps in an attempt to gain control over overwhelming situations. Trauma therapists who become overloaded by the traumatic material are at best ineffective and at worst, place survivors/victims in a position of taking care of them. This role reversal in 'care giving' and 'caretaking' involves clients with holding details about the trauma in order to 'protect' the therapists. The collective term for unconscious relationship dynamics is traumatic counter transference (Dutton & Rubinstein, 1995).

2.4 Predictive Factors of Secondary Traumatic Stress

Factors that predict STS can be divided into two categories according to the literature: 1) individual characteristics of practitioners and 2) environmental/work-related characteristics surrounding practitioners. Individual characteristics include the following: i) age of practitioners (Good, 1996; Ghahramanlou & Brodbeck, 2000; Nelson-Gardell & Harris, 2003; Creamer & Liddle, 2005; VanDeusen & Way, 2006) ii) marital status of practitioners (Byrne, 2006); iii) practice experience of practitioners (Good, 1996; Chrestman, 1999; Birk, 2002; Creamer & Liddle, 2005; Badger, Royse, & Craig, 2008); iii) personal support received by practitioners

(Rogentine,1997; Pulido, 2005); iv) training of practitioners (Chrestman, 1995; Lepore, 2004; Perrin, DiGrande, Wheeler, Thorpe, Farfer & Brackbil, 2007); v) gender of practitioners (Deighton et al 2007; Linley & Joseph, 2007; Adams & Riggs, 2008); vi) level of education(Dyregrov, Kristoffersen & Gjestad ,1996; Stamm, 1997; Steed & Bicknell, 2001); vii) history of trauma (Meyers & Corneille ,1999); vii) history of psychiatric symptoms (Figley,1995c); ix) personal life stressors (Follett et al ,1994; Schauben & Frazier,1995); x) unresolved personal trauma (Adams , Matto, & Harrington, 2001).

Environmental or work-related factors associated with STS among practitioners include: i) level of exposure and empathy to traumatized clients (Simonds, 1996; Brady, Guy, Poelstra, & Brokaw, 1999; Pinsley, 2000; Myers & Cornille , 2002; Wee & Myers, 2002; Creamer & Liddle, 2005); ii) different type of traumatized clients (Good, 1996; Kassam-Adams, 1996; Pinsley, 2000; Creamer, 2002; Cunningham, 2003; Baird & Kracen, 2006;); iii) degree of workplace support (Hodgkinson & Shepard, 1994; Pearlman & Mac Ian, 1995a; Baird & Jenkins, 2000; Dickes, 2001; Lybeck-Brown, 2002; Slattery, 2003; Perron & Hiltz, 2006; Naturale, 2007).

2.4.1. Individual Factors of Secondary Traumatic Stress

Several studies have recognized age as a risk factor associated with STS. Age is indicated as the reason that older people tend to have better coping skills that would render it easier for them to deal with external stress symptoms and to reduce their level of stress symptoms than younger people (Ghahramanlou & Brodbeck, 2000; Nelson-Gardell & Harris, 2003; Creamer & Liddle, 2005). Ghahramanlou and Brodbeck (2000) conducted a study that focused on sexual assault trauma counselors and found that the age of the counselors had a significant association with the intensity of STS symptoms. A higher age possibly acted as a buffer against the tendency to develop STS symptoms. Ghahramanlou and Brodbeck (2000) also reported anecdotal experiences of monthly staff meetings during which younger counselors reported detailed accounts of their client contacts, recollections of specific assault characteristics, and expressions of anger, frustration, disappointment, and helplessness toward their victimized clients' painful experiences. Further, Arvay and Uhlemann (1996) noted age of the psychotherapists as a factor in research studies indicating that those who were younger were more vulnerable to intrusion and

avoidance symptomology. Empirical survey studies in summary have found that the age of helping professionals working with traumatized populations has a direct impact on professionals' level of STS symptoms. The older professionals tend to have less STS symptoms than the younger professionals(Arvay & Uhlemann ,1996). Age can be recognized as a protective factor that decreases STS. It is in this view that age was selected by the researcher in this study as one of predictive factors of STS; with intentions of finding out if it is predictive of STS in this study. Researchers have increasingly recognized that marital status plays a protective role against STS. For instance, Byrne (2006) studied 467 child welfare social workers in 10 area offices, five from the southeast region and five from the northeast region of the Massachusetts Department of Social Services. The evidence indicated that marital status strongly and inversely affects STS /compassion fatigue with burnout. According to the study results, the household status of living with others appeared to be a significant protective factor against STS/CF. Therefore, marital status can be recognized as a protective factor that decreases STS symptoms because trauma workers who live with their partners have the opportunity to reduce their levels of STS by talking with their partners about their work.

Literature on education level shows two contradictory research results. Some studies indicated that education level did decrease STS symptoms while others contradict. The studies that indicated that education level decrease STS symptoms include those of (Dyregrov et al, 1996; Stamm, 1997; Chrestmann, 1999; Perrin, DiGrande, Wheele, Thorpe, Farfel, & Brackbill, 2007). Chrestman (1999) conducted a quantitative study of adult therapists working with traumatized populations. The study reported that the clinicians with more Continuing Education Units (CEUs) had decreased avoidance symptoms as a result of their exposure to traumatized clients. In addition to the result by Chrestman (1999), Perrin et al. (2007) found that training contributed to decreasing the symptoms of STS for workers assisting the victims of the September 11, 2001, attacks. Stamm (1997) confirmed the existence of compassion fatigue in mental healthcare providers and found that those who were more qualified were at lower risk of experiencing compassion fatigue. Education level can therefore be recognized as a protective factor that decreases STS because those psychotherapists who receive training on how to work with traumatized populations develop the skills to more effectively deal with traumatized populations.

Other studies however have indicated that training did increase the STS symptoms. For instance, Lepore (2004) studied the STS symptoms of 206 crisis intervention workers selected from personal care/nurses 'aides, disaster relief workers, police officers, and professional counselors and found that adequate training does not reduce level of STS symptoms in crisis intervention workers. Further Wilson (1998) conducted a qualitative study which looked at STS in trauma counselors in South Africa. Results of this study showed that both professional and non-professional groups suffered from compassion fatigue. Subjects from both groups indicated feelings of helplessness and powerlessness. Since the examination of the effect between education level and the symptoms of STS has yielded two contradictory research results, it was important that this study further validate how the level of education contributes to the development of STS.

Years of counseling/practice experience have also been indicated in STS literature as predictive factor of STS: Several STS studies (Good , 1996; Chrestman , 1999; Creamer & Liddle , 2005; Badger, Royse, & Craig, 2008) provide evidence that those helping professionals who have less practice are more at risk to develop STS symptoms than those with a great deal of practice. Good (1996) administered a survey to 257 participants that included art therapists, social workers, and other mental health professionals with a master's degree and above. Study revealed that therapists who had more years of experience in practice showed lower STS symptoms. Chrestman (1999) conducted a study among therapists belonging to the International Society for Traumatic Stress Studies (ISTSS), the International Society for the Study of Multiple Personality and Dissociation (ISSMP & D), and the American Association of Marital and Family Therapists (AAMFT). The study discovered that increased professional experience in the therapists was associated with a decrease in STS symptoms (measured by the Impact of Event Scale and the Trauma Symptom Checklist (Elliot & Briere, 1991). Previous empirical survey studies have found that helping professionals with more professional practice experience working with traumatized populations tend to have decreased levels of STS symptoms. In addition, Birk (2002) found that the more years of working with trauma clients increased the level of compassion fatigue. Some studies have however found the opposite to be true: that more practice

experience relate to increasing level of STS symptoms (Landry, 1999; Baird & Jenkins, 2003). Research conducted by Munroe (1991) showed that the development of STS is not protected by level of experience or qualification of the trauma worker. Wee and Myers (2002) study with mental health workers who provided mental health disaster services after the Oklahoma City bombing confirmed too that higher risk of STS and burnout was associated with increased time working with survivors. The discrepancies in findings may be a result of the different populations used, including counselors, marriage and family therapists, social workers, psychologists. Each of these professional groups receives different training. The discrepancies in the results of these studies suggest the need for further investigation.

Evidence suggests that psychotherapists who receive more personal support from their family and/or friends tend to handle their stress better than the ones who receive less support (Rogentine, 1996; Pulido, 2005). For instance, Rogentine (1996) explored the impact of continual exposure to STS among 12 Child Protective Service (CPS) Agencies in Alameda and Contra Costa counties in Northern California. The study found that the CPS workers who appeared to cope better with their stress had a strong network of family and friends. Therefore, psychotherapists who deal with traumatized clients will have fewer symptoms of STS if they receive support from their family and/or friends. Personal support can be recognized as a protective factor that decreases STS since those therapists with more emotional support from their family members or friends have the opportunity to reduce their levels of STS by talking about their work and receiving positive feedback. Cohesion among colleagues can help in the worst of times and can buffer the sometimes grinding ambiguity of the work. Colleagues are an important part of self-care (Pearlman & Saakvitne, 1995b). They understand the work, and they are also the individuals to whom trauma workers can talk about their clients and how they are affected by the work and what they are doing about it. Colleagues can help us to recognize our successes with clients and to appreciate what we have done. Colleagues can also help each other to maximize the use of problem-solving coping, thinking the problem through and acting on the conclusion rather than the use of avoidance to cope. Colleagues also understand each others' sense of humor and the need to debrief and talk about the frustrations of the work (Tedeschi & Calhoun, 1996; Moran, 2002). Literature on STS also highlights social support as having a

significant effect in the development of STS (Flannery, 1990). However, literature lacks position in the way which social support has been conceptualised in empirical studies. Some empirical studies have shown social support to have a main effect as it is seen to act as an antecedent to stressors. It can occur in the absence of a stressor thereby protecting the individual from any negative outcomes. On the other hand social support has been reported to have a 'buffering' effect, and therefore is only necessary in the presence of stressful events. The confusion between both these distinctions has lead to inconsistent findings in studies investigating the role of social support in trauma (Ortlepp, 1998; Wilson, 1999). This presents a further area for research.

The literature on STS indicates that trauma counselors are at an increased risk of developing STS reactions, as their unresolved conflicts may be triggered by the traumatic experiences of others (Figley, 1995; Pearlman & Mac Ian, 1995; Meyers & Corneille's, 1999; Kassam-Adams, 1999 ; Cunningham, 2003; Nelson-Gardell & Harris, 2003 ; Adams et aI., 2006)). For instance, in a study of 166 child welfare workers, professionals who endorsed a history of sexual abuse, emotional abuse, or neglect were at a greater risk of compassion fatigue than their peers who did not report a trauma history (Nelson-Gardell & Harris, 2003). Likewise, in Adams et al.(2006) study of 236 social workers living and working in New York City following the September 11, 2011 attacks, individuals reporting trauma histories were more likely to endorse symptoms of secondary trauma and overall psychological distress. Meyers and Corneille's (1999) note that having personal history of trauma contributes to vulnerability of STS and to the number of symptoms experienced. In their study of 203 child welfare practitioners in New York City, 82 percent had traumatic experience before they became child welfare workers. Seventy seven percent indicated they had experienced physical assault or been threatened by a client. Prevalence of STS in this population was evident. Pearlman & Mac lan (1995) for instance studied 188 trauma therapists with an extensive questionnaire including the 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. However, other studies have shown that having a personal history of

trauma was not predictive of STS symptoms (Schauben & Frazier, 1995; Kassam-Adams, 1999; Ortlepp & Friedman, 2001). Schauben and Frazier (1995) report in their study of vicarious trauma in counselors working with sexual violence survivors, that counsellors' personal trauma impact did not predict increased vicarious trauma. This discrepancy in findings may be a result of the subjects involved in the samples used. Cornille and Meyers (1999) as well as Nelson-Gardell and Harris (2003) used front-line social workers in child protective agencies. Where the social workers were exposed to child abuse cases, child trauma, and child neglect on a far more regular basis than the studies that did not show that having a personal history of trauma was predictive of STS.

Kassam-Adams (1999) studied a sample that consisted of 100 graduate level psychotherapists dealing with high cases of child abuse, trauma, and neglect not necessarily working in the same type of environment as the Cornille and Meyers (1999) and Nelson-Gardell and Harris (2003) samples. Ortlepp and Friedman (2001) used professional and lay counselors in their sample with differing levels of formal education and found that the type of trauma may be greater predictor of STS than personal history of trauma. Furthermore, Figley (1995) recognized that persons who are exposed to traumatized children are especially vulnerable to compassion fatigue. Young children are completely dependent on adults for their emotional and physical needs. When adults maltreat these vulnerable persons; it evokes strong reactions in the helper. It is important to note too that working with traumatized people may also have positive effects for those who have survived trauma (Schauben & Frazier, 1995; Herman, 1997). In a study of female counselors working with sexual violence survivors, Schauben and Frazier (1995) found no evidence of increased distress among therapists who were survivors of traumatic events. In addition, the authors reported that survivor-counselors indicated that they learned about themselves through their interactions with clients, and were better able to heal from their own victimization experiences. This finding echoes Herman's (1997) assertion that helping others is a vital part of the recovery process for some trauma survivors. For example, Herman states that while there is no way to compensate for an atrocity, there is a way to transcend it, by making it a gift to others. The trauma is redeemed only when it becomes the source of a survivor mission (Herman, 1997). As such, while working with the traumatized may act as a trigger for unresolved issues among

survivors, it may also promote healing and insight. Due to history of trauma importance as an indicator of STS, its contradictory findings, and relatively limited research, it was considered an important variable of research in the current study. A history of treatment for psychological disorder before and acute psychiatric symptoms are also associated with the development of long–term PTSD in crisis workers. Literature that supports this variable is very old indicating a gap in history of trauma literature. These findings have been confirmed in studies that examined responses to traumatic events (Burgess & Holstrom, 1974; Vachon, 1976; Murphy, 1986). Figley, (1995c) confirms too that history of psychiatric symptom is predictive of STS. Unresolved Personal Trauma is yet another predictive factor mentioned in literature. If helpers own trauma history remains unrecognized, unprocessed or unresolved helpers may be sensitized to their own disrupted need areas, and will be at greater risk for missing the clients more pressing needs (Adams, Matto, & Harrington, 2001). In addition, helpers may be more likely to experience the client's intrusive imagery or re-experience his /her own imagery which is reawakened by the client's material, as unresolved trauma of the worker which is often activated by reports similar to that of clients.

Personal life stressors for example divorce, death in the family, financial, legal or medical difficulties among others have also been suggested to contribute to STS (Schauben & Frazier, 1995). Follette et al. (1994) looked at current level of personal stress that is experienced by therapists and found these predicted STS symptoms more than a therapist's personal experience of trauma or actual exposure to clients STS experiences (Schauben & Frazier, 1995). The above studies acknowledge that age, marital status, practice experience, personal support, training, history of trauma, history of psychiatric symptoms, unresolved personal trauma, and personal life stressors could be recognized as individual risk factors that affect the occurrence of STS symptoms resulting from working with traumatized populations. However, these individual factors also cause controversy since some studies have failed to examine the association between these individual factors and the level of STS symptoms. This study utilized the insight of these scholars with a view to finding out if the variables mentioned are also predictive of STS in Nairobi and Nakuru counties, Kenya.

2.4.2. Environmental/Work-Related Factors

The issue of exposure to traumatic material was highlighted by Figley (1995a), Dutton and Rubinstein (1995), and Pearlman and McCann (1990a) as an issue central to their respective theories of CF, STS, and VT, and has become central to discussions of STS (Steed & Bicknell, 2001). STS cannot occur without this exposure to traumatic material. According to STS literature exposure variables can be divided into current risk and cumulative risk. Current risk includes the following exposure variables: the number of current clinical hours spent with trauma survivors; the percentage of trauma survivors in the therapist‘s current caseload; and/or the perceived level of exposure to graphic details with current clients. The exposure variables for cumulative risk include the number of months or years working with trauma survivors and/or the number of clinical hours spent with survivors over the course of social worker‘s career.

The following three studies focus only on the exposure variables of current risk. First, Chrestman (1999) conducted a quantitative study of adult therapists working with traumatized populations. He found that a higher percentage of time spent with trauma clients in general clinical activities led to increasing avoidance symptoms of the STS symptoms. In the same study, an increased percentage of trauma clients in the caseload predicted increasing levels of dissociation, traumatic symptoms, and intrusion. Further, Chrestman found that the therapists with a higher percentage of trauma clients in their caseloads reported a decrease in their children‘s activities away from home and less communication with family and friends. Second, Lee (1995) assessed the degree of STS among 175 marriage and family therapists randomly selected from the population of national marriage and family therapists listed in the 1992 AAMFT Directory of Clinical Members and Approved Supervisors through a mail survey. The study found that the more hours a therapist spent listening to a client traumatic material, the greater the therapist’s intrusion score. Third, Schauben and Frazier’s (1995) qualitative and quantitative investigation of STS in 148 female therapists working with victims of sexual violence, found that higher client caseloads correlated with more disrupted beliefs, more symptoms of PTSD and more self-reported vicarious traumatisation. Fourth, Cornille and Meyers (1999) administered a survey to assess STS symptoms among a sample of 183 participants from child protective services (CPS) who had worked for more than one year with abused and neglected children in New York. They

found that the level of work exposure with victims of child abuse and neglect was strongly associated with the presence of STS symptoms in the CPS workers. The following four studies took into account both current and cumulative exposure variables. First, Pinsley (2000), using a convenience non-probability sample, conducted a mail survey of 163 therapists working with sexual assault survivors in community mental health programs and university or hospital-based crisis programs and private practice within the five boroughs of New York City . After studying therapists with caseloads comprised of 50% or more rape and incest survivors over the previous year, the study found that the sampled therapists reported more intrusive and avoidant symptoms of STS symptoms (measured by the Impact of Event Scale) associated with trauma distress than those therapists whose caseloads had fewer than 50% of such clients. Second, Meyers and Cornille (2002) administered a mail survey to 205 Child Protective Service (CPS) workers, recruited though contact with the directors of the Family and Children‘s Services in 92 counties in New York , who responded to abused and neglected children. The study indicated that the CPS workers who had worked with abused children for longer periods of time experienced more severe STS symptoms (measured by Impact of Event Scale-Revised) than those with fewer years of experience. For example, CPS workers with five or more years experience with abused children reported more severe obsessive-compulsive and anxiety symptoms, including panic attacks and feelings of terror. Also, CPS workers who worked 40 hours per week or more reported experiencing more anger, irritability, jumpiness, exaggerated startle response, trouble with concentration, hyper-vigilance, nightmares, and intrusive thoughts and images than those who worked less than 40 hours per week. Furthermore, CPS workers putting in longer hours reported feeling more distressed, depressed, anxious, hostile, suspicious, paranoid, and delusional than their counterparts with a reduced schedule. Third, Wee and Myers (2002) conducted a mail survey to 74 crisis counsellors, employed by the Oklahoma Department of Mental Health and Substance Abuse Services or contract agencies that provided disaster mental health services following the bombing of the Alfred P. Murrah Federal Building in Oklahoma City. They found that respondents who had worked for more months with bombing survivors had higher mean distress scores than those who had worked for fewer months. The amount of time working with bombing survivors was significantly associated with compassion fatigue, which is related to STS symptoms, as measured by the Compassion Fatigue Self-Test for Helpers (Figley,

1995b). Therefore, previous empirical studies have found that more exposure to traumatized populations contributes to a higher level of STS symptoms for helping professionals. The more recent studies, which have examined both current and cumulative exposure variables, have found a significant correlation between exposure variables and STS. Lastly, in relation to level of exposure, Green (1994) argues that the primary risk factor associated with the development of PTSD, and inferentially STS, is the level of severity of exposure to stressors. Although there are several studies in this area, they reflect conflicting results (Kassam-Adams,1995; Cornille & Meyers, 1999; Steed & Bicknell, 2001). Due to these discrepancies the relationship between level of exposure to traumatic material and STS is worthy of further exploration.

Empathy is listed in STS literature as an excellent resource for trauma workers. Figley (1995; 2003) believes that empathy is a paradox. Although it is the key characteristic that leads individuals to become helpers and is an excellent resource for trauma workers, it is also what leads to having an emotional connection to someone thereby increasing ones vulnerability to symptoms of STS. One relevant published research conducted by Regehr, Goldberg and Hughes (2002) that explored the relationship between empathy and trauma in ambulance paramedics found that paramedics who are more emotionally empathic and provided higher quality care, also had several consequences (e.g. sleeplessness, anger, and flashbacks). These consequences in turn led to STS (Regehr et al., 2002). This study is congruent with Figley's understanding of empathy as a paradox and is also widely held by other authors (Steed & Bicknell, 2001; Stamm, Varra, Pearlman & Giller, 2002 ; Adams et al, 2004) there however exist very limited empirical studies on the relationship between empathy and STS to support this claim , despite the factor that there is theoretical literature on empathy in relation to STS and Figleys's constant referral to its paradoxical properties. This creates a critical gap in STS literature as empathy is hypothesized to be one of the main factors in the process of STS formation. Empathy is therefore critical area for study in this study.

Type of traumatized clients is yet another factor indicated in STS literature as predictive of STS. The following evidence shows that the level of STS for helping professionals differs, depending

on the type of trauma caseload they experience. First, some researchers have found that workers who treat victims of human-induced violence and crime, such as sexual assault or domestic violence, experience more severe STS than those workers who treat victims of naturally occurring trauma, such as cancer or natural disasters (Kassam-Adams, 1995; Cunningham, 2003). Cunningham (2003) gave two reasons for this: First, although working with both populations causes stress, those clinicians who worked with clients who were sexually abused were exposed to the clients' account of trauma induced at the hands of another human. Human-induced trauma such as sexual abuse, according to Danieli (1994) massively and mercilessly exposes caregivers to the potential boundlessness of human evil and ugliness. It also creates anger, helplessness, and other negative feelings within helping professionals; and Second, clinicians working with sexual abuse survivors and the clinicians working with victims of naturally caused trauma like cancer might exhibit different symptoms due to the different nature of the exposure. Clinicians who work with victims of sexual abuse might be more likely to have a long-term relationship with the same client by providing individual psychotherapy over several months; this would give those helping professionals to more traumatic stories or materials.

Second, some researchers have discovered that helping professionals who treat children have higher levels of STS than those who treat adults. For example, one study, recruiting primarily via the Disaster Mental Health List (Creamer, 2002), used a quantitative mail study of 80 mental health professionals affiliated with various disaster relief organizations such as American Red Cross, Green Cross, Salvation Army, who served as disaster mental health (DMH) workers in response to the attacks of September 11,2001. This study found a higher degree of STS (measured by the Impact of Event Scale (Horowitz, Wilner, & Alvarez, 1979) in workers who spent more time with child clients, who discussed more morbid or graphic material, and who dealt with sensory-related material. Facing victimization in children would make clinicians feel more vulnerable and helpless since children have less power and control over abuse than adults. Third, other types of difficult cases, such as clients with psychosis, have been recognized as contributors to increasing the STS symptoms of helping professionals. Good (1996) conducted a survey to 257 participants by handing the survey questionnaires to the participants of the American Art Therapy Association Conference in San Diego and by mailing the surveys to eight

public and private mental health agencies in California, Florida, Georgia, Kansas, New York, New Mexico, Mississippi, and Pennsylvania. The study examined the participants' level of STS symptoms (measured using the Compassion Fatigue Self-Test for Psychotherapists by Figley (1995a). Good found that therapists who work with dissociative clients had significantly higher incidences of STS. Therefore, previous empirical studies have shown that a certain type of caseload including clients who are victims of sexual assault, victimized children, and psychotic clients increases the professionals' level of STS symptoms. Because some controversy remains about the results and because the measuring instruments used did not measure appropriately STS, this study addressed the type of caseload and used the secondary traumatic stress scale which measures only STS to ascertain if type of caseload is predictive of STS.

2.5 Coping with Secondary Traumatic Stress

In coping literature there is lack of clear definitions and inconsistent terminology on what coping is. Coping is often referred to in terms of strategies, styles, resources, approaches, and skills. These terms may differ conceptually. Several studies using the term "coping style" presume that personality is a stable attribute and accounts for the predisposition for people to cope in certain ways. Support is provided by studies showing personality dispositions related to post-trauma outcomes mediated by coping (Shakespeare-Finch, Gow & Smith, 2005). Alternatively, other researchers use the term "strategy" and advocate a contextual response, whereby coping is viewed as being flexible across situations and over time (Suls & David, 1996; Skinner, Edge, Altman, & Sherwood, 2003). Current coping theories contend that the effectiveness of any given strategy is dependent on the context of the traumatic incident (Zuckerman & Gagne, 2003). This study lends support to the "contextual" views of coping; that differential coping strategies are utilized according to the situation/context. The study looks at coping in terms of contextual response where psychotherapists view coping as being flexible across trauma situations and over time. According to this view, any particular strategy that the person employs to deal with the trauma can be either adaptive or maladaptive depending on the circumstance. Literature reviewed included both adaptive and maladaptive ways of coping with trauma. Adaptive coping include; preventive strategies such as personal strategies, professional strategies, and organizational strategies and emotional self care. Maladaptive coping include avoidance or

dissociation strategies. This review begins with adaptive strategies. First, personal strategy:under personal strategy areas to examine include physical self care, emotional self care and social self care.

