Secondary Traumatic Stress in Canadian School Counsellors:

Presence and Predictions

by

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Abstract

A non-experimental survey design was used to study participant self-identified presence of secondary traumatic stress (STS) in Canadian school counsellors ($N = 57$) in relation to counsellors' education and training, trauma-specific training, work experience, supervision, number of trauma clients and coping strategies. Counsellors were not necessarily protected from STS if they spent time using coping strategies, but were much less likely to be affected by STS if they engaged in supervision. Many of the school counsellors (59.6%) who participated in this research do engage in supervision, and those with trauma-specific training were less likely to have a peer-identified trauma disorder. Peer-identified trauma disorder played a large role in the results of the study. If peers identified the participant as suffering from a trauma disorder, they were very likely to have a formal trauma diagnosis and were also likely to have higher traumatic stress scores. Finally, counsellors in the high STQ group who were identified by their peers as being affected by a trauma disorder were also likely to have a high number of trauma survivors on their caseload. Implications for future research and education and training are discussed.

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Chapter I: Introduction

Throughout the history of humankind the role of the counsellor has existed informally across many different cultures, as individuals received reassurance and counsel through a variety of historical figures such as priestesses and priests, healers, shamans, medicine men, elders and other religious and political figures. Many of these figures predate the modern world. For example, from about the late 4th century BC to the 4th century AD, philosophers and physicians from the Hellenistic schools of philosophy and therapy practiced psychotherapy among the Greeks and Romans (Feltham, 1997). Counsellors known as *mantrakis* existed in early medieval India in the year 1055 AD (Singh, 2008). Similarly, early Asian and Aboriginal cultures reference the role of the Shaman as advisors and counsellors (Hallowell, 1992, Robinson & Johnson, 1997). Counsellors in their most primitive form evolved over the centuries to the progenitors of modern psychological therapeutic approaches such as Behaviourism, Psychoanalysis, Cognitivism, and Humanism, to name a few.

In spite of the lengthy existence of the field of counselling and psychotherapy, prior to the 1980's very little research and discussion was available about the adverse effects that providing counselling might have on counsellors themselves. It appeared to be a common misperception that counsellors were immune to the emotional difficulties their clients were dealing with. This was in spite of the development of theories such as humanistic psychotherapy that allowed the counsellor to act less as the all-knowing professional, and more as facilitator to their clients' own self-actualizing abilities while focusing on the therapeutic relationship. More recently concerns about counsellors' stress

have come to the forefront of many discussions in the field of counselling, resulting in a growing body of literature and research.

The Therapeutic Relationship: A Vehicle for Counsellors' Potential Secondary Traumatic Stress Exposure

The formation of a therapeutic relationship, the context in which healing of trauma occurs (Pearlman & Saakvitne, 1995), can potentially produce negative effects in the counsellor. In general, counsellors who treat trauma survivors are at greater risk of acquiring traumatic responses themselves (McCann & Pearlman, 1990). This phenomenon is commonly referred to as Secondary Traumatic Stress (STS). STS is considered to best describe the post-traumatic condition experienced by those who are exposed to traumatic events through their close emotional interactions with trauma survivors, and was the focus of this study.

Secondary traumatic stress theory has garnered considerable interest from researchers and service providers since the term was first introduced by Figley (1995). STS is thought to occur when the stress encountered is initiated by the accumulation of experiences across a variety of situations directly related to the treatment of survivors of trauma (Figley, 1995; O'Halloren & Linton, 2000) and is not attributed to some other related concept or factor. Figley (1995) further defines the term as experiencing stress associated from knowing about a significant others' traumatizing event, while helping or wanting to help the trauma survivor. The signs and symptoms associated with STS have come to be widely recognized and accepted in the mental health field.

STS consists of a set of symptoms that parallel those of Posttraumatic Stress Disorder (PTSD) (Bober & Regehr, 2006). The Diagnostic and Statistical Manual of Mental Disorders, fourth edition (DSM-IV) defines PTSD as the development of symptoms of stress following exposure to an extreme traumatic stressor involving direct personal experience that may involve actual or threatened death or serious injury, or threat to one's physical integrity (American Psychiatric Association [APA], 2000). Other traumatic stressors which may produce the development of PTSD include: witnessing an event that involves death, injury, or a threat to another person's physical integrity; learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or close associate (APA, 2000).