Practitioners report that there are several activities that contribute to their physical wellbeing: sleep, rest, exercise, good nutrition, reliable transportation, massages, hot tubs, and engaging in sex. (Krucoff & Krucoff, 2000) .While each of these is important to physical self-care, exercise is crucial. The importance of vigorous exercise in stress reduction has been documented in the stress management literature (Flannery, 1990).Whatever form of exercise is selected, it is clear that doing it regularly increases one's overall strength, endurance, cognitive clarity and sense of well-being. A study of 117 trauma therapists conducted by Pearlman and Mac Ian (1995) found that socializing, exercising, spending time with family and friends were helpful in coping with traumatic material**.** Moran (2002) stated that humour is an important physical coping strategy. Workers must, however, exercise caution in using humour to cope. The overuse of humour may be a form of denial or a cover-up of what is really going on with the trauma worker. It is also a red flag if a person loses his or her sense of humour and if it becomes excessive it may be an avoidance technique (Moran, 2002). It is important that the practitioner have a good relationship with his or her family physician. There are times when exercise is beneficial but additional interventions are needed. When exercise helps, but the practitioner still finds him or herself depressed, the family physician may find it necessary to monitor health concerns and ensure that the practitioner is treated accordingly (Pearlman & Mac Ian, 1995). The physician can also assess when brain chemistry has been altered and can help the worker decide on the most effective intervention. Physical coping strategies are cited in literature however; there is clearly a need for additional studies to identify and confirm how physical strategies contribute to STS. Second, social self care: Literature on STS conceptualizes social support as a multidimensional construct. Support systems can encompass the provision of a) cognitive support, including explanations for the traumatic event; b) emotional support, including reassurance, acceptance, love, caring, trust, intimacy and empathy; c) informational support, including provision of information or skills which are helpful in finding solutions to a problem; d) appraisal support, including feedback given to a person as an evaluation of personal performance and help with

decision making; e) inclusion support, including encouraging feelings of belonging to the community or a group and access to social contacts and group activities such as spirituality; and f) instrumental support, including tangible or practical assistance such as material and financial assistance. Social self-care is an essential component of prevention of STS. Several studies have found that having a support system can reduce the impact of working with clients who have experienced trauma (Schauben & Frazier, 1995; Ennis & Sharon, 2003; Kadambi & Truscott, 2003; Angelea, 2007). Lower levels of STS have been found among those therapists that had an outlet to discuss the personal impact of working with traumatized clients than those that did not (Kadambi & Truscott, 2003). Schauben and Frazier (1995) found that therapists working with sexual violence offenders in their sample who reported that they actively sought social support reported lower levels of STS than those who did not. These therapists identified clinical team meetings, meetings with colleagues, and debriefing periods with team members following treatment, and supervision related activities such as forums in which they felt they had opportunities to address the negative impact of their work.

Dershimer (1990) emphasized employer support as a critical factor for helping professionals who work with traumatized populations. Valent (1995) suggested that the experiences of STS needed to be processed in treatment teams, in consultations with colleagues, and in debriefing meetings in order to effectively integrate them. Perceived social support has also been found to be associated with lower levels of STS symptoms (Ennis & Sharon, 2003). Previous studies on social coping strategies are mixed. With some studies indicating that it is a buffer against STS while others indicating it is not a buffer. Studies that found social support a buffer against STS includes: Dickes (2001), who examined the relationship between workplace support and STS symptoms, the study conducted mail surveys with 219 psychologists and found an association between the level of workplace support and the degree of STS in those therapists who treated sexually abused clients. Other benefits include reconnecting with others and sharing potential coping resources (Catherall, 1995). Pearlman and Mac Ian (1995) found that 85% of trauma counsellors reported discussion with colleagues as their most common method of dealing with Vicarious Trauma. Another issue is to whether or not social support should be measured as a moderator variable or a main effect. Studies have shown conflicting results with regards to the

role of social support in STS and thus creating confusion (Flannery, 1990; Sarason & Sarason, 1996). Social support as a main effect acts as directly promoting health and health behaviours therefore protecting the trauma worker from negative outcomes. In this view social support is beneficial regardless of whether or not the trauma worker is under stress (Durrant, 1999). On the other hand the buffering hypothesis states that low levels of social support are not inherently stressful but in situations of trauma, trauma workers who have high levels of support will experience less negative outcomes than those with lower social support (Durrant, 1999). Although there has been empirical support with regards to both social support as a moderator and a main effect, results that have emerged are inconclusive and unclear about the exact role of social support in an individual's experience of STS (Wilson, 1998). Furthermore in reviewing current literature it has become evident that the terms mediator and moderator are used interchangeably and there is still a lack of understanding into the precise ways in which social support prevents or relieves STS. It is important that this study further validates how social support contributes to development of STS.

Third, emotional self-care involves self-reflection and has intrapersonal and interpersonal aspects as well. Each practitioner can assess how the work is affecting him or her emotionally. Periodically taking the Compassion Fatigue Self-Test is one way to monitor the ways in which one may be affected. In the times that are most difficult, practitioners benefit from having someone to talk with, whether that is a colleague or supervisor. It may also be necessary to seek professional counselling when intrusive thoughts, rumination, and an inability to leave the work at the workplace become the rule rather than the exception. Practitioners can support each other in seeking help when they recognize intrusive thoughts and rumination in each other. Interpersonal aspects of emotional self-care involve being able to be intimately connected to significant others and friends (Tedeschi & Calhoun, 1995). This involves having an emotional life outside of work and not allowing the work to intrude into personal time. Spirituality or the meaning the therapist makes out of traumatic life events may play a part in STS (Pearlman & Saakvitne, 1995b; Brady, Guy, Poelstra & Brokaw, 1999; Dane, 2000). According to Pearlman and Saakvitne (1995b), those therapists who lack a clear philosophy of life and causality, or who have struggled with issues regarding meaning, purpose, and spirituality may be at risk for STS.

Further research indicates that counselors with a "larger sense of meaning and connection" are less likely to experience vicarious trauma (Pearlman & Saakvitne, 1995b). In a survey of trauma counsellors, 44% reported that spirituality provided an effective coping mechanism in dealing with the effects of their work (Pearlman & Mac Ian, 1995). Finding meaning can help trauma counselors alleviate the impact of vicarious trauma. For psychotherapists who have dealt with trauma or are surviving trauma, the ultimate aim is to make sense of the event, which involves a cognitive process of ascertaining meaning in relation to their experience. This concept is universally accepted in coping theories and is assumed to promote better adjustment in managing the trauma (Tedeschi & Calhoun, 1996; Regehr et al, 2002). A study conducted by Dane (2000) found that spirituality was an important coping tool used by child welfare trauma workers that helped them find meaning in their work. Maintaining a spiritual life helps practitioners keep their worldview balanced and their belief system intact in a world of good and evil and helps them remember that there are happy, stable and healthy people.

In addition, Wittine (1995) suggested that psychotherapists with a strong sense of spirituality are more likely to accept existential realities and their inability to change the occurrence of these realities. He further suggested that counsellors' acceptance of these existential realities allows them to be more present with their clients. More specifically, counsellors who are at risk for developing STS can use whatever source brings them a sense of spirituality. Organized religions, meditation, and volunteer work are just a few examples of activities that may facilitate a sense of spirituality. Lee and Waters (2003) concluded that spirituality is a protective buffer for cumulative traumatic experiences. Maintaining a spiritual life helps practitioners keep their worldview balanced and their belief system intact in a world of good and evil and helps them remember that there are happy, stable, healthy people. Ultimately, it is up to the individual psychotherapists to determine how he or she will choose to develop his or her sense of spirituality. Emotional coping strategy is therefore an important area of study in this research.

Professional factors are also used as coping strategies in the workplace. Professional development consists of two focused tasks (Skovholt, 2001). The first task is getting quality feedback on individual performance, reflecting on it, and gauging individual practice and professional growth. The second task is using continuing education. For example, a person can

pursue formal education, attend seminars, collaborate with colleagues, and/or create a customized professional development plan. Pearlman and McCann (1995) further state that it is important for helping professionals to participate in debriefing and personal therapy sessions, professional training or development and peer support groups. They further emphasize importance of case supervision and consultation as a way of dealing with affect overload and the intrusive imagery that can disrupt the therapist's life. Peer supervision methods are helpful in providing trauma counselors with validation and support, in providing them with the opportunity to share new information related to therapeutic work, and in allowing them to vent their feelings (Oliveri & Waterman, 1993).Peer supervision has also been found to decrease feelings of isolation and increase counsellor objectivity, empathy, and compassion (Lyon, 1993). Peer supervision offers several benefits to trauma counsellors. First, consultation with colleagues provides an opportunity for counsellors to examine their perspective, thus aiding in decreasing cognitive disruptions.

Peer supervision also gives counsellors an opportunity to debrief and express reactions regarding client stories (Catherall, 1995). Whereas limits of confidentiality prevent counsellors from being able to debrief with support systems, peer supervision serves as a medium for counsellors to debrief in an ethical manner. Furthermore, supervision helps alleviate issues of counter transference and traumatic reactions (Rosenbloom et al, 1995). Discussion of therapeutic successes in formal peer supervision helps to reaffirm a counsellor's confidence in his or her clinical skills (Pearlman & Saakvitne, 1995b). Lybeck-Brown (2002), conducting a qualitative study with 10 therapists, found that supervision played a key role in explaining the impact of working with traumatized clients on professionals. After surveying the psychological symptoms of 79 domestic violence advocates in Massachusetts through a mail survey, distribution of surveys at meetings, and via a website, Slattery (2003) found that a higher level of co-worker cohesion and quality of clinical supervision in the work environment led to fewer reported PTSD symptoms. Activism is also noted as helpful. It may involve collaborating with colleagues to organize a self-help group to address STS in the workplace or volunteering with one of the community programs that address trauma from a perspective different from that of one's own agency. What these activities do for practitioners is to allow them to address trauma from a

different perspective, preferably one that allows them greater control. Certain activities can help the practitioner maintain a balanced worldview (Pearlman & Saakvitne, 1995b; Figley, 2002b). One helpful activity is to start the day with a list of work to be achieved, prioritize it, and then try to organize it so that emotionally draining tasks are not piled together. Pearlman and Saakvitne (1995b) suggest several activities that are essential to professional self-care such as getting up from a seat and moving around. Leaving the work for a lunch break is frequently mentioned as a refreshing activity that is all too often ignored by therapists. Another technique to reduce stress while working at a computer is to have free weights at the work station to relieve tension in neck and back muscles. Lifting and stretching reduce the tension that builds up when you do not move around.

Rourke (2007) argues that professional strategies such as maintaining professional connection with the colleagues and balanced work life are other key ways to cope with and prevent STS. A communication technique helpful to workers is for the worker to answer, when asked to take on a task not essential to the completion of his or her own work, "Let me think about that." This allows the worker time to evaluate whether or not this additional task needs to be taken on at all. It can be helpful for seasoned workers to validate the experiences of novice workers, especially around their natural apprehension and anxiety. Talking to colleagues about their experience in responding to trauma offers trauma workers support in dealing with after effects (Dyregrov et al, 1996). Professional coping strategies are of utmost importance for well-being of the caregivers because it has a direct impact on the level and quality of care provided (Pearlman & Saakvitne, 1995b; Herman, 1997; Zimmering et al. 2003). While there has been an increase in the number of studies on professional coping strategies, there is no consistency in the assessments used or in the factors studied; the uncertainty sometimes puts caregivers at greater risk of developing STS. Investigating the professional factors involved in the development and treatment of STS is very important. It is therefore a critical area for further research. Organizational factors are cited too in literature as coping strategies. It includes factors such as sufficient clientele time, atmosphere of respect and safe physical space for therapists and client (Pearlman & Saakvitne, 1995b). How trauma is conceptualized by the organization and even by society at large can play a role in STS. For example, a therapist's experience can sometimes be dismissed or even blamed on the therapist. Brady et al. (1999)

has stated that organizations can help reduce STS by providing a work environment that is emotionally supportive, physically safe, and consistently respectful. Organizational factors may serve to increase or buffer the impact of this stress over time. Naturale (2007) through case studies of disaster, with an emphasis on those social workers who suffered from STS responses in the midst of their fieldwork found that in the workplace, organizational supports decreased the stress that had triggered one of the worker‘s STS symptoms. These interventions helped mitigate potential STS from occurring in those staff members who interacted with the social worker experiencing the strain of disaster circumstances. The support providers received from their coworkers and supervisors emerged as a protective factor against STS (Adams et al., 2001; Way et al., 2004; Slattery & Goodman, 2009; Choi, 2011). Pearlman and Mac Ian (1995) found the protective nature of support particularly salient for therapists who had a personal history of trauma. Additional work variables shown to protect service providers against STS included access to strategic information from the organization (Choi, 2011); work environments characterized by shared power, respect for diversity, and consensual decision making (Slattery & Goodman, 2009); and work in a private practice versus an agency (Adams et al., 2001). By contrast, the research on STS has given relatively little attention to organizational issues (Bell, Kulkarni, & Dalton, 2003).

In summary, extensive research supports the organizational risk factors for burnout, including high workloads, low autonomy, and lack of supervision. Less evidence is available on the relationship between organizational factors and STS. Maladaptive coping strategies that are mentioned in literature include increased use of alcohol and drugs, compulsion to make hasty major life decisions, tendency to completely avoid any feelings or thoughts about the event, increased television watching or web surfing or becoming fatalistic or helpless. Previous researches on maladaptive coping have found them predictive of STS. For instance study by Follette et al. (1994) found the use of maladaptive coping strategies predictive of trauma symptoms. Pryce, Roff and Klemmack (2006) and Simon, Pryce, Roff, Klemmack (2006) also indicate in their studies that maladaptive coping are predictive of STS. They examined association between alcohol use and STS symptoms within 779 Red Cross workers who responded to September 11, 2001 twin bombing in New York. The study results indicated that Red Cross workers who reported increase use of alcohol had a higher level of STS. What is not clear from this study though is whether the psychotherapists are at risk, or if the use of such

maladaptive coping strategies is merely a manifestation of the experience of STS. Zuckerman and Gagne (2003), raise the caution that the terminology "maladaptive" implies negative connotations when, in practical terms, it is actually possible that "maladaptive" strategies may be beneficial in dealing with some situations. In support of Zukerman and Gagne (2003), Figley (2008) asserts that in coping assessment some responses that are typically viewed as being maladaptive may actually be a successful approach in some critical situations. Maladaptive coping strategies are therefore worth investigating in this study.

2.6 Theoretical Framework

Secondary traumatic stress theory and ecological theory of trauma used in this study provide an explanation to the occurrence of STS and provide indicators of what is incorporated in the framework.

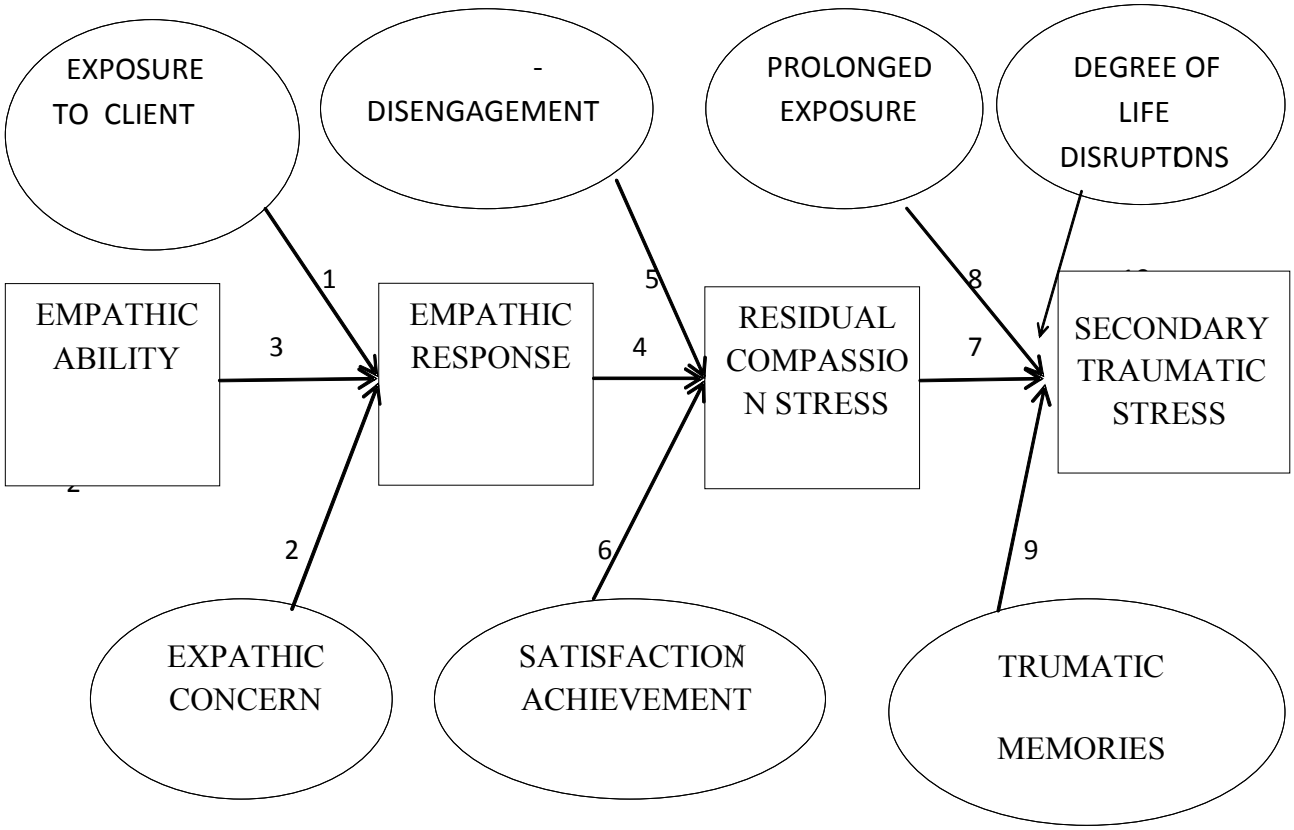
2.6.1 Secondary Traumatic Stress Theory

This theory is credited to Figley's (1995). Figley came up with this theory to conceptualize accurately the indices of traumatic stress for both those "in harm's way" and those who care for them and become impaired in the process. The basic premise behind STS theory is that individual stress symptoms are communicable, and those who are close to the trauma survivor can be infected with the trauma symptoms (Figley, 1995). Often the problems experienced by people close to a trauma survivor mimic the trauma symptoms in the survivor. This may result from an internalization process, whereby psychotherapists identify so closely with the experiences of the victim that they begin to internalize the trauma symptoms of the victim and experience their own stress reactions. These effects are considered secondary, because they occur in those who have not been directly traumatized by the event. Frequently, these effects may resemble PTSD symptoms, but may be less intense (Figley, 2002). This theory posits that helpers attempt to understand the trauma victim by identifying with the victim. They do this by trying to clarify the reasons for the traumatic event by answering Figley's (1995) five victim questions- What happened? Why did it happen? Why did I act as I did then? Why have I acted as I have since? If it happens again will I be able to cope? The helper tries to answer these questions for the victim in order to adapt their own behaviour in accordance with their answers. In this process

the trauma worker actually experiences very similar difficulties to those of the victim. Figley (1995) proposed the STS theory to explain the STS phenomenon. The STS theory identifies empathy and exposure as central elements to the development of STS. Other aspects include the counselors behaviour towards the victim, exposure to trauma, sense of satisfaction derived from helping, and the ability of the counsellor. STS theory is a function of six interacting variables. The main aspect of this theory is empathy. Figley separates empathy into three types: empathetic ability, empathetic concern, and empathetic response. Empathetic ability relates to the effectiveness of the trauma worker, and their ability to recognise the pain of others. In other words the trauma workers ability to accurately convey genuineness, unconditional positive regard, and respect to the victim. A trauma workers empathetic ability is usually the characteristic that leads them to become a helper. Thus the concept of empathetic ability is linked to empathetic concern, which constitutes the motivation to respond to the victim. Without this motivation the trauma worker plays no significant role and would be useless to the victim.

The third element is emotional contagion that is experiencing the feelings of the client as a function of exposure to their trauma and the therapist's simultaneous identification with the experience of similar feelings to those experienced by the client. The fourth empathetic response is a combination of the trauma workers empathetic ability and empathetic concern, and it measures the level of effort exerted by the helper in helping the client deal with pain and guiding the way for healing through hope and support (Figley, 1995). The fifth disengagement which refers to the extent to which the helper can distance himself/herself from the ongoing trauma of the clients and the sixth is sense of achievement which is the effort to help the client to relieve suffering. The sense of achievement and disengagement accounts for how much the helper experiences STS. Thus, if a sense of achievement is experienced there will be little STS as the psychotherapist is satisfied with the reduction in suffering. However, if disengagement is experienced the response is more STS, which in turn increase the risk of STS as the psychotherapists has become actively involved with the trauma, suffering and difficulties of the clients .This portion is depicted in Figure 2.1.

Figure 2.1.Trauma Transmission: Secondary Traumatic Stress Theory (Figley, 2002b)



If compassion stress is permitted to build up, and the subsequent three other variables Prolonged exposure, traumatic memories and degree of life disruptions are present, the therapist is at great risk of STS. One of the variables is prolonged exposure, meaning an ongoing sense of responsibility for the care of the suffering, over a protracted period of time. Traumatic recollections are memories that trigger the symptoms of PTSD and associated reactions. These memories may be from the psychotherapist's experiences with other, rather demanding or threatening clients. The last variable of the chain that cause STS is life disruption, the unexpected changes in schedule, routine, and meaning of life, responsibilities that demand attention for instance illness, changes in life style, professional or personal obligations

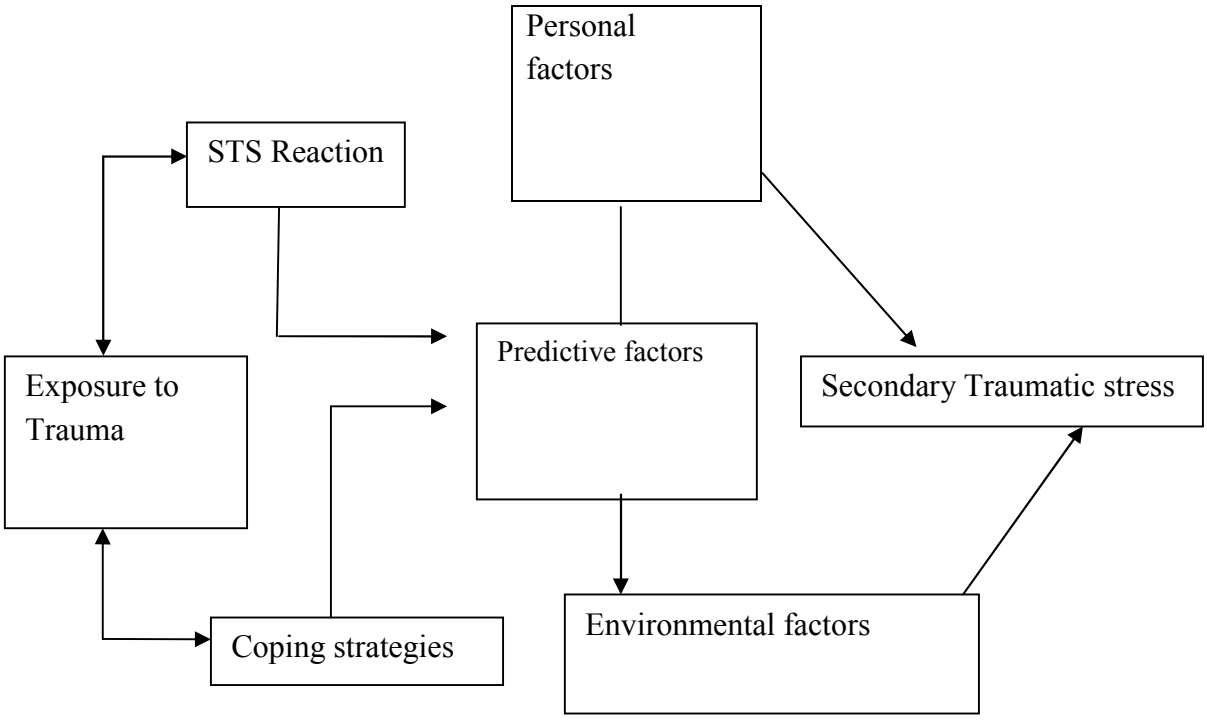
Normally such disruptions create a certain but tolerable level of distress. However, when combined with the other variables, these disruptions can increase the chances of developing STS (Figley, 1995a). Figley's (1995a) theory on STS transmission indicates that the STS symptoms may be prevalent in psychotherapists who identify so closely with the experiences of the victims and internalize the symptoms. It is therefore possible that the psychotherapists will have to cope with these symptoms in order to remain objective and continuing helping the client. This may involve a series of deliberate and natural behaviours and feelings that can be associated with the psychotherapists attempt to integrate the memories of the trauma, trauma work performed, and the traumatic incident listened to. As they try to cope predictive factors such as prolonged exposure and degree of life disruption may dictate whether the therapists remains or moves towards emotional mobility by successfully integrating the STS; or if unsuccessful, moves toward emotional immobility. Unsuccessful integration results in STSD. Figley's (2002a) trauma transmission theory provides a useful framework for understanding the onset of STS. However, it does not take adequate consideration of other environmental variables such as coping strategies that play a vital part in the therapeutic relationship. Despite this criticism Figely's model has provided a useful theoretical framework for this study.