The DSM-IV further states that an individual's response to the traumatic stressor must consist of intense fear, horror or helplessness, and their symptoms should include persistent reexperiencing of the traumatic event through recurrent and intrusive recollections, dreams or flashbacks; persistent symptoms of increased arousal such as difficulty falling or staying asleep, hypervigilance and exaggerated startle response; persistent avoidance of stimuli associated with the trauma such as deliberate avoidance of thoughts, feelings, conversations, activities, situations, or people who arouse recollections of the event; and numbing of general psychic and emotional responsiveness characterized as diminished responsiveness to the external world, diminished interest or participation in previously enjoyed activities, feeling detached or estranged from other people, noticeably reduced ability to feel emotions with emphasis on those associated with tenderness, intimacy, and sexuality (APA, 2000).

STS responses are closely associated with those of PTSD, and may include intrusive thoughts and imagery, emotional numbing and avoidance behaviours, hyper-arousal symptoms, alcohol abuse, somatisation and physical problems similar to those experienced by direct trauma survivors (Palm, Polusny & Follette, 2004; Schauben & Frazier, 1995). The primary difference between PTSD and STS appears to be the position of the stressor. In PTSD, the primary stressor may directly harm or threaten the individual, and in STS, the secondary traumatic stressor is the traumatised individual (Figley, 1995). It appears that in the therapeutic relationship, the client may act as the secondary traumatic stressor to the counsellor and the therapeutic relationship is the vehicle through which they can become secondarily traumatized.

Counsellors Need Protection

There are a number of reasons offered in recent literature explaining why counselling trauma survivors is especially demanding, resulting in the necessity for counsellors to engage in coping strategies and self-care in order to protect themselves. Conversely, strategies that trauma survivors engage in to support themselves (which may have allowed that person to survive at a time when there were no other means available) may include: self-harm, suicidal behaviour, aggressive behaviour, and anti-social behaviours (Etherington, 2009). These strategies in and of themselves can be quite negative, cause additional problems, traumatize that person further (Etherington, 2009), and can make counselling survivors of trauma especially difficult.

Pearlman and Saakvitne (1995) further outline reasons why providing service for trauma survivors places special demands on the counsellor: (1) In order to help survivors

with their trauma, counsellors cannot protect themselves from the reality that traumatic events are a very real part of society and of the larger world. While the counsellor listens to graphic stories of trauma on a regular basis, such as sexual abuse, both their professional and personal world view can be powerfully shifted and altered; (2) Awareness of the potential for trauma in their own lives is inevitable, as the presence of the trauma survivor in the counselling session is an inescapable reminder that the counsellor's life could be permanently altered in a moment; (3) For the counsellors who have survived a traumatic event, their personal experience of pain can be reopened by the client's own exploration of their survival of trauma; (4) Clients who survived trauma at the hands of primary caregivers tend to have a highly developed sense of mistrust, and powerful emotional needs that are extremely difficult to treat. It is common for these clients to unconsciously reenact earlier abusive, painful, and demeaning relationships, both within and outside the therapy relationship; (5) The counsellor may be cast into malevolent, dangerous, or exploitative roles through the trauma survivor's reenactments or projections of expectations of harm or abuse learned in that client's earlier relationships. This can affect the counsellor's ability to maintain the level of therapeutic engagement, as they are attempting to protect their identity and sense of self; (6) As a counsellor to trauma survivors, it is inevitable that disclosure of traumatic experiences will be revealed, making the counsellor a witness to past troubling and disturbing events, and possibly secondarily traumatized. The factors outlined above clearly demonstrate that the client can act as the secondary traumatic stressor, inadvertently putting counsellors at risk of being affected by those clients' material. It is equally important to establish *which* population of counsellors is most likely to be affected.

Counsellors Who Need Protection

Arvay and Uhlemann (1996) identified a profile of "impaired counsellors" which they described as having high trauma scores on all measures studied. Their profile for a counsellor at high risk of STS includes less than a masters degree level of training, employment in a community agency, less than ten years' experience, treatment of a high number of trauma clients on their caseload, feeling they have a very intensive caseload, feeling affected by their clients' traumatic material, and having a reliance on non-professional and personal supports rather than clinical supervision or personal therapy. STS can affect counsellors and others working with any traumatized population (Pearlman & Saakvitne, 1995). It is clear that counsellors in general are at risk of acquiring STS. In light of this, it would be imperative to examine counsellors exposed to trauma who share the profile of an at-risk counsellor as outlined above.