2.6.2. Ecological Theory of Trauma

Another model that attempts to provide a theoretical framework for STS is that of Dutton and Rubinstein (1995). They developed an ecological framework of trauma which integrates aspects of Figley's model and also incorporates features relating to STS such as prevalence of STS, predictive factors and coping strategies which are lacking in Figley's (1995a) trauma transmission theory. Therefore Dutton and Rubinstein's (1995) theory provides a further conceptual development of STS. According to Dutton and Rubinstein (1995) there are a range of reactions that trauma workers may experience due to their work with trauma clients. These reactions are categorised into three areas. The first category relates to indicators of psychological distress such as avoidance efforts, intrusive imagery, physiological arousal, addictive behaviours, somatic complaints and/or social impairments. A second category of reactions experienced by the trauma therapists refers to shifts in assumptions and beliefs about the world such as changes in cognitive schema (Janoff- Bulman, 1992; Pearlman & McCann, 1990). Normal everyday

living is based on assumptions that allow people to set goals, plan activities and order their behaviours. These assumptions exist on a preconscious level and are thought to be disrupted by exposure to trauma either directly or indirectly, which then cause psychological stress and symptom formation (Janoff-Bulman, 1992). Relational disturbances, is the last category of reactions to secondary traumatic stress. Firstly relational disturbances may occur within the psychotherapy relationship as a result of mistrust between the client and trauma worker. In addition, as a result of secondary exposure, trauma workers relationships may suffer. With regards to these categories, Dutton and Rubinstein (1995) ecological theory of STS consists of four components: (1) the traumatic event to which the trauma worker is exposed; (2) trauma workers coping strategies; (3) the trauma workers PTS reactions; and (4) personal and environmental factors (Dutton & Rubinstein, 1995). The framework for understanding the interrelationships between these components is illustrated in Figure 2.

Figure 2.2. Ecological Theory of Trauma (Dutton & Rubinstein's, 1995)



Dutton and Rubinstein (1995) stated that exposure to traumatic material is unique for every trauma worker. This is due to four main reasons. Firstly, the traumatic material differs in degrees of severity from one victim to another. Secondly, the trauma therapist is not only exposed to traumatic material but the emotions that the victim experiences in relation to the event such as pain, anger and powerlessness. Thirdly, the trauma therapist is also exposed to the re-victimisation of their client which may occur as a result of social systems. Fourthly, the trauma therapist is exposed to the realisation that STS does occur, which may in turn challenge their cognitive beliefs. Lastly, the trauma worker may also have to deal with previous trauma that their client endured, which may resurface (Dutton & Rubinstein, 1995). All these different means of exposure to traumatic material make the psychotherapists vulnerable to STS. The second component of this theory involves coping strategies. Dutton and Rubinstein (1995) assert that coping responses affect the development and course of STS reactions (Dutton & Rubinstein, 1995). According to Dutton and Rubinstein (1995) there are two types of coping strategies: personal such as attending to personal needs, developing supportive relationships and professional including peer supervision and consultation. Dutton and Rubinstein (1995) also discuss the role of personal and environmental factors, which they believe may be predictors of STS. Personal factors comprise of the trauma workers inner strengths, their resources and their vulnerabilities. Research conducted by Dutton and Rubinstein (1995) found that variables measuring level of experience to be the best predictor of levels of stress for trauma workers (Dutton & Rubinstein, 1995).

This theory is useful in recognizing some of the core components of STS mainly focusing on environmental factors. Dutton and Rubenstein (1995) discuss the following environmental factors as being important: social support; organisations response to the trauma worker; the context within which the trauma worker works and lives; and social and cultural factors such as gender. All these factors influence how the trauma worker responds emotionally to their clients and consequently develops STS (Dutton & Rubinstein, 1995).This theory provides further explanation for the development of STS. It makes reference to both predictive factors of STS and coping strategies which are the independent variables of this study. It therefore compensates for what is lacking in the Figley's model. Besides these two theories are more relevant to trauma

workers than other theories in this field, they are more comprehensible and they can easily be integrated into a working theory of STS. Hence combined they provide a broader and more inclusive approach for the development of STS.

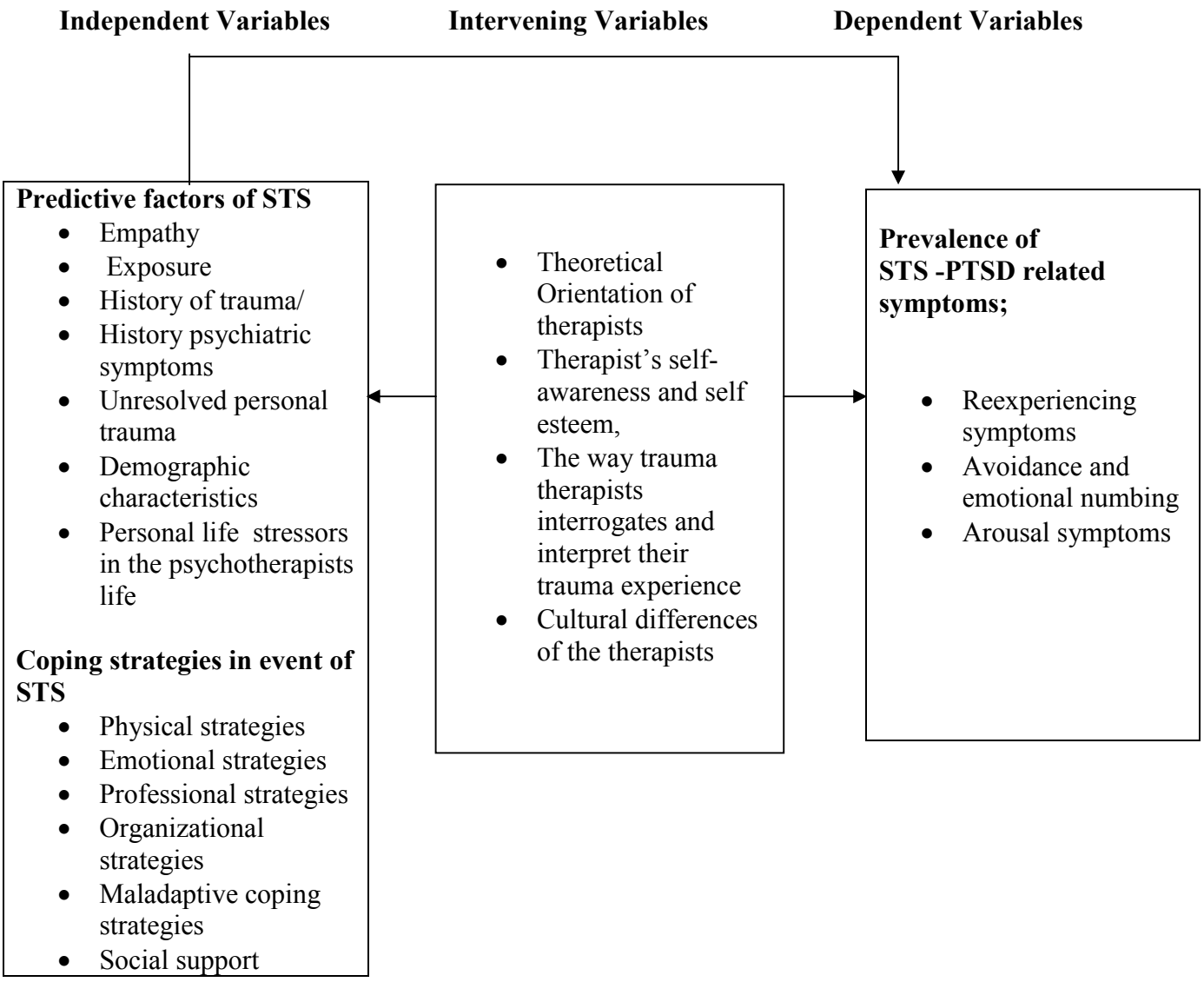
2.7 Conceptual Framework

In an attempt to improve the ideas derived from Figley's (1995) theory and Dutton and Rubenstein's (1995) theory, the current study came up with the following framework depicted in Figure 2.3**.** This framework provides the foundation for the current research and provides a means of organizing the theoretical concepts to be explored in a logical fashion. The framework presents an understanding of the components involved in the development of STS and their interrelationships. This framework stresses that STS is a result of exposure to traumatic material. However, the variability in the levels of STS can in part be attributed to independent variables; predictive factors and coping strategies

Predictor variables determine the extent to which the psychotherapists can distance him/her from the ongoing clients/victim(s) traumatic account or the extent to which the psychotherapists is satisfied with his or her efforts. This in turn accounts for how much the therapists experiences STS. Several predictor variables are hypothesized as making the psychotherapists vulnerable to STS: Empathy and exposure in terms of professional counselling experience and psychotherapists' case load, history of trauma, history of psychiatric symptoms, unresolved trauma, social support, other stressors in the psychotherapists' life and demographic characteristics. This model also indicates that coping strategies such as personal, professional, organisational and maladaptive factors also have an impact on the degree to which the trauma worker experiences STS as an outcome. Coping variables dictate whether psychotherapist either successfully or unsuccessfully integrates the STS, depending on the coping strategies employed. Successful integration requires effective psychological assimilation and accommodation of the trauma work, the traumatic incident, and the aftermath into the self with little or no emotional remnant. Unsuccessful integration results in STSD the hall mark of which is the STS of the psychotherapists. Intervening variables includes theoretical orientation of the therapist, personality of the therapists, therapist's self-awareness and self esteem, ability to self regulate,

and the way trauma therapists interrogate and interpret their trauma experience and cultural differences of the therapists. The last component of this model is the dependent variable; STS reactions of the trauma worker. Engaging in therapeutic work with trauma victims can and does impact on the psychotherapists. In the process of helping they experience emotions that are strikingly similar to those of the victim (STS). The dependent variable STS manifests as PTSD symptoms. Figure 2.3 shows the illustration.

Figure 2.3. Conceptual Framework on Prevalence of STS, Its Predictive Factors and Coping Strategies among Psychotherapists



CHAPTER THREE
RESEARCH METHODOLOGY

3.1 Introduction

This chapter deals with the procedures that were followed in carrying out the study. It examines the various steps that were followed in the entire research. It includes the research design, population of study, instrumentation, sampling procedure, and data collection procedures and data analysis.

3.2 Research Design

This study was descriptive in approach and utilized the survey design. Descriptive survey design is used to designate any research activity in which the researcher gathers data from a sample of a population for the purpose of examining characteristics, opinions or interactions of that population (Fraenkel & Wallen, 2000). Descriptive design was also selected because of its high degree of representativeness, and the ease with which the researcher obtained the respondents characteristics (Kathuri & Pals, 1993). Descriptive survey designs are not only useful in collecting data from large numbers of people but also generally involve the use of questionnaires (Barnyard & Grayson, 2000). This study used questionnaires to collect data on prevalence and predictive factors of STS and coping strategies among psychotherapists. There was no manipulation of variables and the researcher did not control the research setting. The variables prevalence of STS, selected predictive factors and coping strategies were studied without manipulation.

3.3. Location of Study

The study was conducted in Nairobi and Nakuru counties. These areas were selected due to their geographical, cultural and socio-economic diversities. The counties have also experienced many traumatic events. Nairobi County for instance has experienced grenade attacks, the bombing at the prayer rally at Uhuru Park, Westgate Mall attack, witnessed the Nakumatt fire tragedy, Sinai village petrol fire tragedy, Mathare slum landslides and the 1998 bombing of the American embassy among others. It also has many informal settlements like Korogocho, Mathare, Waithaka, Kawangware, Kangemi and Kibra. Within these informal settlements traumatic events

like rape, domestic and sexual violence, death, poverty, HIV/AIDS among others are rampant. (Harder, Mutiso, Khasakhala, Burke & Ndetie, 2012) .The study was conducted in the following constituencies that form the county of Nairobi; Makadara, Kamkunji, Embakasi, Starehe, Langata, Westlands, Parklands, Kasarani, Dagoreti, Kibra, Roysambu, Ruaraka, Kariobangi, Kayole, Nairobi West and Mathare. Nakuru County on the other hand has been the centre of election conflicts for a long time, for instance in 1992 general elections it suffered clashes. It also bore the brunt of post 2007 election violence and had 19 internally displaced camps as a result. It also has informal settlement such as Ponda Mali, Ronda, Kaptembwa, Abongolea, Farii, Kivumbini and Kanyi among others. Traumatic incidences are rampant in these informal settlements. It also witnessed the Sachagwan petrol tragedy. The study was conducted in Nakuru town, Naivasha, Molo, Rongai, Kuresoi, and Subukia areas.

3.4 Population of the Study

The study was based on survey of psychotherapists living and practicing in Nairobi and Nakuru counties of Kenya. The study included psychotherapists who are primarily engaged in therapy with clients in these two counties and who are registered members of KCPA. It is the association that is recognized by the government currently as the umbrella body for psychotherapists with approximately 50% of all practicing psychotherapists. In fact those who apply for government counselling positions are required to be members of the association. Psychotherapists were the population of interest for the current study as they are likely to suffer STS due to the relatively high levels of trauma incidences in Nairobi and Nakuru counties. It also included supervisors in Nairobi and Nakuru counties registered with KCPA. The supervisors were the key informants in the study since they directly oversee the clinical work of psychotherapists. Table 3.1 and Table 3.2 give the breakdown of psychotherapists and supervisors registered by KCPA in the counties.

Table 3. 1

Registered Psychotherapists with KCPA

County	Female	Male	Total
Nakuru	117	33	150
Nairobi	480	122	602
Total	597	155	752

Source: Kenya Counselling and Psychological Association database (2012)

Table 3. 2

Registered Supervisors with KCPA

County	Female	Male	Total
Nakuru	2	2	4
Nairobi	7	5	12
Total	9	7	16

Source: Kenya Counselling and Psychological Association database (2012)

3.5 Sampling Procedure and Sample Size

The sample was determined by the use of the formula by Kathuri and Pals (1993).The formula is as follows:-

$$S = \{\frac{x^2 \mathrm{N\ P\ (1-P)}}{d^2\ (\mathrm{N-1}) + x^2\ \mathrm{P\ (1-P\ )}}\}$$

Where

S-required sample size

N- The given population size

P- Population proportion of 0.50

d- Degree of accuracy (in this case, amount error of 0.05)

$\chi 2$ - Chi-square value for one degree of freedom at a confidence level of 0.95

Thus

$$S = \left\{ \frac{x^2 NP(1-P)}{d^2(N-1) + x^2 P(1-P)} \right\}$$

$$N = 752;\ P = 0.5;\ d = 0.05;\ \chi^2_{0.025}(1) = 5.02$$

$$S = \left\{ \frac{5.02 \times 752 \times 0.5 \times (1-0.5)}{0.05^2 \times (752-1) + 5.02 \times 0.5(1-0.5)} \right\}$$

$$S = \left\{ \frac{5.02 \times 752 \times 0.5 \times (1-0.5)}{0.05^2 \times (752-1) + 5.02 \times 0.5(1-0.5)} \right\}$$

$$S = \left\{ \frac{5.02 \times 752 \times 0.5 \times 0.5}{1.8775 + 1.255} \right\}$$

$$S = \left\{ \frac{943.76}{3.1325} \right\}$$

$$S = 301.2801277$$

$S = 302$

Kathuri and Pals (1993) developed a table of random numbers based on the above formula detailing the appropriate sample size selection from various known populations (N). From the given formula, the sample size of the study was determined. Kenya Counseling and Psychological Association (KCPA) had 752 practicing psychotherapists in the two counties. The sample size was therefore 302 respondents. Practicing psychotherapists were then randomly sampled from KCPA database. Nakuru County had 150 practicing psychotherapists and Nairobi County had 602 practicing psychotherapists. Proportionate sampling was used to identify respondents and enable researcher get a representative sample for each county. Out of 117 females in Nakuru a proportionate sample of 47 female respondents were selected and out of 33 male's proportionate sample of 13 males were selected. Nakuru therefore had a total of 60

respondents. They all participated in the research. Practicing female psychotherapists from Nairobi were 480, proportionate samples of 193 respondents were selected and out of 122 practicing male psychotherapists, 49 were proportionately sampled. Nairobi County therefore had a total of 242 practicing respondents. The actual respondents for Nairobi were 241 and not 242 as initially planned. This is because one female respondent returned the questionnaire without answering. Stratified random sampling was then used to select the respondents for study. All the registered supervisors in Nairobi and Nakuru counties were purposively sampled since the number was small. Nairobi had 12 registered supervisors but one was left out since she had not seen any therapists for supervision. Nakuru had 4, who all participated in the study. The total sample of the respondents for this study was therefore 301 psychotherapists and 15 supervisors totalling to 316. Response rate for the study was 99.51 %. Table 3.3 gives the sample distribution of respondents in the counties.

Table 3.3

Sample Distribution of Respondents in the Counties

County	Psychotherapists		Supervisors		Total
	Male	Female	Male	Female	
Nakuru	13	47	2	2	64
Nairobi	49	192	4	7	252
Total	62	239	5	10	316

3.6 Instrumentation

Three research instruments were used in this study. The first was a questionnaire in which the first section assessed demographic variables such as age, gender, marital status, education level, region in the country where client practices and aspects of professional activities such as years in professional counselling. The second section sought information on how predictive factors contribute to STS among psychotherapists in Nairobi and Nakuru counties of Kenya. Predictor variables were derived from existing literature on STS. Ohaeri (2003) suggests that important

variables in predicting STS include degree of exposure, personal history of trauma and social support. These were assessed among other variables selected due to their relevance in the literature as promising predictive variables. Finally the questionnaire sought information on how coping strategies contribute to STS among psychotherapists in Nairobi and Nakuru counties of Kenya

The second instrument was a Secondary Traumatic Stress Scale (STSS). It was adapted from Bride (2004). However modifications were done on it to suit the study. It determined prevalence of STS among psychotherapists. STSS is a17-item self report instrument designed to assess the frequency of intrusion, avoidance and arousal symptoms associated with STS resulting from working with traumatized populations (Bride, 2004). Each of the STSS items corresponds to one of the 17 PTSD symptoms listed in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (APA, 2000). The instrument required that respondents indicate how frequently on a five point Likert-type scale ranging from 1(never) to 5 (very often) each item is/was true for them. The STSS includes a total score and three subscales score representing intrusion, avoidance and arousal symptoms. Scores were obtained by summing the items assigned to each subscale and the entire instrument. Bride (2007) has proposed a cut off score, where those who obtain a score at or above 38 are considered to have STS. A symptom was endorsed if respondents indicated that the symptom was experienced 'occasionally', 'often' or 'very often' .Table 3. 4 indicate the normative score as provided by Bride (2007).

Table 3.4

Normative Score Outlined By Bride

Symptom Severity Level	STSS Score
Little to no STS	17-28
Mild STS	28-37
Moderate STS	38-43
High STS	44-48
Severe STS	49+

Note: STS (Secondary Traumatic Stress), STSS (Secondary Traumatic Stress Scale; Bride, 2007).

The third instrument was an interview schedule which was conducted among the supervisors in Nairobi and Nakuru counties who were registered by KCPA. They were considered key informants in respect of the supervisory role they render to the psychotherapists. The interview schedule also supplemented the questionnaire for quality data as it provides for probing. The questions asked were confined within the study objectives.

3.6.1 Piloting of Instruments

Pilot study was conducted in Uasin Gishu County. Uasin Gishu happens to have the third largest number of registered practicing psychotherapists after Nairobi and Nakuru. It also has the same characteristics as Nakuru and Nairobi counties for instance; it bore the brunt of post 2007 election violence just like Nakuru County. Piloting served to check the clarity of the questionnaire, STSS and interview schedule items and layout. It also eliminated ambiguities in wording, checked time taken to complete the questionnaire and helped identify commonly misunderstood items. A pilot group consisting of 15 psychotherapists took part in the study. This was 5% of the population of the psychotherapists in Uasin Gishu County. The pilot group of supervisors consisted of 2 respondents which was 10% of their total population. A pilot sample of between 1% and 10% of the population of study is considered acceptable (Mugenda & Mugenda, 2003).

3.6.2 Validity of the Instruments

The researcher sought the expertise of two supervisors and other research experts from the Department of Psychology, Counselling and Educational Foundations in the Faculty of Education and Community Studies of Egerton University for the purposes of verifying the study instruments, framing items and critical examination of variables. The development of research instruments was done by examining the research objectives and hypotheses, personal experience and related studies to confirm proper coverage of all the objectives. This ensured that the content validity of the instruments was established. The researcher used the results of the pilot test to adjust the questionnaire items and make them appropriate and understandable thereby increasing their validity.

3.6.3 Reliability of the Instruments

A pilot study was conducted before the main study to measure the reliability of instruments. Psychotherapists practicing in Uasin Gishu County and registered by KCPA were selected. STSS that was used to measure prevalence of STS has been used in the past and has displayed very good internal consistency with Cronbach Alpha reported for full STSS at .93 and .94, intrusion subscale at .80 and .79, avoidance subscale at .87 and .85 and arousal subscale at .83 and .87 (Bride, Robinson, Yegidis & Figley, 2003). Evidence has also been reported for convergent, discriminate and factorial validity with appropriate variables (Bride, Radey & Figley 2007). A reliability coefficient of 0.70 and above was considered acceptable (Fraenkel & Wallen, 2000). The Cronbach's coefficient alpha was computed in determining the internal consistency of the STSS instrument. A reliability coefficient of 0.91 was obtained which according to Coolican (2001) is considered a high degree of reliability.

3.7 Data Collection Procedure

The researcher obtained a letter of introduction from Graduate School then sought a research permit from the National Commission for Science, Technology and Innovation. Permission was also sought from the office bearers at KCPA headquarters office. The researcher made appointments with the psychotherapists and supervisors. On the agreed dates the researcher visited the respective respondents and collected data using questionnaires and conducted interviews. The questionnaires were administered in person by the researcher to the respondents and were collected immediately after responding to them. The researcher took notes and recorded answers given by the respondents. Respondents were also assured that their participation was voluntary and confidential with regard to their responses. Respondents were guaranteed anonymity, as no identifying details were asked, it was also communicated to them that they could omit any questions that they did not want to answer. However in filling out the questionnaire they gave their consent to participate in the study.

3.8 Data Analysis

The data collected from the questionnaire, STSS and interview schedule were organized, coded and analyzed using both descriptive and inferential statistics. In objective one STSS scale

adopted from Bride (2004) was used to determined prevalence of STS among psychotherapists. STSS is a17-item self report instrument designed to assess the frequency of intrusion, avoidance and arousal symptoms associated with STS resulting from working with traumatized populations (Bride, 2004). Percentages and frequency tables were used to determine the prevalence of STS. In objective two, means, standard deviation and t-test were used to compare prevalence of STS among psychotherapists in Nairobi and Nakuru counties. In objective three, percentages, frequency tables, means, standard deviation and chi -square were used to establish how predictive factors contribute to STS. Chi-square test is in fact, a technique through the use of which it is possible to test the significance of association between two attributes (Kothari, 1990). In objective four, percentages, frequency tables, means and standard deviation were used to establish coping strategies employed by psychotherapists in the county of Nairobi and Nakuru. The data was analyzed using the Statistical Package for Social Sciences (SPSS) version 18.0. In addition to this, since interview responses of the 15 supervisors were qualitative data analyses were done and findings presented as excerpts.

CHAPTER FOUR
RESULTS AND DISCUSSION

4.1 Introduction

This chapter presents results and discussion of the research findings on prevalence of STS, its predictive factors and how they contribute to development of STS and coping strategies among psychotherapists in Nairobi and Nakuru counties. The chapter is divided into various sections with each focusing on a specific objective. The first section of this chapter presents the demographic characteristics of the respondents. This was then followed by a presentation of the results and discussion of the findings of the study based on the four objectives of the study namely:

i) To determine the prevalence of STS among psychotherapists in the counties of Nairobi and Nakuru of Kenya.

ii) Compare the prevalence of STS among psychotherapists in the counties of Nairobi and Nakuru of Kenya.

iii) To establish how selected predictive factors contribute to STS among psychotherapists in Nairobi and Nakuru counties of Kenya:

iv) To establish how coping strategies employed by psychotherapists contribute to STS in the counties of Nairobi and Nakuru of Kenya.

4.2 Demographic Characteristics of the Respondents

Demographic characteristics of psychotherapists included age, gender, marital status, and educational level, the profession of the therapists and the years of counselling experience. Tables 4.1, 4.2, 4.3, 4.4, 4.5 and 4.6 give the findings.

Table 4.1

Distribution of Psychotherapists by Age

Age range	Nakuru		Nairobi		Nakuru & Nairobi	
	f	%	f	%	f	%
19 - 27 years	4	7.0	32	13.4	36	12.2
28 - 36 years	19	33.3	72	30.1	91	30.7
37 - 45 years	16	28.1	75	31.4	91	30.7
46 - 54 years	16	28.1	39	16.3	55	18.6
55 years and above	2	3.5	21	8.8	23	7.8
M						39.11
SD						10.03
n = 296						

The age range for respondents was 19 years to 55+ years with the psychotherapists falling within the age range of 28-36 years and 37-45 years both showing 30.7%. The least was age range 55+ years (7.8%). The mean age was 39 years. The low percentage of respondents within the range of 55+ years could be explained by the fact that this age bracket may probably have retired. The higher percentage of psychotherapists within the age range 37-54 years indicates that psychotherapy as a career has attracted those who may already be in other careers like pastors, teachers, nurses among others.

Table 4.2

Distribution of Psychotherapists by Gender

	Nakuru		Nairobi		Total	
Gender	f	%	F	%	f	%
Male	14	23.3	53	22.0	67	22.3
Female	46	76.7	188	78.0	234	77.7
n = 301						

Table 4.2 indicates that the sample was predominately female (77.7%).This is consistent with studies that have been previously done that indicate that those who are involved in the helping professions are largely females. Coral (2011) notes that many of the professional human service workers tend to be women. Levant, Wimer and Williams (2011) observed too that there is an increasing higher preference for choice of psychotherapy as a career among women than men to an extent that male therapists are increasingly becoming difficult to find. The implication of this disparity is that most clients with preference for male therapists may have difficulty accessing them.

Table 4.3

Distribution of Psychotherapists by Marital Status

	Nakuru		Nairobi		Total	
Marital status	f	%	f	%	f	%
Single	6	10.3	74	30.9	80	26.9
Married	47	81.0	155	64.9	202	68.0
Separated/divorced	5	8.6	8	3.3	13	4.4
Widowed	0	0.0	2	0.8	2	0.7
n =297						

Table 4.3 revealed that 67.8% of the psychotherapists were married, 26.8 % were single, and 4.4% were separated while 0.7% were widowed. Nairobi County seems to have many unmarried psychotherapists compared to Nakuru. The implication of this finding is that Nairobi county respondents are likely to suffer high prevalence of STS than Nakuru since research has increasingly recognized that marital status plays a protective role against STS (Byrne, 2006). For instance, Byrne (2006) studied 467 child welfare social workers in 10 area offices, five from the southeast region and five from the northeast region of the Massachusetts Department of Social Services. The study participants were recruited at monthly area office staff meetings. Byrne (2006) examined the social workers 'resilience factors by levels of STS /compassion satisfaction The evidence indicated that household status strongly and inversely affects STS /compassion fatigue. According to the study results, the household status of living with others appeared to be a significant protective factor against STS. Marital status can be recognized as a protective factor that decreases STS symptoms**.**

Table 4.4

Distribution of Psychotherapists by Education Level

	Nakuru		Nairobi		Total	
Education level	f	%	f	%	f	%
Certificate	2	3.4	10	4.3	12	4.1
Diploma	29	50.0	74	31.8	103	35.4
University (Bachelor)	17	29.3	80	34.3	97	33.3
University (Masters)	7	12.1	60	25.8	67	23.0
University (PhD)	3	5.2	9	3.9	12	4.1
n =291						

Table 4.4 showed that 35.4% of psychotherapists had Diploma level education, followed by 33.3% with Bachelors' level, 23.0% with Masters level and only 4.1% with PhD, indicating that fairly big number of psychotherapists who practice in Kenya have diploma level of education.

Psychotherapy in Kenya is offered by practitioners with Diploma level compared to the western world where practicing psychotherapists must have PhD level of education (APA, 2000). This means therefore that they may not comfortably and ethically deal with complex issues that emerge in therapy and they may predispose themselves to STS as result. These findings concur with those of Macritchie (2006) study on STS, level of exposure, empathy and social support in trauma workers in South Africa that showed that the majority of the samples were non-professionals (66%) and only 34% were professionals. This finding also concurs with those of Nyanzi (2002) that found inadequate training of practicing psychotherapists in Kenya.

Table 4.5

Profession of Psychotherapists

Profession of psychotherapists	f	%
Counseling psychologist	248	82.6
Clinical psychologist	7	2.3
Psychologist	20	6.8
Addiction counsellor	1	0.3
Clinical officer	2	0.7
Social worker	12	4.0
Nurse	8	2.7
Pastor	1	0.3
Total	300	99.7

Table 4.5 indicates that the primary profession of respondents was counseling psychologists (82.6 %.), followed by Psychologist (5.7 %), social workers (3.0%) and nurses (2.7 %). This is important for this study since it fills up a critical gap in trauma literature since most studies have basically looked at social workers.

Table 4.6

Distribution of Psychotherapists by Years of Counselling Experience

	Nauru		Nairobi		Total	
Years counselling	f	%	f	%	f	%
5 yrs	31	52.5	148	61.9	179	60.1
6-10 yrs	21	35.6	67	28.0	88	29.5
11-15 yrs	6	10.2	20	8.4	26	8.7
16-20 yrs	1	1.7	1	0.4	2	0.7
20+ yrs	0	0.0	3	1.3	3	1.0
n=298						

Table 4.6 indicates that a majority of psychotherapists, 60.1% had 5years or less of experience, 29.5% had 6-10 years of practice and only 8.7% had 11-15 years of experience. This points to the fact that counselling as a profession is still very young in this country.

4.3 Prevalence of Secondary Traumatic Stress

Prevalence of STS focused predominately on assessing for PTSD related symptomology such as intrusion, avoidance and arousal symptoms. Bride (2007) STSS was used to analyze data. Respondents indicated on a five point likert-type scale ranging from 1(never) to 5 (very often) how each factor is/was true for them. The STSS includes total score and three subscales score representing intrusion, avoidance and arousal symptoms. Scoring of STSS conducted at 3 different levels first, Summing up the scores on each item for each sub scales. A cut off score of 38 proposed (ranging from moderate to high to severe STS) are considered to have STS. Second, data presented into categories classifying scores into levels of STS. Those that scored less than 28 – had little or no STS; scores at 28-37 - mild STS; scores at 38-43 - moderate STS; scores at

44-48- high STS and scores 49 and above - severe STS. Third, to analyze whether a symptom was endorsed or not the respondent indicated that the symptom was experienced 'occasionally', 'often', or 'very often'. Prevalence of STS was also looked at from the supervisor's point of view. The supervisors were key informants in this study as they oversee the clinical work of psychotherapists. The results according to individual symptoms of STS are stated in Table 4.7, 4.8 and 4.9.

Table 4.7

Psychotherapists Responses on Intrusive Symptoms of STS

Statement	Response									
	Never		Rarely		Occasionally		often		Very often	
	f	%	f	%	f	%	f	%	F	%
Heart pounding at thought about work with traumatized clients	90	29.9	143	37.9	87	28.9	7	2.3	3	1.0
Sense of reliving the trauma experienced by client(s) everyday	60	19.9	86	28.6	102	33.9	42	14.0	11	3.7
Reminders of my work with trauma clients upset me	82	27.2	78	25.9	117	38.9	19	6.3	5	1.7
Thoughts about work with traumatized clients when not intended	50	16.6	79	26.2	123	40.9	46	15.3	3	1.0
Disturbing dreams about work with trauma clients	143	47.5	66	21.9	62	20.6	22	7.3	8	2.7
n=301										

Five intrusive symptoms of STS contained both the most and the least frequently reported symptoms. The most frequently reported symptom, intrusive thoughts related to work with traumatized clients was endorsed by 40.9 % of the respondents, 38.9% occasionally endorsed

reminder of trauma work upsetting them, 33.9 % occasionally endorsing experiencing sense of reliving trauma experienced by clients, 28.9 % occasionally experiencing physiological reactions and 20.6 % experiencing disturbing dreams. These findings suggest that psychotherapists experienced intrusive symptoms and are consistent with those of Munroe (1991) who studied therapists and found that they suffered from intrusive symptoms similar to their combat PTSD clients. Bride (2007) study indicated too that the most frequently reported STS symptom among child protective workers were intrusive thoughts, with 40.5% respondents endorsing that they thought about their work with traumatized clients without intending to.

Table 4.8

Psychotherapists' Responses on Avoidance Symptoms of STS

Statement	Response									
	Never		Rarely		occasionally		Often		V.Often	
	f	%	f	%	f	%	f	%	F	%
Emotionally numbing	91	30.2	86	28.6	88	29.2	26	8.6	10	3.3
Sense of foreshortened future	78	25.9	77	25.6	95	31.6	42	14.0	9	3.0
Detachment from others activities	89	29.6	84	27.6	67	22.3	51	16.9	10	3.3
Less active than usual after therapy with traumatic clients	67	22.3	87	28.9	92	30.6	45	15.0	10	3.3
Avoidance of people /places	102	33.9	88	29.2	72	23.9	31	10.3	8	2.7
Avoiding of clients	112	37.2	79	26.2	55	18.3	49	16.3	6	2.0
Inability to recall information on work with clients	101	33.6	75	24.9	75	24.9	49	15.3	4	1.3
n =301										

Seven avoidant symptoms were assessed in which the respondents endorsed response ranged from 31.6% sense of foreshortened future to 18.3% avoiding of clients after dealing with trauma cases. Other avoidance symptoms reported included: detachment from others occasionally

(30.6%), occasional emotional numbing (29. 2%), occasional avoidance of people /places /things (23.9%), and occasional inability to recall information on work with clients (24.9%). These findings suggest that the respondents in this study made an unconscious effort to both physically and psychologically avoid thoughts or feelings that reminded them of the trauma. The highest endorsement for instance was psychological sense of foreshortened future, followed closely with physical detachment from others. This study is also supportive of earlier study by Smith (2011) on juvenile justice education workers, that endorsed sense of foreshortened future as the highest (53.4%) followed by detachment from others (50.9) and emotional numbing (38.1%).This findings are consistent too with STS theory that states that being exposed to another's traumatic material has the potential to cause avoidance symptoms in the helper (Dutton & Rubenstein, 1995; Figley, 1995; Pearlman & Saakvitne, 1995; Salston & Figley, 2003; Steed & Bicknell, 2001).

Table 4.9

Psychotherapists Responses on Arousal Symptoms of STS

	Response									
Statement	Never		Rarely		Occasional		Often		V. often	
	F	%	f	%	f	%	f	%	f	%
Sleep difficulties	125	41.5	73	24.3	75	24.9	24	8.0	4	1.3
Exaggerated startle reflex	125	41.5	72	23.9	79	26.2	25	8.3	0	0.0
Concentration difficulties	85	28.2	89	29.6	86	28.6	34	11.3	7	2.3
Irritability	103	34.2	67	22.3	81	26.9	44	14.6	6	2.0
Hyper vigilance	150	49.8	57	18.9	60	19.9	22	7.3	12	4.0
n=301										

Across the five arousal symptoms assessed, 28.6% endorsed occasionally experiencing concentration difficulties and 26.9% endorsed occasionally experiencing irritability. Other

arousal symptoms reported included: sleep difficulty (24.9%), exaggerated startle reflex (26.2%) and hyper vigilance (18.9%). The finding of this study supports those of other studies. For instance Bride (2007) study that endorsed irritability and concentration as the most frequently experienced STS symptoms. Smith et al. (2011) study on assessment of STS in juvenile justice education workers that endorsed concentration difficulties as the highest (47.5%) followed by irritability (41.5%), hyper vigilance (27.7%) and startle response (26.3%).

4.3.1 Prevalence of STS Symptom among Psychotherapists

The study used the STSS to determine prevalence of STS. STSS is a17 item instrument adapted from Bride (2004) and designed to assess the frequency of avoidance, arousal and intrusion symptoms associated with STS. It includes a total score and three subscales scores representing intrusion, avoidance and arousal. Full scale and sub scales scores were obtained by summing the items assigned to each, with higher scores representing greater severity of STS symptoms. According to Bride (2007), individuals who obtain an STSS total score of 38 or higher are considered to have PTSD due to STS. Table 4.10 indicates prevalence of STS symptoms among psychotherapists and Table 4.11 indicates prevalence by symptom category.

Table 4.10

Prevalence of STS Symptom among Psychotherapists

Prevalence of STS	STSS score	Nakuru		Nairobi		Nakuru and Nairobi	
		f	%	f	%	f	%
Little or no STS	17-28	21	35.0	63	26.1	84	27.9
Mild STS	28-37	16	26.7	56	23.2	72	23.9
Moderate STS	38-43	7	11.7	27	11.2	34	11.3
High STS	44-48	6	10.0	27	11.2	33	11.0
Severe STS	49+	10	16.7	68	28.2	78	25.9
n=301							

*Note.*STS=secondary traumatic stress, STSS=secondary traumatic stress scale

Table 4.10 indicates distribution of STS symptoms of respondents using STSS scale scores outlined by Bride (2007). The majority of respondents from both Nakuru and Nairobi were found to be experiencing mild to no symptoms of STS (51.8 %) while 11.3% were experiencing moderate STS symptoms and 36.9% were experiencing high to severe symptoms. This provides evidence for the argument regarding the primacy of the nature of the traumatic stressor in the development of PTS symptomology. It is argued that the lesser immediacy of the stressor to the self, the less intense the effects are likely to be (Green, 1990). Among respondents, total scores on the STSS (Bride, 2007) ranged from 17, indicating no STS to 67. According to Bride (2007), individuals who obtain an STSS total score of 38, ranging from moderate to high to severe STS or higher are considered to have PTSD due to STS. In the current study, 48.2 % of participants were found to be experiencing what constitutes clinical levels of PTSD symptoms of intrusion, avoidance, and arousal due to STS. These score of 42.8 is very high compared to other researches that have been done on prevalence of STS. The findings confirm as Figley (2003) puts

it: What most caregivers know intuitively that, there is a cost to caring. The findings are consistent too with STS theory in the study that states that being exposed to another's traumatic material has the potential to produce traumatic stress in the helper (Figley, 1995; 2003; Salston & Figley, 2003; Steed & Bicknell, 2001). The findings of this study supports those of other studies .For instance Deighton et al (2007) observed high level of STS (32%) among 103 psychologists, clinical social workers and psychiatrists working with survivors of torture. Birk (2001) too observed high levels of STS among therapists who work with torture survivors. In Kassam-Adams (1999) study among 100 psychotherapists working in outpatient agencies, 50% reported levels of STS that suggested need for clinical attention. A study of mental health workers who responded to the Oklahoma City bombings reported that 20.6% of the respondents had moderate to severe levels of PTSD and 53.5% had moderate to extremely high risk of compassion fatigue (Wee & Myers, 2002).

In addition to this, studies done in South Africa by Mac Ritchie (2006) f that explored the psychological impact of trauma workers who worked with victims of violent crimes showed that 30% of respondents had clinical levels of STS. Durrant (1999) and Wilson (1998) studies also showed similar results. Several studies have however reported ranges of symptoms in the mild or not clinically significant range (Brady et al, 1999; Ortlepp & Friedman, 2001) Studies done by Adams and Riggs (2008); Bride, (2007) ; Kadambi and Truscott, (2004) have found between 5% and 15.2% of mental health therapists reporting clinical levels of STS.These differences may be due to the type of trauma material in the various studies. For instance Kassam-Adams (1999) and Steed and Bicknell (2001) focused on sex trauma, while Wee and Myers (2002) looked at disaster trauma among mental health workers and found a much larger and robust finding than many studies in this area. Adams and Riggs (2008) looked solely at therapist trainees where only 25% of participants were exposed to trauma clients. The discrepancy in prevalence as Bride (2004) puts it may also be due to the make-up of the study sample and the instruments used to assess STS. In comparison to other studies, Bride (2007) for instance looked at a sample primarily of white females, all of whom were master's level social workers with a mean of 16.15 years of experience,15.2% of this sample displayed clinical levels of STS. Results from the current study found that participants with clinical levels of STS, as measured by the STSS, were

triple (48.2%) that reported by Bride (2007). However, unlike Bride's (2007) sample that comprised social workers only, the current sample was inclusive of mental health therapists beyond social work, including other professionals such as clinical psychologists (2.3%), counselling psychologists (82.6 %), psychologists (5.7%) and nurses (2.7%). Thus, it is possible that the difference in reported clinical levels of STS in the current study may be due to the application of the STSS measure beyond the original sample of clinical social workers in Bride's (2007) study. Another factor that seems to explain this difference is the instrument used to measure STS. For instance Kadambi and Truscott (2004) looked at therapists who were predominantly treating sexual trauma clients, cancer patients and a general client population. STS was measured by the Impact of Events Scale (Horowitz, Wilner, & Alvarez, 1979). Kadambi and Truscott (2004) concluded that only 5% of their sample showed clinical levels of symptoms. The IES self-report instruments for the assessment of posttraumatic stress does not include questions that assess for hyper arousal symptoms and does not assess for all forms of avoidant symptoms that are also indicative of PTSD (Joseph, 2000). STSS on the other hand is a measure with established cut off scores, which help to provide a more complete picture regarding the prevalence rates for clinical levels of PTSD related symptoms in trauma therapist populations and has been able to provide one of the most complete reviews to date of intrusive, avoidant, and arousal symptomology. It is also highly correlated with other PTSD measures (Joseph, 2000).

It is important to note too that of these respondents Nairobi County has prevalence higher than Nakuru. Nairobi for instance has STS standing at 39.4% while Nakuru has only 26.7%. This is most likely due to the several traumatic events that had taken place in Nairobi prior to data collection for this study, for example the grenade attacks, bombing of Uhuru park prayer rally, Sinai village petrol fire tragedy, Mathare landslide among many. Besides it has many informal settlements where traumatic incidents such as rape, domestic violence, sexual violence, death among others are rampant. These findings further suggest that levels of STS are higher among service providers with increased experiences of trauma.

Table 4.11

Prevalence of STS by Symptom Category

	Nairobi (n=241)		Nakuru(n=60)		Nrb and Nakuru (n=301)	
Prevalence of STS	M	SD	M	SD	M	SD
Intrusive symptoms	2.2929	0.74966	2.2500	0.65729	2.2844	0.73134
Avoidance symptoms	2.3586	0.87822	2.1190	0.85398	2.3109	0.87729
Arousal symptoms	2.1817	0.91542	1.8633	0.79787	2.1183	0.90102

The findings of Table 4.11 are based on the scores from the Likert-scale adopted from Bride (2007). The study indicates more evidence of avoidance symptoms reported with mean of 2.3109 and SD of 0.87729, followed by intrusive symptoms with mean 2.2844 and SD of 0.73134. The least was arousal symptoms with mean of 2.1183 and SD of 0.90102. Nakuru county however has an intrusive symptom as the most frequently reported STS symptoms with mean of 2.2500, followed by avoidance symptoms with mean of 2.1190 and SD of 0.85398. This supports study by Bride (2007) among 282 clinical social workers that identified intrusive symptoms as the most frequently reported STS symptom. A study by Linley and Joseph (2007) and Sprang, Clark & Witt-Woolsey (2007) that reported mean compassion fatigue scores that represented below average levels of intrusive, avoidant and arousal symptomology contradicts this findings. These discrepancies in prevalence of STS may be explained by the different clients dealt with by the psychotherapists. For instance, Linley and Joseph (2007) had client population where 30% were identified as trauma victims while Sprang et al. (2007) focused on general client population. This is important to the study since it explains why Nairobi County has higher levels of intrusive, avoidance and arousal symptoms compared to Nakuru. Nairobi psychotherapists have dealt with more traumatic events such as the grenade attacks, West Gate Mall attack, Sinai village petrol tragedy, Uhuru Park prayer rally bombing, and Mathare slum landslide among others while

Nakuru psychotherapists have dealt with general client population where percentage of trauma clients may be minimal.

4.3.2 Supervisors responses on Prevalence of Secondary Traumatic Stress

In order to get additional information on the prevalence of STS among psychotherapists, the researcher interviewed supervisors who directly oversee the professional clinical work of psychotherapists. The researcher interviewed 11 supervisors from Nairobi County and 4 from Nakuru County registered with KCPA. The total numbers of supervisors interviewed were 15. They were considered key informants in respect of the supervisory role they render to the psychotherapists. The qualitative data on prevalence of STS among psychotherapists was organized by question and category and looked across all respondents and their answers in order to identify consistencies and differences. Key statements that provide summaries of what most of the psychotherapists mentioned were identified and quoted in this study. Table 4.12 outlines supervisor's comments on prevalence of STS.

Table 4.12

Supervisor's Comments on Prevalence of STS

Question	Responses Categories
1.) Do you deal with trauma clients and materials? Please give examples	a) Examples of traumatic clients and materials dealt with
2.) Do the supervisees/psychotherapists you see present STS related symptoms?	a) Re-experiencing/intrusive symptoms b) Avoidance /numbing symptoms c) Arousal symptoms

Excerpt 1:

Question 1: Category A

Researcher: Do you deal with trauma clients and materials? Please give examples

Supervisor 1: Yes. Cases include domestic violence, sexual violence, cases of witchcraft, and tragedies like the Sachagwan petrol tragedy in Nakuru, child abuse, terminal illness, and death among others.

Supervisor 2: Yes .Cases like grenade attack victims have become many, I dealt with victims of Sinai fire tragedy, Mathare land slides, victims of Uhuru park prayer rally, death, cases of sexual abuse and domestic abuse among others.

In summary, from the interviews all the supervisors indicated that they deal with trauma clients and traumatic material.

Excerpt 2:

Question 2: Category A

Researcher: Do the supervisees/psychotherapists you see present with STS related symptoms such as intrusive/ reexperiencing symptoms?

Supervisor 1: Yes they do, most of the supervisees I see experience illusion and flashbacks about their clients. This is especially so among psychotherapists who work at the hospitals where work entails a lot of disclosure of death cases to families.

Supervisor 2: Yes they experience STS related symptoms, some are overwhelmed by what their clients say. They actually see what their clients talk about and feel like they feel.

Supervisor 3: Yes they do, one reported re-experiencing suicidal ideation, anxiety, and hallucinations about clients. Another supervisee, who witnessed the death of her client, kept hallucinating about it.

Supervisor 4: Yes, one who had dealt with victims of the Mathare land slide in Nairobi shared that she used to go home carrying all her clients sorrow and pain. She kept experiencing their pain and any reminder-I mean she was living in it, everything made her think about it, pictures about it just popped in. She tried not to think about it but it couldn't happen. She then decided not to talk to anybody because she could not bear to hear any more stories, so she really shut down. She could even hear her clients in her office.

The supervisors agreed across board that the supervisees they see experienced intrusive symptoms. These responses from the supervisors are similar to those of the psychotherapists in this study. The responses are also consistent with that of Bride (2007) that reported intrusive symptoms among child protective workers. In this study the respondents indicated that they thought about their work with traumatized clients without intending to. Similarly Figley's (1995) research suggests that similar to PTSD the individual re-experiences, in fantasy, the traumatic event that occurred to the victim. Figleys's research further supports that of Munroe (1991) who studied male veterans' administration therapists in Boston and found that they suffered from intrusion and withdrawal symptoms similar to their combat PTSD clients.

Excerpt 3:

Question 2: Category B

Researcher: Do the supervisees/psychotherapists you see experience STS related symptoms such as avoidance or numbing of the trauma?

Supervisor 1: Yes they do, in fact this is the most common symptom displayed. I remember one supervisee/ psychotherapists who worked in the internally displaced camps (IDP) following 2007 Post Election Violence reached appoint where he avoided the camp, others became detached not willing to talk to anybody.

Supervisor 2: Yes, in fact one supervisee had lost meaning/no longer felt anything. He looked at life as very unfair, especially for victims, he kept wondering if life is worth living.

Supervisor 3: I have seen quite a number, majority of supervisees actually display avoidance symptoms. The supervisees put a lot of effort to avoid the whole thoughts and feelings that remind them of trauma clients and trauma materials. One therapist narrated how she avoided the whole ordeal of her client's narration of what happened at the Sinai village petrol tragedy.

Supervisor 4: Yes they do, I dealt with a supervisee who cried in sessions when remembering what her clients went through. Another stopped following Kenyatta Avenue Street in Nairobi because she dealt with victims of Nakumatt down town supermarket fire tragedy which was located at that street.

Supervisor 5: Yes. Quite a number .A good example is a supervisee from Nakuru County who avoided relationships with or meeting parents of a raped child client she had helped. She was avoiding experiencing further pain. Another one also avoided meeting parents of client who reported that his family practiced witchcraft.

The reports from supervisors unanimously agree that the supervisees they see experienced avoidance symptoms and that they were the most common symptoms displayed by psychotherapists, this supports findings from the psychotherapists themselves that also found avoidance symptoms as the most commonly displayed. Bride, Robinson, Yegidis, and Figley (2004) found that of 287 social workers in a south eastern state in the United States, more than half (53.3%) acknowledged the effects of STS on their personal and professional lives. High rates of compassion fatigue have also been detected among crisis counsellors following the Oklahoma City Bombing (Wee & Myers, 2003), hospice nurses (Abendroth & Flannery, 2006), emergency nurses (Hooper, Craig, Janvrin, Wetsel, Reimels, & Anderson, 2010), and oncology nurses (Dominguez-Gomez & Rutledge, 2008).