School Counsellors are at Risk

One group of counsellors that have not garnered as much attention in STS literature as other professionals, such as community counsellors and trauma counsellors, is the school counsellor. There are a number of situations that students may encounter which could expose school counsellors to direct or indirect personal trauma, such as immigration from war torn countries, transgenerational effects of colonization, increasing numbers of reported child abuse, child sexual abuse, and poverty. For example, Statistics Canada (2005) has tracked the occurrence of family violence in order to monitor trends over time. The survey results demonstrate that within the 61% of the national volume of crime in 2003, children and youth under the age of 18 represented approximately 21% of

Canada's population, and accounted for 21% of physical assaults. Furthermore, these children and youth under the age of 18 represented a disproportionately high number of victims of sexual assault (61%). Females were over represented in this category, being victims in approximately 8 out of 10 sexual assaults (Statistics Canada, 2005). Children in the school population tend to reflect the statistics of the overall population, providing evidence that school counselors are in the position to have trauma-related stories disclosed to them.

Another factor to consider is the increasing presence of refugees. The New Canadian Children and Youth Study (NCCYS) conducted by Beiser et al., (2008) looked at more than 4,000 immigrant and refugee children living in six Canadian cities: Toronto, Montreal, Winnipeg, Edmonton, Calgary and Vancouver. These children are being followed longitudinally in order to investigate their welfare, and how they are adapting to their new surroundings. According to Beiser et al. of the approximately 340,000 children who entered Canada between 1992 and 1998, 25% (roughly 75,000) came as refugees. Similarly, they also report that of the 200,000 to 250,000 people who come to live in Canada; approximately 50,000 to 60,000 are children below the age of 15, many of which have had turbulent past lives. Furthermore, poverty is a serious threat to a child's health and wellness. Recent studies have shown that overall, 13% of Canadian children and more than 30% of immigrant children live in poor, unstable, and sometimes dangerous environments (Beiser et al., 2008).

Colonization is another trauma related issue that has garnered more recent attention. More specifically, the transgenerational effects of the residential school system ripple down throughout the generations to the Aboriginal school children today. These

residual effects of residential school traumas amongst Aboriginal Canadians are extensively discussed in current documentation (Anderson, 2003; McKenzie, Blackstock, Trocmé & Bennett, 2004; Seidl & Bone, 1995). Some of the effects of colonization include low rates of educational success, markedly high rates of poverty, incarceration, unemployment, alcoholism, family breakdown, suicide and sexual abuse (Anderson, 2003). Awareness of the cross-generational vagaries of colonization has increased in recent times initiating further investigation into these issues (Anderson, 2003).

Research has revealed that Aboriginal youths were split evenly on whether they would prefer to talk to counsellors within their community who understand their culture, or counsellors outside their community, where they may have more anonymity (McKenzie et al., 1995). The school counsellor, an individual outside their community, with known confidentiality requirements, may then be a likely candidate from whom these students will seek support. While the majority of students in the Canadian school system have access to counsellors in one form or another, some such as Aboriginal children from small communities and reserves do not.

In light of the literature presented above, it appears that school counsellors are also likely as other counselling populations to encounter clients who have faced traumatic circumstances in their young lives. The question that now needs to be asked is, "Do school counsellors experience STS?" School counsellors will need to be surveyed in order to see if they are exposed to STS and to determine if they share the profile of an at-risk counsellor as outlined by Arvay and Uhlemann (1996) reviewed previously. A review of the literature and research conducted on this population will be presented and discussed to determine how best to examine counsellors' STS.

The aim of this survey research was to reveal if counsellors in Canadian school divisions were exposed to and affected by STS. In order to determine this, participants were asked to complete a Secondary Trauma Questionnaire (STQ) developed to assess STS across both therapist and non-therapist populations who have had extended contact with trauma survivors (Motta, Kefer, Hertz, & Hafeez, 1999). Participants were also asked to complete a Coping Strategies Inventory (CSI) to explore strategies counsellors engage in to protect themselves from STS (Bober & Regehr, 2006). A more detailed description of these measures can be found in the methodology section of this report (see Chapter III).