Excerpt 4:

Question 2: Category C

Researcher: Do the supervisees/psychotherapists you see experience STS related symptoms such as arousal due to trauma?

Supervisor 1: Yes they do, Arousal symptoms reported include insomnia reported by majority of psychotherapists, dreaming about cases, intense physical reactions such as muscle tension in the neck, back and spine. One supervisee always felt tired even if she got enough sleep, was tired all of the time and experienced pain from her knees to shoulders to the whole body.

Supervisor 2: Oh yes, supervisees I see are always in a constant state of arousal, you know that need to keep doing things for clients but at their own expense and as result they get easily stressed for not being able to do it all, even during sessions. One supervisee who worked with Sinai village petrol tragedy victims could not leave the site, he wanted to see it through, and he

couldn't pull out, couldn't remove himself from the site and live clients suffering. He was actually at the site for 3 consecutive days.

Supervisor 3: Yes, a case in point is when my supervisee started displaying difficulty concentrating and became really jumpy and as a supervisor I had to keep redirecting her for anything concrete to come out of session. Exaggerated startle response has also been reported by a good number of supervisees I see. I have seen a supervisee getting startled even with the slightest noise since it reminded her of the sound of grenade attacks like the ones she heard at the prayer rally in Uhuru Park.

Supervisor 4: Yes they do. One of my supervisee even screamed at the top of his voice when a book fell on his leg during supervision.

Supervisor 5: Yes I have seen supervisee who displayed irritability and anger. One therapist felt angry that there was nothing he could do to stop the suffering of Sinai village petrol tragedy victims whose houses were burnt. He felt angry on seeing other people going about life like nothing happened. When he saw people at disco on Tom Mboya Street in Nairobi on the night of the incident he felt really angry, to him it was weird how people could be dancing when such an incident has occurred, and he felt like screaming at them and asking them if they knew what had happened.

It is clear from reports of the supervisors that psychotherapists experienced arousal symptoms. Again these findings are endorsing previous findings of psychotherapists in this study who also indicated psychotherapists experiencing arousal symptoms. Previous researchers have also endorsed the findings of this study. A study conducted by Creamer and Liddle (2005) on mental health workers responding to an attack on September 11, 2001 by terrorist's in New York City showed elevated levels of STS arousal symptoms. Further a study by Ennis and Sharon (2003) also indicated arousal symptoms in sex offender's therapists.

4.4 Comparison of STS Prevalence among Psychotherapists

The following results are based on objective two of the study that compared prevalence of STS among psychotherapists in Nairobi and Nakuru counties. An independent-samples t-test was conducted to compare prevalence of STS among psychotherapists in Nakuru and Nairobi counties. The results are summarized in Table 4.13.

Table 4.13

Comparison of Prevalence of STS among Psychotherapists in Nakuru and Nairobi counties

County	n	M	SD	t	df	P
Nakuru	60	35.40	1.516	1.880	299	0.061
Nairobi	241	38.88	0.844			
Total	301					

According to Table 4.13, a t-test found that there was no significant difference in prevalence of STS among psychotherapists in Nairobi and Nakuru counties. The t-value obtained was 1.880 with 299 degrees of freedom. Based on $p < .05$, the p-value of 0.061 was indicative of the fact that the null hypothesis was accepted as true. These results suggest that statiscally Nairobi means are not higher than Nakuru. There was no significant difference among the psychotherapists in Nairobi and Nakuru counties.

4.5.0 Predictive Factors and their Contribution to STS

The study looked at the following predictive factors of STS, demographic characteristics, exposure to traumatic material, empathy, history of trauma, history of psychiatric symptoms, unresolved personal trauma and personal life stressors as potential predictors of STS. The identified predictive factors were selected due to their relevance in literature as promising predictive variables. The study sought to establish how predictive factors contribute to STS

among psychotherapists in Nairobi and Nakuru counties of Kenya. Findings of objective three are summarized in Tables 4.14 to 4.18.

4.5.1 Demographic Characteristics of Psychotherapists.

This study sought to find out how demographic characteristics contribute to STS. Bride (2007) STSS was used. Respondents indicated on a five point Likert -type scale ranging from 1(never) to 5 (very often) how each demographic characteristic is/was true for them. The STSS includes total score and three subscales score representing intrusion, avoidance and arousal symptoms. Scores were obtained by summing the items assigned to each subscale and the entire instrument. Bride (2007) has proposed a cut off score where those who obtain a score at above 38 are considered to have STS. The results are listed in Tables 4.14, 4.15, 4.16, 4.17 and 4.18.

Table 4.14

Prevalence of STS by marital status of psychotherapists

	Single		Married		Separated/divorced		Widowed	
Prevalence of STS	f	%	F	%	f	%	f	%
Little or no STS	17	21.3	61	30.2	6	46.2	0	0.0
Mild STS	18	22.5	48	23.8	4	30.8	1	50.0
Moderate STS	12	15.0	20	9.9	1	7.7	0	0.0
High STS	10	12.5	21	10.4	1	7.7	0	0.0
Severe Sts	23	28.8	52	25.7	1	7.7	0	50.0
n=297								

Table 4.14 indicates 54 % of the married have mild to little or no STS compared to 43.8 % of the single. Forty one point three percent of singles have high to severe STS compared to 36.1% of the married. This study result is consistent with the findings of previous studies (Byrne, 2006; Lindsay, Gray, Grubaugh, 2006**)** that also recognized marital status as playing a protective role against STS; they have shown that the household status, such as living with others, was a significant protective factor against STS. Therefore, marital status can be recognized as a

predictive factor of STS because psychotherapists who live with their partners have the opportunity to reduce their levels of STS by talking with their partners about their work.

Table 4.15

Prevalence of STS by Education Level of Psychotherapists

	Certificate		Diploma		Bachelors		Masters		PhD	
Prevalence	f	%	f	%	f	%	f	%	f	%
Little or no STS	3	25.0	31	30.1	24	24.7	17	25.4	6	50.0
Mild STS	1	8.3	25	24.3	30	30.9	11	16.4	2	16.7
Moderate STS	0	0.0	11	10.7	11	11.3	10	14.9	1	8.3
High STS	2	16.7	12	11.7	11	11.3	8	11.9	0	0.0
Severe Sts	6	50.0	24	23.3	21	21.6	21	31.3	3	25.0
n=291										

Table 4.15 indicates that 55.6% of respondents with bachelors' degree have mild to little STS, followed by those with diploma level of education. More than half of respondents (66.7%) with certificate level of education had high to severe STS. It is clear from the study that a higher education level is a buffer against STS. This is consistent with a study done by Baird and Jenkins (2003) that indicated that lower levels of education was related to higher STS. Chrestman (1999) also conducted a quantitative study of adult therapists working with traumatized populations. The study reported that the clinicians with more Continuing Education Units had decreased avoidance symptoms, which are closely related to STS. In addition to the findings by Perrin et al.

(2007) also found that training contributed to decreasing the symptoms of STS for workers assisting the victims of the September 11, 2001, New York terrorist's attacks.

Table 4.16

Prevalence of STS by Years of Psychotherapy

Prevalence of STS	5or Less yrs		6-10yrs		11-15yrs		16-20yrs		21+yrs	
	f	%	f	%	f	%	f	%	F	%
Little or no STS	45	25.1	24	27.3	12	46.2	2	100	1	33.3
Mild STS	37	20.7	27	30.7	7	26.9	0	0.0	0	0.0
Moderate STS	24	13.4	6	6.8	2	7.7	0	0.0	2	66.7
High STS	18	10.1	11	12.5	2	7,7	0	0.0	0	0.0
Severe Sts	55	30.7	20	22.7	3	11.5	0	0.0	0	0.0

n= 298

Results from Table 4.16 suggest that fewer years of experience is a contributing factor to STS symptom severity. Those with more years (11-15) of psychotherapy had mild to little STS (73.1 %) while those with five or less years had high to severe STS (40.8%). Previous studies on STS have reported discrepancy on years of psychotherapy as a predictive factor of STS. Studies where an association was found reported that fewer years experience was associated with more severe intrusion symptoms (Arvay & Uhlemann, 1996; Adams et al, 2001; Way, VanDeusen, Martin, Applegate, & Jandle, 2004) and more severe avoidance symptoms (Arvay & Uhlemann, 1996; Kadambi & Truscott, 2004). In addition to this, studies by McLean, Wade and Encel (2003); Kadambi and Truscott (2004) show that fewer years experience have been found to significantly predict PTSD symptom levels. Study by Anderson (2000) also found heightened

distress in new social workers. Study by Cornille and Meyers (1999) that found that child protective workers who were employed for a long time reported higher levels of STS than those who had logged fewer years in the field contradicts findings of this study . Birk (2002) study too supports that more years working with trauma clients increased the level of compassion fatigue and burnout. Wee and Myers (2002) also found that higher risk of STS was associated with increased time working with survivors among mental health workers after disaster services following the Oklahoma City bombing. Steed and Bicknell (2001) study amongst 67 Australian therapists working with sex offenders further found that those in the field for longer than nine years, were most at risk of developing trauma symptoms. In the current study it is plausible that number years of psychotherapy may play a part in moderating STS and therefore the duration of employment is a factor that predicts STS

Table 4.17
Prevalence of STS by Age of Psychotherapists

	19-27yrs		28-36yrs		37-45yrs		46-54yrs		55+yrs	
Prevalence of STS	f	%	f	%	f	%	f	%	f	%
Little or no STS	10	27.8	23	25.3	27	29.7	14	30.9	4	17.4
Mild STS	10	27.8	26	28.6	17	18.7	12	21.8	7	30.4
Moderate STS	4	11.1	10	11.0	8	8.8	9	16.4	3	13.0
High STS	3	8.3	8	8.8	13	14.3	6	10.9	1	4.3
Severe Sts	9	25.0	24	26.4	26	28.6	11	20.0	8	34.8

n=296

Table 4.17 indicates that psychotherapists within age range 19-27 (55.6%) have mild to little or no STS, followed closely by those within age range 28-36 (53.9%) and age range 46-54 (52.7%). Psychotherapists who are 55+ yrs are indicated to have high to severe STS (52.1%) followed by

age 37-45 (51.7%), indicating that older psychotherapists are more vulnerable to STS than younger ones. These findings are consistent with findings in literature , for instance In a study that focused on the staff of sexual assault and domestic violence agencies older and more experienced therapists reported higher levels of distress than their co-workers (Baird & Jenkins, 2003). Norris, Byrne, and Diaz (2001) in a very large review of primary, non occupational traumatization during disasters also concluded that age in the middle years of 40 to 60 cumulatively increase the risk of adverse outcomes in therapists. Nevertheless, when Nelson-Gardell and Harris' (2003) analyses controlled for respondents' personal histories of childhood abuse, they found older child welfare workers had lower risk for secondary traumatic stress than younger child welfare workers contradicting these findings. Other studies too found youger age vulnerable to STS (Ghahramanlou & Brodbeck ,2000; Arvay & Uhleman,1996; Lindsay et al. 2000; Simon et al., 2005). The explanation for this difference would be survival bias as suggested by Maslach et al. (2001). That is older psychotherapists who develop symptoms of STS may be likely to depart from the profession, leaving behind resilient therapists who demonstrate fewer symptoms and those older therapists who stay on are likely to display more STS, It is however prudent to consider age as predictive factors of STS.

Table 4.18

Prevalence of STS by Gender of Psychotherapists

	Males		Females	
Prevalence	f	%	f	%
Little or no STS	25	37.3	59	25.2
Mild STS	17	25.4	55	23.5
Moderate STS	7	10.4	27	11.5
High STS	8	11.9	25	10.7
Severe Sts	10	14.9	68	29.1
n=301				

Table 4.18 indicates that men have mild to little or no STS (62.7%) compared to females (48.7%). This is similar to studies by Brady et al. (1999) that found that females are likely to exhibit more trauma symptoms. Kassam-Adams (1999) study too found that female therapists reported greater trauma symptoms compared to their male counterparts**.** Perkonigg, Kessler, Storz and Wittchen (2000) study also report men having experienced more traumatic events in their lives, but women have a higher prevalence of PTSD. A similar study found that, indeed, men are exposed to more traumas throughout life, except for sexual violence, to which women are more prone to experience. This exception is significant, as sexual traumas bring about PTSD/STS at the highest rates (Kimerling et al, 2002). In contrast, Wee and Myers (2002) study reported men having more STS symptoms. Kimerling et al (2002) argue that it is likely that male's risk for PTSD catches up with women's in settings that are chronically affected by war or violence. This is evident by the fact that studies that found women reported more STS (Kassam-Adams 1999, Brady et al, 1999) for instance involved work with traumatized children. The one that found men reported more STS involved terrorist attack (Wee & Myers, 2002). Further this difference may also be explained by the fact that women are socialized as nurtures and so are likely to put in more emotions in the helping process than men. Two other studies found no gender differences (Pearlman & Mac lan, 1995; Meldrum, King, & Spooner, 2002). These findings coupled by mixed results in previous studies would seem to suggest that if there is gender difference, it is not consistent enough to be of great concern as a predictive factor for the development of STS. It would therefore be overly simplistic to look at gender as a predictive factor for STS without looking at other factors such as nature of client trauma, nature of the women among others.

4.5.2 Exposure to Trauma

Exposure variable is one of the selected predictive factors of this study. It has been highlighted by Figley (1995), Dutton and Rubinstein (1995), and Pearlman and McCann. (1990) as an issue central to their respective theories of CF, STS, and VT. It has also become central to discussions of STS (Steed & Bicknell, 2001). It was conceptualized in the study as: number of hours per week spent doing trauma work; number of clients seen per day; monthly average caseload that

includes trauma clients and type of trauma dealt with in the past three months. Findings are displayed in Tables 4.19, 4.20, 4.21, and 4.22.

Table 4.19

Hours Spent Doing Trauma Work per Week

No of hours spent	Nakuru		Nairobi		Total	
	f	%	f	%	f	%
0-10 hrs	8	15.5	43	18.5	51	17.8
11-20hrs	40	75.5	153	65.7	193	67.5
21-30hrs	4	7.5	21	9.0	25	8.7
31-40 hrs	1	1.9	12	5.2	13	4.5
41-50hrs	0	0.0	4	1.7	4	1.4
Total	53		233		286	

The results in Table 4.19 show that majority of therapists n=193 (65.7%) spent 11-20 hrs doing trauma work with clients. This means that the psychotherapists are putting more hours than they should thus making them vulnerable to STS. Several studies done prior to this are in support of this viewpoint, demonstrating that individuals who spend more time at work are more likely to experience STS. First, Lee (1995) assessed the degree of STS among 175 marriage and family therapists randomly selected from the population of national marriage and family therapists. The study found that the more hours a therapist spent listening to a client‘s traumatic material, the greater STS. Second, Chrestman (1995) conduct a quantitative study of adult therapists working with traumatized populations and found that a higher percentage of time spent with trauma clients in general clinical activities led to increasing avoidance symptoms of the STS. Third, Meyers and Corneille (2002) did a study among 205 Child Protective Service (CPS) workers. CPS workers who worked 40 hours per week or more reported experiencing more anger, irritability, jumpiness, exaggerated startle response, trouble with concentration, hyper-vigilance, nightmares, and intrusive thoughts and images than those who worked less than 40 hours per

week. Fourth, Figley (1995) found that the amount of time working with bombing survivors was significantly associated with compassion fatigue, which is related to STS symptoms. In the current study number of hours spent doing trauma work is predictive of STS.

Table 4.20

Number of Clients Seen Per Day

Statement	Nakuru		Nairobi		Total	
No of clients seen per day	f	%	f	%	f	%
1-5	39	68.4	175	76.4	214	74.8
6-10	12	21.1	50	21.8	62	21.7
11+ clients	6	10.5	4	1.7	10	3.5
Total	57		229		286	

Finding on table 4.20 show that 74.8% saw 1-5 clients per day. This is consistent with findings from other studies in the literature that also found high percentage of clients seen per day. First, Chrestman (1999) reported a relationship between the number of clients in therapists' caseload and increased STS symptoms in his study among therapists who were indirectly exposed to trauma. Pinsley (2000) study among 163 therapists working with sexual assault survivors in community mental health programs and university or hospital-based crisis programs and private practice within the five boroughs of New York City concurs with Chrestman. The study found that the sampled therapists reported more intrusive and avoidant symptoms of STS associated with trauma distress than those therapists whose caseloads had fewer than 50% of such clients. Schauben and Frazier's (1995) qualitative and quantitative investigation of STS in 148 female therapists' working with victims of sexual violence, found that higher client caseloads correlated with more disrupted beliefs, more symptoms of PTSD and more self-reported vicarious traumatisation. Number of clients seen per day is therefore predictive of STS.

Table 4.21

Monthly case load of psychotherapists

Statement	Nakuru		Nairobi		Total	
Average Monthly case load	f	%	f	%	f	%
0-50	48	85.7	201	86.3	249	86.2
51-100	5	8.9	18	7.7	23	8.0
101-150	0	0.0	5	2.1	5	1.7
151+	3	5.4	9	3.9	12	4.2
Total	56		233		289	

Table 4.21 indicates that 86.2% of the psychotherapists in Nairobi and Nakuru counties had between 0-50 clients in a month. This study supports findings from previous researches indicating that large caseloads and high percentages of trauma clients are associated with an increased risk of STS response. For example, in Creamer and Liddle's (2005) study on compassion fatigue in disaster mental health workers following the terrorist attacks of September 11, 2001, the authors found that case loads with higher percentages of traumatized clients and longer work assignments were associated with higher levels of STS. Likewise, in Sprang et al. (2007) research on work-related stress responses among rural health providers, the caseload percentage of clients with PTSD predicted workers' levels of compassion fatigue. Further, a study by Corneille and Meyers (1999) on STS among child protective service workers found that staff with high caseloads experienced higher levels of STS. Schaben and Frazier's (1995) qualitative and quantitative investigation of STS in 148 female therapists working with victims of sexual violence supports this study too. The study found that higher client caseloads correlated with more STS symptoms. Kassam-Adams (1995) study on psychotherapists working with sexual assault victims also found that there was a significant relationship between workload and symptoms of traumatic stress reported. Lee (1995) assessed the degree of STS among 175 marriage and family therapists and found that the more hours a therapist spent listening to a client's traumatic material, the greater the therapist's STS intrusion score. On the other hand contrary to this finding study by Follette, Polusny and Milbeck (1994)

that examined predictors of STS symptoms in professional exposed to traumatic stress through their jobs found that the percentage of caseload was not significant in predicting STS. Baird and Jenkins (2003) also found no relationship between monthly caseload and STS. Thus although the results have been mixed, evidence from previous studies and the current study indicate that higher trauma caseload is a predictive factor of STS.

Table 4.22

Type of Trauma Handled by Psychotherapists

Statement	Nakuru		Nairobi		Total	
Type of trauma dealt with	f	%	f	%	f	%
Death /terminal illness	13	16.7	43	53.9	56	15.9
sexual violence/rape	12	40.7	68	30.6	80	32.6
Drug addiction	5	0.0	6	1.4	11	4.1
domestic violence/child abuse	9	37.1	48	20.8	57	23.2
Accident	2	14.8	18	8.2	20	6.8
Kidnapping	1	1.9	6	2.7	7	2.5
PTSD	2	3.7	18	8.1	20	7.2
Divorce and separation	10	7.4	8	3.7	18	5.8
Suicide	0	0.0	8	3.6	8	1.1
Discontinuation	0	0.0	1	0.5	1	0.4
Female genital mutilation	0	0.0	1	0.5	1	0.4
Total		54		225	279	

The findings in Table 4.22 indicate that psychotherapists are seeing more sexual and domestic violence cases than any other case. Majority 32.6% dealt with sexual violence/rape followed by 23.2% domestic violence and 15.9% death/terminal illness. This finding is consistent with those of other researchers. First, Cunningham (2003) study found workers who treat victims of human-induced violence and crime, such as sexual assault or domestic violence. Second, Corneille and Meyers (1999) study also found 183 participants from child protective services (CPS) who had worked with abused and neglected children . Likewise, Perrin et al. (2007) after

studying therapists with caseloads comprising of 50% or more rape and incest survivors, found that the sampled therapists reported more intrusive and avoidant symptoms of STS associated with trauma distress than those therapists whose caseloads had fewer than 50% of such clients. The findings of this study indicate that psychotherapists are seeing more sexual and domestic violence cases than any other case. This is significant since in trauma literature, sexual traumas are indicated to bring about STS at the highest rates (Kimerling et al., 2002). Overall, observation of the findings of the exposure variables in this study, it would be prudent to argue that exposure is actually predictive of STS in agreement with Figley (1995), Dutton and Rubinstein (1995), and Pearlman and McCann (1990) who highlighted it as an issue central to their theories of CF, STS, and VT, respectively.

4.5.3 Empathy

Empathy is yet another predictive factor of STS. It is listed in the literature as a major resource for effective counselling and a predictive factor of STS. It is also associated with many positive qualities that influence an individual to become a counselor. It was therefore selected as one of the variables for this study. Empathy was conceptualized using statements: understanding of clients better by imagining how things look from their perspective; recognizing the pain of clients during therapy; being touched by the things that happen to clients; conveyance of genuineness, unconditional positive regard and respect to trauma clients; and motivation to respond to clients. Results obtained from this study are mixed. Findings are presented in Table 4.23

Table 4.23

Empathy by Prevalence of STS

Empathic Statement	Response: STS prevalence — Little or no STS		Mild		Moderate		High		Severe		n =301				
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	$\chi 2$	*df*	*p*
Understand my clients better by imagining how things look from their perspective	81	3	71	1	33	1	32	1	77	1	294	7	1.355	4	0.852
Recognizes the pain of clients during therapy	80	4	72	0	34	0	28	5	68	10	282	19	17.430	4	0.002
Touched by the things that I see or hear happen to clients	64	20	57	15	34	0	28	5	72	6	255	46	16.036	4	0.003
Convey genuineness, unconditional positive regard and respect to trauma clients	80	4	72	0	33	1	32	1	76	2	293	8	3.434	4	0.488
Motivated to respond to my clients	78	6	67	5	32	2	30	3	72	6	279	22	0.291	4	0.990

Table 4.23 indicates that across the five indicators of empathy only two showed a significant association with STS; ability to recognize pain of client during therapy and often being touched

by the things I see happen to my clients. First, the indicator on being able to recognize the pain of client during therapy indicates that majority of respondents exhibited little or no STS. These findings confirm what Figley (1995; 2003) explains, that empathy is paradox-despite it being an excellent resource for trauma workers, it may also be a major key factor in the transmission of traumatic material from primary to secondary victim. Second, for the indicator on am often quite touched by the things that I see or hear happen to the clients , n=72 have severe STS while for those who do not, n=20 have little or no STS. Other researchers have found too that one of the many ways therapists can develop trauma is through empathic engagement (Bell, Kulkarni, & Dalton, 2003; Canfield 2008). These two indicators are thus predictive factors for the development STS. The implication is that psychotherapists capacity to be touched by the things they see happen to clients and their ability to recognize pain of clients during therapy, even though are important for effective therapy are again the same factors that make them vulnerable to STS.

The other three indicators namely, I try to understand my clients better by imagining how things look from their perspective; conveying genuineness, unconditional positive regard and respect to trauma clients and motivation to respond to my clients, did not show an association with STS prevalence. It is evident that empathy is not a predictive factor of STS from the three indicators. First, there was no association between prevalence of STS and empathy Indicator: trying to understand clients better by imagining how things look from their perspective. Ninety seven point seven percent of the respondents indicated that they try to understand their clients better. These findings are consistent with Figley (1995) argument that empathy is an innate characteristic in people who choose to do trauma work and therefore it is likely to have no effect on the psychotherapist's. Second, there is no significant association between therapists conveying genuineness, unconditional positive regard and respect to trauma clients. A big number (n=80) of the psychotherapists that conveyed gaminess, unconditional positive regard, and respect to trauma clients, experienced little or no STS. Interestingly almost a similar number n=76 who conveyed the same had severe STS. The implication of this is that conveying genuineness, unconditional positive regard and respect to trauma clients does not predict STS prevalence. In fact, it is what Figley (1995) STS theory calls empathic ability-the effectiveness of the trauma worker to accurately convey genuiness, unconditional positive regard, and respect to the victim. Findings are also consistent with Adams et al. (2004) that states that it is what

makes psychotherapists do therapy in the first place. Third, there was no significant association between a therapists being motivated to respond to client and prevalence of STS. Seventy eight of the respondents who were motivated to respond to their clients had little to no STS and again 72 of the respondents who were also motivated to respond to their clients also had severe STS. This is what Figley (1995) calls empathic concern- the motivation to respond to the victim. According to him without this motivation the trauma worker plays no significant role and would be useless to the victim. It is therefore an innate characteristic in people who choose to do trauma work. It may or may not therefore be a major key factor in the transmission of traumatic material from primary to secondary victim, and thus explains why there is no significant association between a therapists being motivated to respond to clients and prevalence of STS. In conclusion empathy is not a predictive factor of STS.