This study also surveyed school counsellors across Canada and collected demographic information that was reflected in Arvay and Uhlemann's outline of an at-risk counsellor as well as other areas suggested in the literature to be possible sources of counsellor stress. Variables surveyed included gender, age, area of specialization, years of work experience as a school counsellor, credit hours in counsellor training obtained, level of education obtained, trauma-specific training, type of professional membership, overall student population, number of clients on a caseload, number of trauma survivors on a caseload, and clients' type of presenting issue. These variables will be discussed in further detail in the literature review portion of this report (see Chapter II).

Chapter II: Literature Review

Who Does STS Affect? – A Review

In the past two decades, research on STS has increased in volume and focused on individuals in the helping profession such as social workers, community and agency counsellors, therapists, psychiatric nurses, psychiatrists and psychologists. A majority of research before that concentrated on those individuals most likely to be exposed to trauma such as Armed Forces Personnel and their spouses (Ben Arzi, Solomon & Dekel 2000; Figley, 1987; Nelson & Wright, 1996), first-response trauma workers such as military medical personnel (Baker & Armfield, 1996), emergency service personnel, disaster and trauma workers (Palm, Polusny & Follette, 2004), community based counsellors (Arvay & Uhlemann, 1996; Dunkley & Whelan, 2006b), child protective service workers (Cornille & Woodard Meyers, 1999; Dane, 2000) and volunteer helpers (Dunkley & Whelan, 2006b).

Theoretically, counsellors who form relationships with survivors of trauma are considered to be at higher risk of the impact of exposure to trauma than the general population. Recently, concern has emerged for the well-being of the people who act as professional support service providers for those who are the primary trauma survivors (Arnold et al., 2005; Arvay, 2001; Arvay, & Uhlemann 1996; Brady, Guy, Poelstra & Fletcher Brokaw, 1999; Collins & Long 2003; Dunkley & Whelan 2006a; Figley 1995; Munroe, Shay, Fisher, Makary, Rapperport & Zimmering, 1995; Schauben & Frazier 1995; Suozzi & Motta 2004).

Arvay and Uhlemann (1996) profiled counsellors who are at high-risk of STS and determined that factors such as, less than a masters degree level of training, employment in a community agency, less than ten years' experience, treatment of a high number of trauma clients on their caseload, feeling they have a very intensive caseload, feeling affected by their clients' traumatic material, and relying on non-professional and personal supports rather than clinical supervision or personal therapy may contribute to possible STS exposure (Arvay & Uhlemann, 1996). It may be noteworthy that the researchers did not weight their list of factors that contribute to a counsellor at-risk, but did note that despite research results, the findings of this study reported correlations among data (rather than confirmation of causal relationships). In light of this, it would be imperative to examine counsellors exposed to trauma who share the profile of an at-risk counsellor as outlined above (Arvay & Uhlemann, 1996).

School counsellors are one group of professionals who provide services to primary trauma survivors and as previously reviewed, there are a number of situations that their students may encounter which could expose them to direct or indirect personal trauma, such as immigration from war torn countries, transgenerational effects of colonization, increasing numbers of reported child abuse, child sexual abuse, and poverty.

STS: Related Terms & Concepts

McCann and Pearlman (1990) coined the term "vicarious traumatisation" which refers to the cumulative negative and transformative changes in the counsellor from providing help to survivors of traumatic life events (as cited in Arvay, 2001). In contrast, "secondary traumatisation" is used to describe not only the effects of providing service to

trauma survivors upon mental health professionals, but also the impact on friends and family members whose lives are closely connected with a survivor of trauma (Arvay, 2001). Despite these slight contrasts, Arvay notes, "In my opinion, both terms refer to the same phenomenon" (2001, 285).

Collins and Long (2003) note that descriptions for terms 'compassionate fatigue' and 'secondary traumatic stress' can be synthesized, demonstrating they can be used interchangeably. Similarly, Figley (1995) prefers the term compassion fatigue to STS, and states it is a natural consequence of working with trauma survivors' experiences of extremely stressful events, while at the same time engaging empathically with their clients. In light of the literature reviewed above, STS, vicarious traumatisation and compassion fatigue will be subsumed under the title "STS" for the purposes of this research study.