4.5.4 History of Trauma

History of trauma has received most attention in literature as a predictive factor of STS. It was therefore selected as one of the predictive factors of STS and was conceptualized using the statements: having experienced sexual trauma prior to trauma work; having experienced kidnapping prior to trauma work; having experienced serious injury/threat of serious injury prior to trauma work; having experienced divorce or separation prior to trauma work; having experienced learning of a traumatic event suffered by close friend prior to trauma work; having witnessed actual death prior to trauma work: having witnessed traumatic accident prior to trauma work; and having witnessed violence or threat with a weapon prior to trauma work. History of trauma has yielded mixed results as shown in Tables 4.24, 4.25, 4.26, 4.27 and 4.28.

Table 4.24

Experiences of Kidnapping and Traumatic Accidents by Prevalence of STS

STS Prevalence	History of trauma statement response			
	Kidnapping experienced		Witnessed traumatic accident	
	Yes	No	Yes	No
Little or no STS	14	70	52	32
Mild STS	8	64	45	27
Moderate STS	2	32	12	22
High STS	6	27	20	13
Severe STS	3	75	35	43
n=301	33	268	164	137
$\chi 2$		9.509		12.185
df		4		4
p		0.050		0.016

Table 4.24 indicates a significant association exists between 2 indicators of history of trauma and STS prevalence. First, there was a significant association in STS prevalence among the therapists who had a kidnapping experience prior to trauma work $\chi^2_4 = 9.5(p<.05)$. For the therapists who had such experience, n=14 had little or no STS, while for those that had not had such experience n=75 had severe STS. This implies that a therapist experiencing of kidnapping prior to trauma work does not necessarily indicate that they will experience STS. Second, there was also a significant association in STS prevalence among the people who had witnessed traumatic accident prior to trauma work $\chi^2_4 = 12.1(p<.01)$. For those that had witnessed such accident, n=52 had little or no STS while for those that had not witnessed such accident n=43 had severe STS. These two variables are therefore predictive of STS. Adams et al. (2004) confirms that prior trauma history may impact the development of STS. This is consistent by Creamer and Liddle (2005), study that found a relationship between therapist personal trauma and STS symptomology among therapists who work with victims of violent crimes.

Table 4.25

Experiences of Sexual Trauma by Prevalence of STS

Prevalence of STS	History of trauma statement response Experienced sexual trauma	
	Yes	No
Little or no STS	20	64
Mild STS	12	60
Moderate STS	6	28
High STS	13	20
Severe STS	15	63
n=301	66	235
$\chi 2$		7.914
df		4
P		9.095

There was no significant association between prevalence of STS having experienced sexual trauma prior to trauma work, for those that had experienced sexual trauma prior to trauma work $\chi^2_4 = 7.9(p>.05)$. Thirty two of the respondents had mild to little or no STS. While those that had not experienced sexual trauma prior to trauma work n=124 also had mild to little or no STS. Worth noting is that a significant number (n=73) of those who had had no such experience also experienced high to severe STS. Schauben and Frazier (1995) study contradicts the findings of this study. The study assessed a history of rape or incest and found that therapists with childhood sexual trauma history reported more severe STS related symptoms. Study by Nelson-Gardell and Harris (2003) also correlates sexual abuse with STS. Further a study by Faravelli, Giugni, Salvatori and Ricca (2004) in Italy also reported rates of PTSD among respondents were significantly higher than among respondents of other life threatening trauma, 95% and 47% respectively. This contradiction can be explained by the fact that working with

traumatized people may also have positive effects for those who have survived trauma. Schauben and Frazier (1995) in a mixed-methods study of female counselors working with sexual violence survivors reported that survivor-counselors indicated that they learned about themselves through their interactions with clients, and were better able to heal from their own sexual victimization experiences. Findings that are echoed by Herman's (1997) that helping others is a vital part of the recovery process for some trauma survivors. Herman states that while there is no way to compensate for an atrocity, there is a way to transcend it, by making it a gift to others. The trauma is redeemed only when it becomes the source of a survivor mission. As such, while working with the traumatized may act as a trigger for unresolved issues among survivors, it may also promote healing and insight. Psychotherapists in this study may have used helping to heal their sexual trauma. In addition to this, they may have also utilized personal therapy as indicated in objective four on professional coping strategies. Sexual trauma is therefore not predictive of STS.

Table 4.26

Experiences of Serious Injury by Prevalence of STS.

Prevalence of STS	History of trauma statement response Experienced serious injury/threat of serious injury	
	Yes	No
Little or no STS	29	55
Mild STS	25	47
Moderate STS	11	23
High STS	16	17
Severe STS	37	41
n=301	118	183
$\chi 2$		5.459
df		4
p		0.243

As shown in Table 4.26, no significant association was noted between prevalence of STS and having experienced serious injury/threat of serious injury prior to trauma work $\chi^2_4 = 5.4$ ($p>.05$). Fifty four of the respondents that had not experienced serious injury had mild to little or no STS. An almost similar number (n=53) of those that had not experienced serious injury also had mild to little STS. Interestingly too those that had experienced serious injury/threat of serious injury prior to trauma (n=102) had little or no STS, another n=58 also had high to severe STS. History of trauma indicator having experienced serious injury/threat of serious injury is not predictive of STS. This finding contradicts findings from previous studies that indicated that experience of serious injury especially injury from assault predicted STS. A study in North Ireland for instance found a statistically significant difference in physical injuries between 72% of respondent with PTSD diagnosis and 40% of those without (Bowness, O'Gorman & Sayers, 1991). Schiraldi (2000) in a study of 166 child welfare workers, who endorsed a history of sexual abuse, emotional abuse, or neglect were at a greater risk of compassion fatigue than their peers who did not report a trauma history. Resnick (1994) also found an association between panic attacks during assault and follow up PTSD. Watson, Anderson and Gearhart (1995) in their study found that the severity of the perceived threat to one's own life during the exposure predicts PTSD. This discrepancy is most likely due to how prevalence rate for prior trauma experiences have been operationalized across studies and the subjective nature of the variable itself. This study did not find experience of serious injury /threat of serious injury prior to trauma predictive of STS

Table 4.27

Experiences of Divorce or Separation by Prevalence of STS

Prevalence of STS	History of trauma statement response Experienced divorce or separation	
	Yes	No
Little or no STS	26	58
Mild STS	21	51
Moderate STS	9	25
High STS	15	18
Severe STS	24	54
n=301	95	206
$\chi 2$	3.585	
df	4	
p	0.465	

Table 4.27 indicates no significant association between having experienced divorce/separation and prevalence of STS $\chi^2_4 = 3.5(p>.05)$. For those that experienced divorce or separation prior to trauma n=47 had mild to little or no STS while n=39 had high to severe STS. On the contrary for those that had not experienced divorce, A big number n=109 also had mild to little or no STS while another n=72 of this group had high to severe trauma. This finding indicates that experiencing divorce or separation does not predict STS. A finding that stands in opposition to the existing research in STS literature. Hauff and Vaglum (1995) found, that in a prospective study of resettled Vietnamese boat refugees, chronic family separation was a predictor of pathology in a follow-up of UN peacekeeping soldiers. The discrepancy can be explained in terms of psychotherapists in this study may have gone for personal therapy and may have dealt with this issue as indicated elsewhere in this study. It may also be that the history of trauma in psychotherapists was so different from trauma of their clients that the therapists' issues were

not triggered. Further the psychotherapists may have disengaged or were satisfied with their separation and divorce.

Table 4.28

History of trauma by Prevalence of STS

	History of trauma statement response					
Prevalence of STS	Witnessed traumatic event suffered by close friend		witnessed actual death		witnessed violence or threat with a weapon	
	Yes	No	Yes	No	Yes	No
Little or no STS	64	20	35	49	51	33
Mild STS	60	12	35	37	49	23
Moderate STS	28	6	24	10	21	13
High STS	27	6	18	15	16	17
Severe STS	64	14	37	41	48	30
n=301	243	58	149	152	185	116
$\chi 2$	1.597		8.602		3.689	
df	4		4		4	
p	0.809		0.072		0.450	

Table 4.28 indicates that there is no significant association between having experienced traumatic event suffered by a close friend, witnessed actual death and witnessed violence with a weapon and STS prevalence $\chi^2_4 = 1.5(p>.05)$. For those that had experienced traumatic event suffered by a friend n=124 had little to no STS, while those who had not experienced traumatic event suffered by a close friend, (n=32) had mild to little or no STS. Majority of those who had experienced actual death STS n=70 had mild to little or no STS while those that had not experienced actual death n=86 had mild to little or no STS $\chi^2_4 = 8.6(p>.05)$. Among the respondents who had witnessed violence or threat with a weapon n=100 had mild to little or no STS $\chi^2_4 = 3.6(p>.05)$. Another n=64 of this category had high to severe STS. For those who

had not witnessed violence or threat with a weapon n=56 had mild to little or no STS. The lack of an association between having experienced traumatic event suffered by a close friend, witnessed actual death and witnessed violence with a weapon and STS prevalence stands in contrast to the majority of the existing research findings, which has found that survivors of traumatic events are at an increased risk of developing STS when exposed to traumatic clients and materials. (Williams & Sommer, 1995; Pearlman & Mac Ian, 1995; Figley, 1995; Adams, 1999; Cunningham, 2003; Kassam-; Nelson-Gardell & Harris, 2003; Adams et al, 2006). This is also the view espoused by Dahl (1993) in a study of female rape victims, that showed that women who had previously experienced psychological instability, had been exposed to a rapist who used a weapon, and after the rape had been blamed by someone in her own network, ran a 90% risk of suffering from PTSD one year after the rape.

Meyers and Cornille's (1999) further note that history of trauma indicators: experiencing traumatic event suffered by a close friend, witnessing actual death and witnessing violence with a weapon contributes to vulnerability of STS and to the number of symptoms experienced. In their study of 203 child welfare practitioners in New York City, eighty two percent had traumatic experience before they became child welfare workers. Seventy seven percent indicated they had experienced physical assault or been threatened by a client. Prevalence of STS in this population was evident. However, the current result parallels the findings of Schauben and Frazier (1995), who detected no increase in psychological distress among sexual violence counselors who were themselves survivors of traumatic events. Instead, the authors reported that survivor-counselors felt that they learned about themselves through their interactions with clients, and were better able to heal. The concept of compassion satisfaction or achievement outlined in Figleys (2002) theory that informs this study also provides a useful framework for understanding the absence of a relationship between personal trauma history indicators and STS prevalence within the present study. A view endorsed by Tedeschi and Calhoun (2004), who indicated that after surviving a traumatic experience, individuals consciously and unconsciously strives to make meaning of the event. In the process, trauma survivors often exhibit the potential for positive and lasting psychological development across a number of dimensions, such as increased empathy and awareness of one's resiliency (Tedeschi & Calhoun, 2004). While satisfaction and positive psychological developments may not eliminate the negative consequences of trauma, they may play a protective role when a survivor

is confronted with additional traumatic experiences (Tedeschi & McNally, 2011). Within the current sample, it is possible that the positive aspects of surviving trauma provided a counterbalance for the negative consequences, reducing the likelihood that psychotherapists with personal trauma history : having experienced traumatic event suffered by a close friend, witnessed actual death and witnessed violence with a weapon would be "re-traumatized" by their work with trauma clients.

4.5.5 Personal Life Stressors Experienced During Trauma Work

Literature on STS hypothesizes that personal life stressors can predict STS prevalence. The indicators of personal life stressors drawn from STS literature are: experienced divorce or separation during trauma work; experienced sexual trauma during trauma work; experienced financial difficulties during trauma work; experienced legal matters during trauma work; experienced medical difficulties during trauma work; and experienced death of significant person in your life .There are mixed results for this variable as indicated in Table 4.29

Table 4.29

Personal Life Stressors by Prevalence of STS

Personal life stressors	Response STS prevalence														
Statement	Little or no STS		Mild		Moderate		High		Severe		n=301		$\chi 2$	*df*	*p*
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No			
Death of significant person	55	29	53	19	22	12	30	3	50	28	210	91	9.830	4	0.043
Divorce or separation	18	66	23	49	11	23	9	24	12	66	73	228	7.401	4	0.116
Sexual trauma	15	69	12	60	13	21	8	25	16	62	64	237	7.542	4	0.110
Financial difficulties	62	22	58	14	23	11	28	5	60	18	231	70	3.784	4	0.436
Legal matters	23	61	23	49	8	26	11	22	13	65	78	223	5.979	4	0.201
Medical difficulties	42	42	39	33	21	13	20	13	38	40	160	141	2.730	4	0.604
Total =301															

Table 4.29 indicates that across the six statements of personal life stressors derived from the DSM IV TR, there was only one significant association between experienced death of significant person during trauma work and prevalence of STS $\chi^2_4 = 9.8(p<.05)$. Among respondents who said yes, 108 had little to mild or no STS. The rest of the statements showed no significant association between them and STS prevalence. This is similar to the literature on STS as it includes mixed findings regarding personal life stressors. A study by Schiraldi (2000) indicates that recent events in a person's life that are of traumatic magnitude such as job loss,

early parental loss, by death, separation or divorce and financial problems can increases the risk of PTSD. Study by Nelson-Gardell and Harris (2003) also correlates sexual abuse with STS. Schauben and Frazier (1995) study that assessed a history of rape or incest and also found that therapists with childhood sexual trauma history reported more severe STS related symptoms. Green (1990), Symonds (1997), and Walton et al. (1997) studies however contradict findings of this study. Their studies found that counsellor VT or STS symptomatology was not related to counsellors' own history of sexual victimization. This contradiction can be explained by fact psychotherapist in this study may have resolved most of their traumas through personal therapy as indicated elsewhere in this research (Table 4.31) and were therefore able to deal with trauma of their clients effectively. In addition, having been victims themselves may have been an advantage in understanding their clients and being able to model healing.

4.5.6 History of Psychiatric Symptoms

History of psychiatric symptoms is also listed in literature as predictive of STS prevalence. In this study it was conceptualized as: having a history of psychological disorder and a member of my family is/has suffered a psychological disorder. The results of this study are indicated in Table 4.30

Table 4.30

History of Psychiatric Symptoms by Prevalence of STS

STS Prevalence	History of psychiatric symptom statement response			
	I Have a history of psychological disorder		A family member has suffered a psychological disorder	
	Yes	No	Yes	No
Little or no STS	3	81	20	64
Mild STS	5	67	19	53
Moderate STS	2	32	10	24
High STS	2	31	9	24
Severe STS	3	75	20	58
n=301	15	286	78	223
$\chi 2$		1.290		0.454
df		4		4
P		0.863		0.978

Table 4.30 shows no significant Association between histories of psychiatric symptoms indicators and prevalence of STS $\chi^2_4 = 1.2(p>.05)$, and $\chi^2_4 = 0.4(p>.05)$. Those psychotherapists whose response was no history of psychological trauma n=148 had mild to little or no STS. While another group n=106 had high to severe STS. Therapists n=117 who had no member of their family suffering psychological disorder had mild to little or no STS. Another of this group n=82 who had a family member suffering psychological disorder also had high to severe STS. This finding contradicts findings in literature that states that a history of psychiatric symptoms predicts STS (Burgess & Holstrom, 1974; Murphy, 1986; Vachon, 1976). One explanation for this inconsistency may be found in the number of respondents, for example only 15 of the respondents had a history of psychological disorder. This is a very insignificant number to produce any valuable findings. Again only 78 of the respondents had a member of their family suffering psychological disorder. This too could not produce valuable findings that could give conclusive information as to whether history of psychiatric symptoms is predictive of STS symptoms or not.

4.5.7 Psychotherapists Unresolved Personal Trauma

Unresolved personal trauma is yet another factor indicated in literature as predictive of STS prevalence. In this study it was conceptualized using three indicators: do you receive debriefing sessions? ; do you receive supervision sessions? ; and do you attend personal therapy sessions? Findings are displayed in Table 4.31.

Table 4.31

Unresolved Personal Trauma by Prevalence of STS

	Unresolved personal trauma statement response					
Prevalence of STS	Do you receive debriefing sessions?		Do you receive supervision sessions?		Do you attend personal therapy sessions	
	Yes	No	Yes	No	Yes	No
Little or no STS	47	37	68	16	59	25
Mild STS	57	15	61	11	53	19
Moderate STS	22	12	19	15	20	14
High STS	19	14	23	10	27	6
Severe STS	33	45	45	33	50	28
n=301	178	123	216	85	209	92
$\chi 2$		21.917		21.389		5.851
df		4		4		4
p		0.001		0.001		0.211

Table 4.31 suggests that there was a significant difference between two indicators of unresolved trauma: receiving debriefing and receiving supervision and STS prevalence $\chi^2_4 = 21.9(p<.001)$, and $\chi^2_4 = 21.3(p<.001)$. First, those therapists who received debriefing n=104 had mild to little or no STS. Another n=52 had high to severe STS. Those who had not received debriefing n=59 of them also had high to severe STS indicating that whether one goes for debriefing or not the prevalence of STS is more or less the same. These findings agree with Hassle (1989) study that found that those who took part in a formal debriefing found it helpful. Nixon, Schorr,

Boudreaux, and Vincent (1999) endorse this view as well. In a study among Oklahoma City firemen, (63%) of the respondents found Critical Incident Stress Management techniques, in the form of defusing and debriefings, either somewhat or very helpful. Debriefing is therefore not a predictive factor of STS. Similarly, supervision was not a predictive factor of STS, a finding that contradicts the expectation that supervision would predict STS. Previous studies found that more supervision reduced the degree of STS. In this study, however, supervision was associated with higher levels of STS. Those therapists who received supervision n=129 had mild to little or no STS. Another n=68 of these therapists also had high to severe STS. Among the therapists who had not received supervision, n=43 had high to severe STS. This finding contradicts findings in literature that states that supervision is a predictive factor of STS. A study by Slattery (2003) for instance, found that a higher level of co-worker cohesion and quality of clinical supervision in the work environment led to fewer reported PTSD symptoms. Cunningham (2003), in a study to examine impact of trauma on clinicians who works with survivors of sexual abuse, also found that VT is likely to occur in clinicians who have unresolved personal trauma. A position shared by Jordan (2010), those clinicians who have not addressed their personal trauma histories through personal therapy or supervision may experience strong emotions while working with trauma victims. One interpretation of the results suggests that those psychotherapists exposed to more traumatized clients having more STS symptoms might have a great likelihood of receiving supervision. The other explanation would be the quality of clinical work received. It may be that the psychotherapists received poor quality supervision. Slattery (2003) found that a higher level of co-worker cohesion and quality of clinical supervision in the work environment led to fewer reported PTSD symptoms.

There was no significant association between prevalence of STS and attending personal therapy. Those therapists who attended personal therapy, n=112 had mild to little or no STS. Only 44 of the therapists who did not attend personal therapy had mild to little STS. Another 34 who did not attend personal therapy had high to severe STS. This indicates that personal therapy is a predictor of STS symptoms. These findings are consistent with those of Pearlman and Mac Ian (1995) who found that personal therapy was the only variable that contributed to STS. Bobber and Regehr (2006); and Creamer and Liddle (2005) studies also found an association between personal therapy and severe intrusion and avoidance symptoms.

4.5.8 Predictive Factors of STS from the Supervisor's Perspective.

The supervisors were interviewed in order to get additional information on the predictive factors of STS among psychotherapists. They were considered key informants in respect of the supervisory role they render to the psychotherapists. The qualitative data on predictive factors of STS among psychotherapists was organized by question and category and looked across all respondents and their answers in order to identify consistencies and differences. Table 4.32 outlines the questions and categories.

Table 4.32

Supervisor's Responses on Predictive Factors of STS among Psychotherapists

Question	Responses Categories
1.) How do the following predictive factors contribute to STS among the psychotherapists that you supervise?	a) Demographic characteristics of client b) Exposure c) Empathy d) History of trauma e) Unresolved personal trauma f) Personal life stressors g) History of psychiatric symptoms

Excerpt 1: Question 1, Category A

Researcher: How do demographic characteristics ages, educational level, years of psychotherapy, gender and marital status of psychotherapists contribute to STS?

Supervisor 1: The demographic characteristics you are mentioning contribute to a large extent to psychotherapists STS. First, I have realized that young therapists experience more STS compared to older ones. Secondly, those with diploma level education and those who have attended one or two week's workshop training are more vulnerable to STS. This is due to a large extent to the competency level of these supervisees.

Supervisor 2: I have observed that marital status is both a predictive and non predictive factor of STS. Those who are married and are supported by their spouses are less vulnerable to STS. Those married and with no support are vulnerable to STS.

Supervisor 3: The number of years a psychotherapist has worked according to me is so important. I find the supervisees who have worked for a short time really vulnerable to STS. This is due to lack of experience on how to go about with therapy.

Across board the supervisor's responses recognized demographic characteristics such as age, educational level, marital status and number of years a therapist has worked as predictive of STS among psychotherapists. This is similar to findings on demographic characteristics among the psychotherapists in this study and similar too to findings in predictive factors literature. Anderson (2000) for instance found heightened distress in new social workers. Perini et al. (2007) found training contributed to decreasing the symptoms of STS

Excerpt 2: Question 1, Category B

Researcher: How does empathy contribute to STS among psychotherapists that you supervise?

Supervisor 1: Empathy is very important for every psychotherapists but I have realized that it can also be a source of STS for the psychotherapists**.** Among the psychotherapists that I have supervised I would not pinpoint and say for sure that empathy contributes to STS. Some display STS and others do not.

Supervisor 2: I think it does, you know with empathy they must fit into the shoe of the client completely. This means if client is traumatized then they too get traumatized.

Supervisor 3: Empathy is not a predictive factor of STS. In fact it is a very important factor in therapy. They actually get STS when they do not use empathy.

The supervisors across board agree that empathy may be predictive or not predictive of STS. These responses are similar to what Figley (1995; 2003) states, that empathy is paradox-despite it being an excellent resource for trauma workers, it may also be a major key factor in the transmission of traumatic material from primary to secondary victim. Other researchers have

found that one of the many ways therapists can develop trauma is through empathic engagement (Bell et al., 2003; Canfield, 2008).

Excerpt 3: Question 1, Category C

Researcher: How does exposure (number of hours per week spent on trauma work, number of clients seen per day, monthly case load, and type of trauma dealt with) contribute to STS among psychotherapists that you supervise?

Supervisor 1: The number of hours per week spent on trauma work is high among the psychotherapists that I supervise. Majority spend about 10-20 hours doing trauma work.

Supervisor 2: They see about seven clients per day**.** Unfortunately most organizations do not understand what therapy is about and always want their therapists to see even more clients. One of my supervisee for example was told by the organization she worked for to resign if she could not cope with the large caseloads.

Supervisor 3: I have dealt with supervisees who see sexual and domestic violence clients.

Supervisor 4: Lately majority of those that I see have dealt with are grenade attack victim**s** or relatives of the victims. They are usually referred to me by the KCPA.

These findings indicate that the supervisees see sexual and domestic violence clients as well as victims and relatives of those involved in grenade attacks, on average the number of clients that they see per day is seven clients. The higher number of clients seen the more vulnerable the psychotherapists are. Research has supported these findings demonstrating that large caseloads and high percentages of trauma clients are associated with an increased risk of STS. (Chrestman, 1995; Figley 1995; Lee, 1995; Creamer & Liddle's 2005; Sprang et al., 2007). The findings are also similar to the responses that were given by the psychotherapists in this study.

Excerpt 4: Question 1, Category D and E

Researcher: How does history of trauma and unresolved trauma contribute to STS among psychotherapists that you supervise?

Supervisor 1: History of trauma only contributes to STS among psychotherapists when the traumas are not resolved. I do not think it is predictive of STS. I have only seen those who have history of sexual abuse vulnerable to STS. One of my supervisee who was a rape victim could not come to terms with the fact that her client had been raped. She did not want to see men-to her they were beasts since they raped her and raped her client too.

The responses of supervisors were unanimous that history of trauma is not predictive of STS unless unresolved. On the contrary studies previously on history of trauma support the claim that history of trauma increases likelihood of STS (Kassam-Adams, 1995; Pearlman & Mac Ian, 1995; Schauben & Frazier, 1995; Nelson-Gardell & Harris, 2003). The explanation given by the supervisors for this discrepancy is that most psychotherapists go for personal therapy and resolve their issues. This finding is also supported by responses from the psychotherapists in this study that indicated personal therapy as a buffer to STS. Besides psychotherapists in Kenya are very resilient even those who have not gone for personal therapy are hardly affected by trauma adds one supervisor. I think they go through so much and emerge victorious such that such issues really do not affect them.

Excerpt 5: Question 1, Category F

Researcher: How do personal life stressors during trauma work contribute to STS among psychotherapists that you supervise?

Supervisor 1: Psychotherapists that I supervise go through several personal life stressors such as death, divorce, sexual trauma, medical difficulties that can contribute to STS. Most of the psychotherapists deal with these issues through personal therapy and some actually deal with them somehow in the course of therapy with their clients.

Supervisor 2: Those supervisees who experience personal trauma and do not resolve them are really affected. One of my supervisee who had experienced loss of her own child could not deal with clients who presented with loss. In fact I had to confront her during supervision and she really cried.

The supervisors agreed that the majority of the supervisees experienced personal life stressors but they resolve them. However they also pointed out that those who do not resolve their personal life stressors are vulnerable to STS. These findings are echoed in literature as it includes mixed findings regarding personal life stressors. (Nelson-gardell & Harris ,2003; Hauff & Vaglum, 1995; & Schiraldi (2000). However studies by Green (1996), Symonds (1997), and Walton (1997) contradicts findings from the supervisors. The supervisors' explanation for the contradiction is that supervisees who go for personal therapy are able to resolve their personal stressors and are therefore not vulnerable to STS.

Excerpt 6: Question 1, Category G

Researcher: How does history of psychiatric symptoms contribute to STS among psychotherapists that you supervise?

Supervisor 1: I have not come across supervisees who have a history of psychiatric symptoms except for one addiction counsellor whose psychiatric issues were as result of previous alcohol taking. The therapist was however very stable and this condition did not make him vulnerable to STS.

Supervisor 2: I have dealt with a very small number of supervisees whose families have history of psychiatric symptoms and this did not make them vulnerable to STS. It is therefore difficult to state whether history of psychiatric symptoms is predictive of STS or not.

Supervisor 3: I have not dealt with any supervisee with history of psychiatric symptoms.

The agreement among the supervisors is that majority of the supervisees they see have no history of psychiatric symptoms; neither do members of their families suffer from psychiatric symptoms. It is difficult just like in the findings from the responses of psychotherapists in this study to state that history of psychiatric symptoms contribute to STS. A very small number 15 out of 301 psychotherapists had a history of psychological disorder. This is a very insignificant number to produce any valuable findings. Again only 78 of the respondents had a member of their family suffering psychological disorder. This too could not produce valuable findings that could give conclusive information as to whether history of psychiatric symptoms is predictive of STS symptoms or not.

4.6. Coping Strategies Employed by Psychotherapists

These findings are based on the fourth objective of this study: To establish how coping strategies contribute to STS among psychotherapists in Nairobi. The study looked at the commonly recommended coping strategies from previous STS literature including physical strategies, organizational strategies, emotional strategies, social coping strategies, professional coping strategies and maladaptive coping strategies. Each of these coping strategies had indicators. The psychotherapists were asked to indicate how frequently on four point- Likert scale ranging from 1(always) to 4 (never) each item is/was true for them. The higher the score, the higher was the coping strategy. Note that for each statement a mean score was calculated. The mean score ranged from 1 to 4, and was used to guide in ranking the statements so as to understand how the respondents generally varied in their responses on the various coping strategies. This helped to distinguish the importance of each coping activity to the respondents. The study also went ahead to look at each coping strategy to establish if it was buffer against STS. The results are listed in Tables 4.33, 4.34, 4.35, 4.36, 4.37, 4.38, 4.39, 4.40, 4.41, 4.42, 4.43, 4.44, 4.45 and 4.46.

4.6.1 Physical strategies

Table 4.33

Physical Coping Strategies Employed by Psychotherapists

Statement	Response %					
	Always	Often	Occasionally	Never	M	SD
I engage in physical exercises	17.9	32.6	44.4	5.0	2.37	0.832
I go for medical check up	6.0	16.6	50.2	27.2	2.99	0.825
I engage in healthy activities i.e. eating well and get enough sleep	35.9	36.5	24.9	2.7	1.94	0.845
n=301						

Table 4.33 indicates that 44.4% (M=2.37, SD= 0.832) of psychotherapists occasionally engage in physical activities, 50.2% (M=2.99, SD=0.825) of psychotherapists occasionally engage in medical check up while 36.5 % (M=1.94, SD=0.845) often engage in healthy activities and

another 35.9% also always engage in healthy activities. These findings indicate that majority of psychotherapists engage in healthy activities as physical coping strategy. These results confirm similar findings in the literature for instance a study of 117 trauma therapists conducted by Pearlman and Mac Ian (1995a) found the physical activities helpful in coping with traumatic material: socializing, exercising, spending time with family and friends. Wee and Myers (2002) list personal stress management activities in their study of mental health workers following a disaster. These include self care strategies such as exercise, eating right and relaxation. Jordan (2010) endorses this view as well, stating that physical self care include adequate sleep, well balanced diet and taking small breaks during the day. Lonne (2003) further shares the view that interventions targeting prevention of STS prescribe exercise, meditation, healthy eating, and seeking increased support and supervision.

Table 4.34

Level of Physical Coping Strategies

	Always		Often		Occasionally		Never	
Prevalence	f	%	f	%	f	%	f	%
Little or no STS	7	46.7	38	27.0	37	26.2	2	50.0
Mild STS	2	13.3	43	30.5	27	19.1	0	0.0
Moderate STS	3	20.0	14	9.9	17	12.1	0	0.0
High STS	2	13.3	13	9.2	17	12.1	1	25.0
Severe STS	1	6.7	33	23.4	43	30.5	1	25.0
n=301								

Table 4.34 indicates that 60.0% of those who always engage in physical strategies have mild to little or no STS. Those who often use physical strategies 57.5% also have mild to little or no STS. On the contrary 42.6 % who occasionally use physical strategies have high to severe STS. These results confirm similar findings in the literature for instance a study by Iliffe and Steed (2000) with a group of domestic violence service providers had identified engaging in physical activity as a protective factor against STS. Pearlman and Mac Ian (1995b) make a further important point, that the impact of VT can be decreased when counselors maintain a balance of work, play, and rest. This balance includes socializing with friends and family, being involved

in creative activities, and being physically active. Moran (2002) identifies the role of humour in buffering STS .The study indicates that child welfare therapists often use humour to cope with the horrific situations they witness or hear about from the children and families they serve. Physical strategies are therefore important strategies used for coping by psychotherapists and acts as a buffer against STS.

4.6.2 Emotional Self Care

Emotional coping strategies employed by the psychotherapists in the event of STS were drawn from literature and conceptualized as ;i have connection with an organized religion;i engage in meditation; i engage in community service; i write in a journal; and i engage in spiritual practice The psychotherapists were asked to indicate on four point- Likert-scales ranging from 1(always) to 4(never) each item is/was true for them. The higher the score, the higher was the coping strategy. Note that for each statement a mean score was calculated. The findings are in Table 4.35.

Table 4.35

Emotional Coping Strategies Employed by Psychotherapists

	Response %					
Statement	Always	Often	Occasionally	Never	M	SD
I have connection with an organized religion	61.8	18.3	15.3	4.7	1.63	0.906
I engage in meditation	18.6	24.6	36.2	20.6	2.59	1.015
I engage in community service	24.9	23.9	40.2	11.0	2.37	0.977
I write in a journal	11.3	16.6	35.5	36.5	2.97	0.993
engage in spiritual practice n=301	57.5	21.3	18.9	2.3	1.66	0.863

Table 4.35 indicates that that 61.8% (M=1.63, SD=0.906) of the psychotherapists are members of an organized religion, 36.2% (M=2.59, SD=1.015)) occasionally engage in meditation, 40.2% (M=2.37, SD=0.977) occasionally engage in community service, 36.5% (M= 2.97,

SD=0.993) never write in journal, and 57.5 % (M=1.66, SD=0.863) engage in spiritual practice. This finding suggests that majority of the psychotherapists are members of an organized religion and also engage in spiritual practice as a coping strategy. Supporting this findings Dane (2000) found that spirituality was an important coping tool used by child welfare workers that helped them find meaning in their work. In addition, Wittine (1995) suggested that therapists with a strong sense of spirituality are more likely to accept existential realities and their inability to change the occurrence of these realities.

Table 4.36

Level of Emotional Self Care

	Always		Often		Occasionally		Never	
Prevalence	f	%	f	%	f	%	f	%
Little or no STS	13	31.5	49	30,2	19	19.6	3	60.0
Mild STS	11	29.7	40	24.7	21	21.6	0	0.0
Moderate STS	5	13.5	21	13.0	7	7.2	1	20.0
High STS	5	13.5	15	9.3	13	13.4	0	0.0
Severe STS	3	8.1	37	22.8	37	38.1	1	20.0

n=301

Table 4.36 indicates 61.2 % of respondents who always use emotional coping strategies have mild to little or no STS. Those who often use emotional coping strategies 54.9 % have mild to little or no STS. Those who occasionally employ emotional coping strategies 51.5 % have high to severe STS, while 41.2 % have mild to little STS. These findings support results of earlier studies that indicated that emotional coping strategies reduce STS. Wee and Myers (2002) for instance list personal stress management activities in their study of mental health workers following a disaster. These include leisure and diversion activities such as, spending time outdoors, mediation and prayer. Pearlman and Saakvitne (1995) found that those therapists who lack a clear philosophy of life and causality, or who have struggled with issues regarding meaning, purpose, and spirituality may be at risk for STS. In a survey of trauma counsellors, 44

% reported that spirituality provided an effective coping mechanism in dealing with the effects of their work (Pearlman & Mac Ian, 1995). Emotional coping strategies are therefore useful coping strategies for psychotherapists and acts as buffer against STS among psychotherapists.

4.6.3 Social Support

The indicators of social support were conceptualized as: I have received inclusion support such as interacting with workmates, significant others etc; appraisal support in terms of help with decision making; I have received emotional support in terms of reassurance, acceptance, love, trust and intimacy; I have received instrumental support in terms of help to correctly assign blame, distortions and credit more objectively. The psychotherapists were asked to indicate on four point Likert-scale ranging from 1(always) to 4(never) the social support used. The higher the score, the higher was the social coping strategy employed. They also were asked to indicate who offers social support. Further the social support was cross tabulated with prevalence of STS to see if it protected the psychotherapists from STS. The findings on social support are shown in Table 4.37 and Table 4.38

Table 4.37

Social Coping Strategies Employed by Psychotherapists

	Response %					
Statement	Always	Often	Occasionally	Never	M	SD
I have received inclusion support such as interacting with workmates, significant others etc	43.5	37.2	15.6	3.7	1.79	0.835
Appraisal support in terms of help with decision making	17.9	41.2	33.2	7.6	2.31	0.852
I have received emotional support in terms of reassurance, acceptance, love, trust and intimacy	34.2	30.2	31.9	3.7	2.05	0.899
I have received instrumental support in terms of help to correctly assign blame, distortions and credit more objectively n =301	16.6	28.6	36,2	18.6	2.57	0.976

Table 4.37 indicates that 43.5% (M=1.79, SD=0.835) of psychotherapists always received inclusion support, 41.2% (M=2.31, SD=0.852) of psychotherapists often received appraisal support, 34.2 % (M=2.05, SD=0.899) always received emotional support, and 36.2 % (M=2.57, SD=0.976) of psychotherapists occasionally received instrumental support. These findings show that majority of psychotherapists receive inclusion support such as interacting with workmates and significant others, followed by emotional support in terms of reassurance, acceptance, love, trust and intimacy. In support of this findings generally literature on STS demonstrates the utility of support from significant others in the management of STS and includes emotional support, encouragement, advice, companionship, and tangible aid (Flannery, 1990)

Table 4.38

Level of Social Support

	Always		Often		Occasionally		Never	
Prevalence	F	%	f	%	f	%	f	%
Little or no STS	9	23.7	47	32.9	27	24.3	1	11.1
Mild STS	13	34.2	38	26.6	17	15.3	4	44.4
Moderate STS	9	23.7	13	9.1	12	10.8	0	0.0
High STS	1	2.6	12	8.4	19	17.1	1	11.1
Severe STS	6	15.8	33	23.1	36	32.4	3	33.3

n=301

Table 4.38 indicates that 57.9% of psychotherapists who always used social support have mild to little or no STS, 59.5 % who often used social support have mild to little or no STS too while 49.5% who occasionally used social support have high to severe STS. This suggests that psychotherapists must always and often use social support for it to act as a buffer against STS. This is consistent with two South African studies. Durant's (1999) study, on compassion fatigue among medical sciences students, which found that strong social support, indicated lower degrees of risk for compassion fatigue. Ortlepp (1998) study that looked at non-professional trauma debriefers in the work place found that social support was a main effect variable when considering the relationship between participants social support and STS. A

study by Kadambi and Truscott, (2003) has also found that having a support system can reduce the impact of working with clients who have experienced trauma. Lower levels of STS have been found among those therapists that had an outlet to discuss the personal impact of working with traumatized clients than those that did not. Studies by Chrestman (1999), Perrin et al (2007), and Pulido (2005) also support this finding. Dickes (2001) study among 219 psychologists from the American Psychological Association's Clinical Psychology and Clinical Child Psychology directory found a similar association between the level of workplace support and the degree of STS in those therapists who treated sexually abused clients. These results highlight the importance of adequate social Support in the management of STS among Psychotherapists. It is clear therefore that social support is buffer against STS.

Table 4.39

Persons Offering Social Support

Who offers social support	Nakuru		Nairobi		Total	
	f	%	f	%	f	%
Friends	10	18.2	37	17.5	47	17.7
Church and family	3	5.5	12	5.7	15	5.6
Friends and family	11	20.0	31	14.7	42	15.8
Workmates	18	32.7	52	24.6	70	26.3
workmates and family	8	14.5	29	13.7	37	13.9
Family	4	7.3	35	16.6	39	14.7
Church leaders	1	1.8	15	7.1	16	6.0
n=301	55	100.0	211	100.0	266	100.0

It is clear from Table 4.39 that social support is offered by workmates 26.3% , followed by friends 17.7% and then by friends and family 15.8%. This is consistent with findings in Table 4.37 that has listed inclusion support and emotional support as that most used social coping strategy. It also supports findings of MaCritchie (2006) that found that 88% of respondents received support from their friends and 82% from family, while the least support was received

from ones supervisor (13%) and therapist (22%). Fullerton et al (1992) also noted the importance of support from comrades, both during disaster work and after. Families have been identified as a potential source of social support for those at risk of developing compassion fatigue (Figley, 1989; Catherall, 1995). Pearlman and Mac Ian (1995) found that 85% of trauma counselors reported discussion with colleagues as their most common method of dealing with VT. Studies by Figley (1995), Schauben and Frazier (1995), Stamm and Pearce (1995), Ortlepp and Friedman (2002), and Stamm (2002) also endorse the view that supportive relationships with friends, family, colleagues, and/or supervisors are associated with a lowered risk of STS.

4.6.4 Professional Coping

Professional coping strategies were conceptualized using seven indicators: I go for debriefing; I go for supervision and consultation; I go for personal therapy; I remain aware of sense of mastery; I establish a balanced work life; I get quality feedback on individual performance; I resource myself through seminars, conferences, workshops. The psychotherapists were asked to indicate on four point-likert scale ranging from 1(always) to 4 (never) the professional coping strategy they employed. The higher the score, the higher was the professional coping strategy used. The indicators were then cross tabulated with STS prevalence to find out if they acted as buffer against STS prevalence. The findings of these indicators of professional coping are listed in Table 4.40 and Table 4.41

Table 4.40

Professional Coping Strategies Employed by Psychotherapists

	Response %					
Statement	Always	Often	Occasionally	Never	M	SD
I go for debriefing	32.9	33.2	22.6	11.3	2.71	1.038
I go for supervision and consultation	19.6	33.2	33.9	13.3	2.37	0.942
I go for personal therapy	23.9	32.2	33.6	10.3	2.59	0.978
I get quality feedback on individual performance	32.2	32.2	30.6	5.0	2.35	0.903
I resource myself through seminars, conferences, trainings, etc	23.3	29.2	42.9	4.7	2.29	0.875
I remain aware of sense of mastery	23.6	38.9	29.2	8.3	2.22	0.902
I establish a balanced work life n=301	29.6	42.5	26.5	1.7	2.00	0.792

Table 4.40 indicates that 33.2% (M=2.71, SD=1.038) of the psychotherapists often go for debriefing , 32.9% always go for debriefing while 33.9% (M= 2.37, SD=0.942) occasionally go for supervision. It is important to note too that another 33.2 % of psychotherapists also often go for supervision. This suggests that those psychotherapists who go for debriefing may be the same ones going for supervision. Supervision serves as a medium for counselors to debrief in an ethical manner. Supporting this view Catherall (1995), argues that supervision gives counselors an opportunity to debrief and express reactions regarding client stories. Furthermore, Rosenbloom et al. (1995) adds that supervision helps alleviate issues of countertransference and traumatic reactions. Pearlman and McCann (1990) argue that it is important for helping professionals to participate in debriefing sessions and professional training or development, arguments that are consistent with findings in this study. They further emphasize importance of case supervision and consultation as a way of dealing with affect overload and the intrusive imagery that can disrupt the therapist's life. The findings from this study also indicates that 33.6 % (M=2.59, SD=0.978) occasionally go for personal therapy, 32.2% often go for personal therapy and 23.9 also always go for personal therapy. In total a whooping 89.7% respondents go for personal therapy. Personal therapy has been identified in

this study as a way in which psychotherapists resolve their personal trauma and as a predictive factor of STS. These findings are consistent with those from objective three of this study. Further the study indicates that 42.9% (M=2.29, SD=0.875) occasionally resource themselves through trainings, seminars, conferences etc, findings replicates those of Follette et al. (1994), that found 96% of mental health professionals reported that education regarding sexual abuse was imperative to effective coping with difficult client cases. Chrestman (1995) also found empirical evidence that supported use of additional training to decrease the symptomatology of PTSD in counselors working with trauma clients. Furthermore, Alpert and Paulson (1990) suggested that graduate programs for mental health professionals need to incorporate training regarding the impact of clients' childhood trauma and its effects on VT. Study indicates too that 38.9 % (M=2.22, SD= 0.902) often remain aware of sense of mastery. Finally 42.5% often establish a balanced work life. Rourke (2007) argues that professional strategies such as maintaining professional connection with the colleagues and balanced work life are other key ways to cope with and prevent STS. Figley (1995) and Hesse (2002) concur with Rouke (2007). Their studies also identified the significance of keeping a balance between work and personal life in helping reduce the symptoms of STS.

Table 4.41

Level of Professional Coping Strategies

	Always		Often		Occasionally		Never	
Prevalence	f	%	f	%	f	%	f	%
Little or no STS	12	41.4	47	32.9	23	18.7	2	33.3
Mild STS	7	24.1	47	32.9	17	13.8	1	16.7
Moderate STS	6	20.7	11	7.7	16	13.0	1	16.7
High STS	1	3.4	13	9.1	19	15.4	0	0.0
Severe STS n=301	3	10.3	25	17.5	48	39.0	2	33.3

Table 4.41 indicates that 65.5% of the respondents who always used professional coping strategies have mild to little or no STS. The respondents who often use professional coping strategies (65.8%) also have mild to little STS. This indicates that professional coping strategies are buffer against STS. The findings show too that 54.4% of those who occasionally use professional coping strategies have high to severe STS implying the need for consistent use of professional coping strategies if they have to be effective. Consistent use of professional coping make intuitive sense, as this variable could be seen as indicator of previous therapists STS. The results suggest that professional coping strategies are a buffer against STS if consistently used. Further it offers explanation as to why receiving debriefing and supervision in objective three was not a protective factor, a finding that is inconsistent with previous literature and calls for consistent use if they have to be effective. Slattery (2003) confirms that a higher level of co-worker cohesion and quality of clinical supervision in the work environment led to fewer reported PTSD symptoms.

4.6.5 Organizational Coping Strategies

Organizational coping strategies were conceptualized using the statements; my physical setting is spacious, private, and comfortable; adequate resources are provided to me; I take vacation/leave from work when need arises; an atmosphere of respect is available at my work place. The psychotherapists were asked to indicate on four point-likert scale ranging from 1(always) to 4(never) the organizational coping strategy they employed. The higher the score, the higher was the organizational coping strategy. The indicators were then cross tabulated with STS prevalence to find out if they acted as buffer against STS prevalence in the event of STS. The findings of these indicators of organizational coping strategies are listed in Table 4.42 and Table 4.43.

Table 4.42
Organizational Coping Strategies Employed by Psychotherapists

	Responses%					
Statement	Always	Often	Occasionally	Never	M	SD
My physical setting is spacious, private, and comfortable	32.9	33.2	22.6	11.3	2.12	0.997
Adequate resources are provided	19.6	33.2	33.9	13.3	2.41	0.950
I take vacation/leave from work when need arises	23.9	32.2	33.6	10.3	2.30	0.948
An atmosphere of respect is available at my work place	32.2	32.2	30.6	5.0	2.08	0.907
n=301						

Table 4.42 indicates that 33.2 % (M=2.12, SD=0.997) of psychotherapists often have spacious physical setting, 32.9 % always have spacious private and comfortable setting. Another 33.9% (M=2.41, SD=0.950) occasionally have adequate resources provided and 33.2% of this group often have resources provided. Psychotherapists also indicated taking vacation when need arises 33.6 % occasionally take vacation when need arises while 32.2 % often take vacation when need arises. Findings indicate too that 32.2% (M=2.08, SD=0.907) always have an atmosphere of respect available at their work place, while another 32.2% also often have an atmosphere of respect available at their work place. These findings parallel findings from the literature that emerge from the collective voice of the authors. Choi (2011) for instance indicates access to strategic information from the organization protecting service providers against STS; work environments characterized by shared power, respect for diversity, and consensual decision making (Slattery & Goodman, 2009); an atmosphere that is characterized by respect and safety, and can encourage supervisees to identify and explore the feelings that are roused as a result of working with traumatic material (Rosenbloom et al.,1995); role clarity

combined with sufficient supervision with feedback and increased opportunity to participate in decision making (Lloyd et al., 2002; Lonne, 2003).

Table 4.43

Levels of Organizational Coping Strategies

	Response %							
	Always		Often		Occasionally		Never	
Prevalence	f	%	f	%	f	%	f	%
Little or no STS	0	0.0	7	23.3	37	20.8	40	44.4
Mild STS	0	0.0	6	20.0	44	24.7	22	24.4
Moderate STS	0	0.0	2	6.7	27	15.2	5	5.6
High STS	3	100.0	1	3.3	20	11.2	9	10.0
Severe STS	0	0.0	14	46.7	50	28.1	14	15.6
n=301								

Table 4.43 indicates that 50.0 % psychotherapists who often used organizational strategies experienced high to severe STS while 43.3% experienced mild to little or no STS. Those who used organizational coping strategies occasionally 39.3 % experienced high to severe STS and 45.5 % mild to little STS . Among those who have never used organizational coping strategies 68.8 % had mild to little or no STS. Organizational coping strategies are therefore not a buffer to STS. This is contrary to literature on STS regarding association of organizational coping strategies and STS. Ragehr et al., (2004) found that organizational coping strategies had the strongest effect on distress among trauma workers. Naturale (2007) found that in the workplace organizational supports decreased the stress that had triggered one of the worker's STS symptoms. Pearlman and Saakvitne (1995b) further suggested that provision of employee benefits could decrease the impact of VT, including (a) insurance for personal counselling, (b) paid vacations, and (c) limiting the number of trauma survivors on the therapist's caseload. In addition, Chrestman (1995) found empirical evidence suggesting that increased income correlated positively with a decrease in symptoms of psychological distress. The discrepancy in findings can be interpreted as resulting from limited control and autonomy by psychotherapists over their work. Literature on STS indicates that when practitioners have limited control and autonomy over their work, burnout and STS levels tend to be higher and job satisfaction lower

(Guterman & Jayaratne, 1994; Poulin 1994, 1995; Koeske & Kirk 1995b; Balloch, Pahl & McLean, 1998; McLean & Andrew, 2000; Barak , Nissly, & Levin*e* , 2001). In this study only 33.9% and 33.2% indicated adequate resources provided to them occasionally and often. This study also indicates that 33.2% often attended supervision - indicating under utilization. Further researchers suggest that the organizational strategies must be balanced for them to buffer against STS (Lloyd, King, & Chenoweth, 2002; Lonne, 2003). Research specific to human services has suggested a combination of imbalanced organizational variables such as lack of role clarity and high client demands combined with insufficient supervision with little feedback and reduced opportunity to participate in decision making can lead to increased risk of STS among service providers. A combination of these factors therefore explains why organizational strategies in this study are not a buffer against STS contrary to what the literature states.

4.6.6 Maladaptive Coping Strategies

Maladaptive coping strategies were drawn from literature and conceptualized as: increased use or abuse of alcohol, coffee or drugs to relieve stress; temptation to make hasty major life decisions; completely avoiding any feelings or thoughts about the event; not speaking up about the trauma incident or event; a compulsion to work more than usual. The psychotherapists were asked to indicate on four point- Likert scale ranging from 1(always) to 4 (never) the maladaptive coping strategy they employed. The higher the score, the higher was the maladaptive coping strategy utilized. The maladaptive indicators were then cross tabulated with STS prevalence to find out if they acted as buffer against STS prevalence in the event of STS. The findings of these indicators of maladaptive coping strategies are listed in Table 4.44 and 4.45.

Table 4.44

Maladaptive Coping Strategies Employed by Psychotherapist

	Response %					
Statement	Always	Often	Occasionally	Never	M	SD
Increased use or abuse of alcohol, coffee or drugs to relieve stress	2.7	5.6	10.3	41.2	3.70	0.694
Temptation to make hasty major life decisions	4.3	9.0	45.5	41.2	3.24	0.788
Completely avoiding any feelings or thoughts about the event	3.3	15.6	52.5	28.6	3.06	0.757
Not speaking up about the trauma incident or event	6.0	11.0	43.2	39.9	3.17	0.849
A compulsion to work more than usual	8.6	21.3	39.2	30.9	2.92	0.930
n=301						

According to table 4.44 the psychotherapists 41.2 % never use or abuse alcohol, coffee or drugs to relieve stress following/during trauma work, 45.5 % occasionally are tempted to make hasty major life decisions and another 41.2% have never been tempted to make hasty life decisions, 52.5% completely avoid any feelings or thoughts about the event, 43.2 % occasionally do not speak up about the trauma incident and 30.9% occasionally are compelled to work more than usual. This finding confirm what Figley (1995) aptly points out, he has often seen colleagues and friends who abandon clinical work or research with traumatized people because of their inability to deal with pain of others.

Table 4.45

Levels of Maladaptive Coping Strategies

	Response %							
	Always		Often		Occasionally		Never	
Prevalence	F	%	f	%	f	%	f	%
Little or no STS	0	0.0	7	23.3	37	20.8	40	44.4
Mild STS	0	0.0	6	20.0	44	24.7	22	24.4
Moderate STS	0	0.0	2	6.7	27	15.2	5	5.6
High STS	3	100.0	1	3.3	20	11.2	9	10.0
Severe STS	0	0.0	14	46.7	50	28.1	14	15.6
n=301								

Table 4.45 shows 50% of those who often used maladaptive coping have high to severe STS, 39.3 % who occasionally use maladaptive coping have high to severe STS, and 68.8% who never use maladaptive coping have little or no STS. These findings like in other studies indicate that maladaptive coping strategies are not buffer of STS. In support of these findings is Follette et al. (1994) study that found use of negative coping strategies leading to trauma symptoms. Pryce et al. (2006) and Simon et al. (2006) also indicated in their studies that maladaptive coping strategies are not buffer of STS. They examined association between alcohol use and STS symptoms within 779 Red Cross workers who responded to September 11, 2001 twin bombing in New York. The study results indicated that Red Cross workers who reported increase use of alcohol had a higher level of STS. What is not clear from this study though is whether the psychotherapists are at risk, or if the use of such maladaptive coping strategies is merely a manifestation of the experience of STS. Zuckerman and Gagne (2003) raised the caution that the terminology "maladaptive" implies negative connotations when, in practical terms, it is actually possible that "maladaptive" strategies may be beneficial in dealing with some situations. In support of the findings of Zukerman and Gagne (2003) and Figley (2008)

asserts that in coping assessment some responses that are typically viewed as being maladaptive may actually be a successful approach in some critical situations. In view of what Zukerman and Gagne (2003) and Figley (2008) show; these result needs to be further investigated to determine the direction of the relationship.

4.6.7 Means and Standard Deviation of Coping Strategies

Table 4.46

Means and Standard Deviation of coping strategies

	Nakuru (n=60)		Nairobi (n=241)		Nairobi and Nakuru (n=301)	
Coping strategy	M	SD	M	SD	M	SD
Physical strategy	2.58	0.645	2.41	0.600	2.45	0.612
Emotional self care	2.20	0.684	2.24	0.677	2.23	0.678
Social support	2.32	0.624	2.30	0.749	2.30	0.725
Organizational strategies	2.22	0.715	2.38	0.833	2.35	0.813
Maladaptive coping strategies	3.27	0.607	3.16	0.646	3.18	0.639
Professional strategies	2.48	0.676	2.32	0.678	2.35	0.680

Table 4.46 indicates the means and SD deviation of the coping strategies employed by psychotherapists. The most widely used coping strategies by psychotherapists are maladaptive strategies with mean of 3.18 (SD = 0.639), followed by physical strategies with mean of 2.45 (SD = 0.612), followed by social support, organizational and professional coping strategies with mean of 2.35 (SD = 0.813) and mean of 2.35 (SD =0.680), respectively. The least used coping strategies are emotional coping. These findings indicate that maladaptive coping such as increased use of alcohol or coffee, temptation to make hasty major life decisions, completely avoiding any feelings or thoughts about the event, not speaking up about the trauma incident or event and a compulsion to work more are utilized more by the psychotherapists. The

explanation would be that these maladaptive strategies although having a negative connotation are actually beneficial to the psychotherapists, supporting the findings of Zukerman and Gagne (2003) and Figley (2008) that indicate that in coping assessment some responses that are typically viewed as being maladaptive may actually be a successful approach in some critical situations. This finding further supports finding in this study that maladaptive coping are not buffer to STS.

4.6.8 Supervisors perspective on coping strategies of psychotherapists

By virtue of the supervisory role that the supervisors play, they were asked about the coping strategies employed by supervisors in the event of traumatisation. This information was meant to supplement information given by the psychotherapists themselves. The qualitative data on coping strategies employed by psychotherapists in the event of traumatisation was organized by question and category and looked across all respondents and their answers in order to identify consistencies and differences. Table 4.47 outlines the questions and categories.

Table 4.47

Supervisor's perspective on Coping Strategies Employed by Psychotherapists

Question	Response Categories
What coping strategies do the psychotherapists employ in the event of traumatisation?	a) Personal coping strategies i. physical strategies ii. emotional self care iii. social support b) Professional coping strategies c) Organizational coping strategies d) Maladaptive coping strategies

Excerpt 1: Question 1, Category A

Researcher: What personal coping strategies do the psychotherapists employ in the event of traumatisation?

Supervisor 1: They sometimes use physical coping strategies such as exercising, spending time with friends and even eating healthy.

Supervisor 2: Majority of supervisees have a connection to religion and engage a lot in spiritual practice. In fact some of them practice from a religious orientation. I know one who prays a lot when overwhelmed and thereafter gets a relief.

Supervisor 3: They engage in the other coping strategies but very few that I have supervised write in a journal. I think this is so western, Kenyan therapists are yet to pick up journal writing , one or two who use it agree that it helps them cope with trauma, again very few engage in community service.

Supervisor 4: Majority use social support as coping strategy. They interact with workmates, friends, significant others and more importantly church.

Supervisors' responses indicate that the supervisees sometimes engage in physical coping strategies and sometimes eat healthy. The argument by the supervisors is that the psychotherapists are aware of these coping strategies but they have no time to engage in them always. Supervisees in Nairobi wake up by 4.00 am and get back to the house by 10.00 pm. So they don't have the time to engage in physical coping strategies. They also don't eat healthy because most of them work in town where healthy food is so expensive and as a result most resort to fast foods because that is what is easily available and affordable. This response concurs with psychotherapist's responses in this study that indicates that 57.5% of psychotherapists occasionally engage in physical activities**.** Supervisors also agree that the supervisees use social support as coping strategy and also practice from a religious point of view and very few write in a journal or engage in community work. Studies by Figley (1995) , Stamm and Pearce, (1995), Schauben and Frazier (1995) , Ortlepp and Friedman (2002) Stamm (2002) also endorse the view that supportive relationships with friends, family, colleagues, and/or supervisors are associated with a lowered risk of ST. Spirituality is a protective buffer for traumatic experience of supervisees a position that is supported by responses from the psychotherapists in this study and by Dane (2000), and Wittine (1995) that suggested that psychotherapists with a strong sense of spirituality are more likely to accept existential realities.

Excerpt 2: Question 1, Category B

Researcher: What professional coping strategies do the psychotherapists employ in the event of traumatisation?

Supervisor 1: Professional coping strategies? Yes on top of the list is personal therapy. What has helped most is the fact that it is a requirement for most diploma and graduate programmes, so by the time the therapists begins to practice they have resolved most of their unfinished business. A small number go for supervision-to be specific those who are paid for by the organizations that they work for. Very few pay for themselves. Even those able to pay for themselves do not pay because they have very heavy schedules with large caseloads that make them unable to go for supervision.

Supervisor 2: Majority of those I have supervised engage in peer to peer supervision and case conferencing between and among themselves.

Supervisor 3: Some attend seminars, conferences and trainings. Sometimes Kenya counselling and Psychological Associations organize for short courses and they register in large numbers.

The supervisors agree that the supervisees use professional coping strategies such as personal therapy, peer supervision, case conferencing, attending seminars and conferences. This response is also similar to the psychotherapists' response in this study and also to findings in STS literature that confirm that professional strategies such as maintaining professional connection with colleagues, having a balanced work life, attending personal therapy and supervision are the key ways to cope with and prevent STS (Figley, 1995; Hesse, 2002; Slattery, 2003; Rouke, 2007).

Excerpt 3: Question 1, Category C

Researcher: What organizational coping strategies do the psychotherapists employ in the event of traumatisation?

Supervisor 1: Majority take leave of absence from their work places to enable them cope.

Supervisor 2: Organizations also organize for retreats for their staff to enable them unwind and cope with trauma.

Supervisor 3: Organizations have spacious, private and confidential therapy rooms for use by psychotherapists, most of them however do not meet international standards as therapy rooms, but they do help.

It is apparent from the supervisors' responses that the supervisees take leave of absence from work, organize retreats and also have spacious, private and confidential therapy rooms. These findings corroborate the findings in the literature and findings from psychotherapists in this study that indicates that 32.9 % always have spacious private and comfortable setting. 33.9 occasionally have adequate resources provided, 33.2% of this group often have resources provided and 33.6% take vacation when need arises.

Excerpt 4: Question 1, Category D

Researcher: What maladaptive coping strategies do the psychotherapists employ in the event of traumatisation?

Supervisor 1: The maladaptive coping strategies that the psychotherapists engage in are varied. For example the period following the post 2007 election violence saw psychotherapists offering their services to trauma victims. Some supervisees I realized kept shifting from camps that had intense trauma victims to camps that had fewer traumas or picked clients with less traumatic cases.

Supervisor 2: Most supervisors develop the compassion to work more.

Supervisor 3: The majority of therapists that I deal with avoid feelings and thoughts about the traumatic events they have dealt with. I have to do a lot of confronting for them to talk about them. One supervisee had to change profession and kept repeating that he was in the wrong profession and was not wired for therapy work or seeing people who are hurting every now and again.

Supervisor 4: Some are taking areas of specialization at master's level that does not entail therapy. For example I know of therapists who have gone to human resource management and gender studies.

Supervisors' responses indicate use of maladaptive coping strategies just like found in the responses of psychotherapists in this study.

CHAPTER FIVE
SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

This chapter gives summary of the research findings on prevalence of STS, its selected predictive factors and coping strategies among psychotherapists in Nakuru and Nairobi counties of Kenya. The chapter also includes conclusions, related recommendations derived from the conclusions and suggestions for further research.

5.2 Summary of the Research Findings

Based on the study objectives and data analysis, the following major research findings are presented:

i) Objective one on prevalence of STS: Study has established that a prevalence level of STS among psychotherapists is high. The research findings further revealed that avoidance symptoms of STS was the most prevalent, followed by intrusive symptoms then arousal symptoms. Nairobi County have prevalence of STS higher than Nakuru

ii) Objective two to compare the prevalence of STS among psychotherapists in the counties of Nairobi and Nakuru .This study established that there was no statistically significant difference in prevalence of STS among psychotherapists in Nairobi and Nakuru counties

iii) There were mixed results on predictive factors and how they contribute to STS. Some demographic factors were predictive of STS while others were not. Those predictive were age with respondents of 55+ years and 37-45 more vulnerable. Marital status was found to play a protective role against STS Psychotherapists who live with their partners have the opportunity to reduce their levels of STS by talking with their partners about their work. Those with less educational qualifications and less years of psychotherapy were more vulnerable to STS among the respondents .The study also found that females exhibited more trauma symptoms than men. Gender was however not predictive of STS. The respondents were majorly counselling psychologists and the psychotherapists dealt mainly with sexual trauma clients followed by domestic violence clients. Psychotherapists exposed to 0-10 hours of trauma work per week, those who see 0-5

client per day and those with monthly case load of 0-50 clients were vulnerable to STS. There were mixed results for empathy. There was a significant association between psychotherapists being able to recognize the pain of clients during therapy and being often quite touched by things that they see or hear happen to their clients and prevalence of STS.

A cross eight indicators of history of trauma only two were not predictive of STS; experiencing kidnapping prior to trauma and witnessing traumatic accident prior to trauma. The other six, experienced sexual trauma, experienced serious injury or threat of serious injury, experienced divorce or separation, experienced learning of traumatic event suffered by close friend, witnessed actual death, witnessed violence or threat with a weapon revealed no significant association with prevalence of STS. Across six indicators of personal life stressors only one; experienced death of significant person in life during trauma work had a significant association with prevalence of STS.

There was no significant association between STS prevalence and having experienced divorce and separation, financial difficulties, legal matters and experienced medical difficulties. Findings showed no statistically significant association between history of psychiatric symptoms and prevalence of STS. There were no statically significant association between therapists' unresolved trauma, receiving debriefing and receiving supervision and STS prevalence. There was however a significant association between receiving personal therapy and STS prevalence.

iv) Physical, emotional, professional and social supports were found to be both predictive and buffer against STS. Social support was offered mostly by workmates, friends and family. Psychotherapists using these coping strategies had mild to little or no STS. Organizational and maladaptive coping strategies are not predictive of STS nor are they buffer against STS. Those using them had high to severe STS. Maladaptive coping strategies are the most widely used strategy followed by physical strategies.

5.3 Conclusions

Based on the summary findings, the following conclusions are based on the specific objectives of the study:

i. STS is prevalent among psychotherapists in Nairobi and Nakuru counties. Findings of this research demonstrate high prevalence of STS.

ii. There is no association in prevalence of STS among psychotherapists practicing in Nairobi and those in Nakuru county.

iii. Some factors were predictive of STS while others were not. Exposure to STS ,empathy, history of trauma, personal life stressors, history of psychiatric symptoms and unresolved trauma yielded mixed results the study concluded that they are not predictive of STS. Personal therapy however is predictive of STS.

iv. Both adaptive coping strategies and maladaptive coping strategies are utilized by the psychotherapists in the event of traumatisation. The maladaptive coping strategies are the most utilized, followed by physical, social, organizational, professional and emotional coping strategies. Study concludes that adaptive coping strategies are associated with reducing the risk of STS while maladaptive coping is linked to greater risk of negative symptoms.

5.4 Recommendations

Based on the findings of the study the following recommendations were made.

i. The institutions, organizations, supervisors and Kenya Counselling and Psychological association overseeing psychotherapists working with trauma victims need to address the high prevalence of STS among them. Some of the ways in which they can be helped include:

   a) Encouraging them to seek quality supervision and diffusion from qualified supervisors and experienced therapists.

   b) Taking active preventative role by preparing therapist with resources they can turn to regarding STS.

   c) Encouraging networking to ensure best practice with regards to STS.

ii. Since age 25-30 years and age 41-50 years are indicated as vulnerable to STS. Special emphasis should be laid in addressing these age groups. In particular the professional associations, universities, organizations dealing with psychotherapists should establish mentoring programmes where young therapists are mentored by experienced therapists,

and the old therapists are monitored closely to ensure they do not get overwhelmed with traumatic clients and materials.

iii. Less experienced therapists suffered greatest distress. Increased peer to peer support, case conferencing and supervision from more experienced therapists seem particularly important.

iv. Periodic participation in training activities conferences, workshops and seminars may perform an important mediating function for trauma therapists and may be important for their professional and personal development.

v. Organizations and institutions that employ psychotherapists need to diversify their caseloads, limit the number of trauma clients seen to less than five per day and limiting working hours spent with trauma clients.

vi. There is need to recognize and acknowledge that exposure and therapies are important, inevitable resource for psychotherapists in the provision of therapy yet factors that make psychotherapists vulnerable to STS.

vii. Training institutions, professional associations and employers need to encourage psychotherapists to seek personal therapy to enable them deal with unresolved trauma and personal life stressors before and during trauma work.

viii. Encouraging therapists healthy activities such as eating right, getting enough sleep, going for medical check up, exercising, taking vacation and socializing with workmates, friends and family are and sense of spirituality and wellness important.

5.5 Suggestions for Further Research

There is need to conduct further research in the following areas:

(i) The benefits of maladaptive coping strategies in STS prevalence.

(ii) Continued research is still needed to address gaps, clarify role and to further investigate specific predictive factors of STS that have continued to give mixed results such as supervision, empathy and exposure.

(iii) Research institutes and universities need to encourage more research on STS, so that interventions can be clearly focused.

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APPENDICES

APPENDIX A: LETTER OF INTRODUCTION

Dear Respondent,

My name is Lilian Nyagaya and I am a Ph.D. student at Egerton University, currently conducting a research on Prevalence of Secondary Traumatic Stress, its selected predictive factors and Coping Strategies among psychotherapists in Nairobi and Nakuru counties of Kenya. You have been identified as a respondent in this study. Kindly provide the information that has been requested. Please do not indicate your name or your place of work. Any information given will be used for this study only and will be treated with utmost confidentiality. Thank you very much for your co-operation.

Yours sincerely

Lilian Nyagaya
Doctoral Candidate
Egerton University, Njoro

APPENDIX B: QUESTIONNAIRE FOR PSYCHOTHERAPISTS

Instructions: (Please tick where appropriate). If at anytime you wish to skip over a question or end the questionnaire completely, you are free to do so. Kindly give your honest response to each question.

SECTION A

1. Demographic information

1. Age: _____

2. Gender: Male ( ) Female ( )

3. Your relationship status:

(a) Married (c) Separated/divorced
(b) Single (d) Other *(Please Specify*)

4. Your highest education level completed: _____

5) Your profession:

i. Counselling Psychologist
ii. Psychiatrist
iii. Clinical Psychologists
iv. Psychologists
Other: _____

6). Years counselling experience-

i. Five years or less
ii. 10years or less
iii. 11-15 years
iv. 15-20 years
v. 20+ years

7) County where you practice from _____

SECTION B

2. Predictive Factors of Secondary Traumatic Stress

The following are selected predictive factors of secondary traumatic stress. Please fill in the gaps or tick where appropriate.

A. Exposure to traumatic material/Professional experience
(Please fill in the gaps)

i) Number of hours per week do you spend doing therapy with trauma clients_____
ii) Number of clients seen per day _____
iii) Monthly average caseload that includes trauma clients: _____
iv) Type of trauma's you have dealt with in the past 3 months _____

(Please tick and answer the question where appropriate)

No	Item	Yes	No
B	**Empathy**		
i.	I try to understand my clients better by imaging how things look form their perspective		
ii.	I am able to recognize the pain of clients during therapy		
iii.	I am often quite touched by the things that I see or hear happen to my clients		
iv.	I convey genuineness, unconditional positive regard and respect to trauma clients		
v.	I am motivated to respond to my clients		
C	**History of trauma** (Please tick if you have experienced any of these traumas prior to trauma work)		
i.	Experienced sexual trauma		
ii.	Kidnapping		
iii.	Serious injuring/ threat of serious injury		
iv.	Divorced or separated		
v.	Learning of a traumatic event suffered by close friend/relative		
vi.	Witnessed threat of death		
vii.	Witnessed actual death		

viii.	Experienced natural disaster		
ix.	Witnessed traumatic accident		
x.	Witnessing violence		
xi.	Witnessed torture or threat with a weapon		
xii.	Other trauma(indicate)		
D	**Personal life stressors(please tick if experienced any of these during trauma work**		
i.	Divorce or separated		
ii.	Sexual trauma		
iii.	Financial difficulties		
iv.	Legal matters		
v.	Medical difficulties		
vi.	Death of significant person in your life		
vii.	Other trauma (indicate)		
E	**History of psychiatric symptoms**		
i.	I have a history of psychological disorder		
ii.	A member of my family is/ has suffered a psychological disorder		
F	**Unresolved personal trauma**		
i.	Do you receive Debriefing sessions		
ii.	Do you receive supervision sessions		
iii.	Do you attend personal therapy sessions		
iv.	If no, in what ways do you think you would benefit from? a)Debriefing_____- _____ b)Supervision_____ _____ c) Personal therapy _____		

SECTION C

3. Coping Strategies employed by psychotherapists

The following are coping strategies likely to be employed by psychotherapists in the event of Secondary Traumatisation. Please indicate the appropriate response for the coping strategy that you employ by ticking the appropriate space

Always=1, Often=2, Occasionally=3, Never =4

A	**Personal coping strategies**	1	2	3	4
	physical strategies				
i.	I engage in physical exercises as a coping strategy				
ii.	I go for medical check up				
iii.	I engage in healthy activities i.e. eating right, get enough sleep, spend time with friends, use humour				
	Emotional self care-Spirituality				
i.	I have connection with an organized religion				
ii. ‘	I engage in meditation				
iii.	I engage in community service				
iv.	I Write in a journal				
v.	I Engage in spiritual practice (prayer				
	Social support				
i.	I have received inclusion support such as Interacting with workmates, significant others, friends, having quiet time with a confidant				
ii.	Appraisal support in terms of help with decision making				
iii.	I have received Emotional support in terms of reassurance, acceptance, love, trust and intimacy				
iv.	I received Instrumental support in terms of help to correctly assign blame, distortions and credit more objectively Who offers social support to you (please indicate) _____				
B	**Professional coping strategies**				
i.	I go for debriefing				

ii.	I go for supervision and consultation				
iii.	I go for personal therapy				
iv.	I get quality feedback on individual performance				
v.	I resource myself through seminars, conferences, trainings etc				
vi.	I remain aware of sense of mastery (practices that renew cherished sense of identity beyond that of trauma therapists)				
vii.	I establish a balanced work life				
C	**Organizational coping strategies**				
I.	My physical setting is spacious, private, and comfortable.				
ii.	Adequate resources are provide				
	I take vacation/leave from work when need arises.				
iii.	An atmosphere of respect is available at my work place (feeling valued or devalued)				
D	**Maladaptive coping strategies**				
I.	Increased use-or abuse of alcohol , coffee or drugs to relieve stress				
ii.	Temptation to make hasty major life decisions				
iii.	Completely avoiding any feelings or thoughts about the event				
Iv	Not speaking up about the trauma incident or event				
V	A compulsion to work more than usual				

APPENDIX C: SECONDARY TRAUMATIC STRESS SCALE FOR PSYCHOTHERAPISTS

Consider each of the following characteristics about you and your current situation. Please tick the number for the best response. Use one of the following answers:

Never =1, Rarely =2, Occasionally=3, Often =4, Very Often=5

		1	2	3	4	5
	Intrusive symptoms					
1.	My heart starts pounding when I think/thought about my work with clients					
2.	It seemed as if I relive the trauma(s) experienced by my client(s) everyday					
3.	Reminders of my work with trauma clients upset me.					
4.	I thought/think about my work with trauma clients when I did not intend to.					
5.	I had/have disturbing dreams about my work with trauma clients.					
	Avoidance symptoms					
6.	I felt/feel emotionally numb after dealing with trauma clients					
7.	I felt/feel discouraged about the future when exposed to internal and external cues or reminders of the traumatic event					
8.	I had/have little interest in being around others after therapy with traumatic clients					
9.	I became/become less active than usual after therapy with traumatic clients					
10.	I avoided/avoid people, places, or things that reminded me of my work with trauma clients.					
11.	I avoided/avoid working with some clients after dealing with trauma cases					
12.	I noticed/noticed gaps in my memory about client sessions after dealing with trauma cases.					
	Arousal symptoms					
13.	I had/have trouble sleeping after dealing with trauma victims					
14.	I felt/feel jumpy after dealing with trauma clients					
15.	I had/have trouble concentrating on any work after dealing with trauma victims/clients					
16.	I got/get easily annoyed after dealing with trauma victims					
17.	I expected/expect something bad to happen when exposed to internal and external cues or reminders of the traumatic event					

Source 2004, Brian E. Bride.

APPENDIX D: INTERVIEW SCHEDULE FOR SUPERVISORS

The information you give in this interview schedule will be treated with strict confidentiality. Please give your honest response to each of the questions provide.

Prevalence of Secondary Traumatic Stress

1 a) Do you deal with supervisees (psychotherapists) who deal with traumatic materials and clients?

b) Do the supervisees you see present with secondary traumatic stress related symptoms such as reexperiencing of the trauma. Avoidance/ numbing of the trauma and arousal symptoms?

c) Mention some of the cognitive shifts and relational disturbance symptoms that you see the Psychotherapists displaying

Predictive Factors of Secondary Traumatic Stress

2) How do the following selected predictive factors contribute to STS among supervisees? that you supervise

a) Empathy
b) History of trauma
c) Personal life stressors
d) History of psychiatric symptoms
e) Unresolved personal trauma

Coping Strategies Employed by Psychotherapists in the Event of Traumatisation

3) What coping strategies do they employ in the event of secondary traumatisation?