McCann and Pearlman (1990) note that prolonged exposure to a client's traumatic material can cause disruptions in cognitive schemas, such as their world view, and is expressed by changes in dependence/trust, chronic suspicion of others, and changes in safety to a heightened sense of vulnerability; disruptions in self-identity such as changes in independence, to a sense of loss of personal control and freedom and changes in power to an extreme sense of helplessness; and disruptions in general psychological functioning. The acquisition of these trauma responses can lead to a disruption in the individuals' sense of safety in the world and benevolence of the world, as well as their feelings of personal vulnerability and powerlessness (Arnold, Calhoun, Tedeschi & Cann, 2005; Janoff-Bulman, 1992; as cited in Palm et al., 2004). This is problematic because it

challenges the basic core levels of safety and trust for those confronting the effects of STS.

In order to understand this phenomenon more completely it will be helpful to review other related concepts such as "identification", "enmeshment", "transference", "countertransference" and "burnout". The therapeutic relationship between a counsellor and a client at times can result in identification and enmeshment. In general, identification is the incorporation of the qualities of another person into one's personality, and enmeshment occurs when the boundaries between two parties are excessively weak, and there is a low level of individual differentiation and autonomy (Colapinto, 1991). Identification and enmeshment with the client generally interferes with the therapeutic process by causing difficulties around setting limits and boundaries (Sanderson, 2006).

Transference and countertransference can also be initiated by the therapeutic relationship. Transference is generally considered to be a clients' reenactment of feelings and behaviours from other relationships with his or her counsellor (Osachuk & Cairns, 1995). Countertransference refers to the counsellor's response to the client's transference in a way that reinforces the client's inappropriate responses to others, and is often associated with the counsellor's own issues (Osachuk & Cairns, 1995). An important indicator of countertransference is strong feelings toward a particular client (Martin, 2000) and involves a counsellor's conscious or unconscious irrational attachment to or anger at the client (Hamilton, 2008). While countertransference may in some ways mirror STS, it is a separate concept as it is temporary and specific to a particular client in a specific interaction. In contrast, STS results from an accumulation of experiences that affects the therapist both professionally and personally (Hamilton, 2008).

Counsellors may also experience burnout as a result of the formation of a therapeutic relationship. Burnout refers to a state of physical, mental and emotional exhaustion or dissatisfaction with one's work situation (Hamilton, 2008). Valent (2002) points out that burnout typically appears gradually as a result of working with inadequate resources, long-term involvement with emotionally draining situations and may involve frustration with coworkers, supervisors or work situations (as cited in Hamilton, 2008). Personal frustration, inadequate or impaired coping skills (Everall & Paulson, 2004), and a negative internal psychological state (Norcross, 2000) are other signs of burnout. Arvay (2001) notes that STS literature demonstrates a consensus that burnout is a distinct construct from STS. Where burnout can occur gradually, and by working with any type of client group, STS results from hearing shocking, emotionally charged material from clients (Schauben & Frazier, 1995).

Risk and Protection: Strategies for Reducing Counsellor STS:

The signs and symptoms associated with STS have come to be widely recognized and accepted in the mental health field. What is less understood are the protective factors that can help alleviate the impact of STS in mental health professionals. In order to identify how best to protect mental health professionals, it will be helpful to identify which of these professionals are most likely at risk of the impact of STS.

Counsellors at risk:

Research has revealed a number of factors that may expose counsellors to the possibility of developing STS including the profile of an at-risk counsellor described earlier (Arvay & Uhlemann, 1996). For example, researchers and theorists have studied the percentage of trauma clients on a helper's caseload (Arvay & Uhlemann, 1996; Bober

& Regehr, 2006; Brady et al., 1999; Dunkley & Whelan, 2006b; Ortlepp & Friedman, 2002; Schauben & Frazier, 1995). Brady et al. (1999) conducted a national survey of women psychotherapists ($n = 1000$) and indicated that participants with higher levels of exposure to sexual abuse material reported significantly more trauma symptoms but did not display significant disruptions of cognitive schemas. Schauben and Frazier (1995) surveyed women psychologists and sexual violence counsellors ($n = 148$) and found that participants' symptomatology was related to the percentage of sexual violence survivors on their caseload, but not their own personal history of sexual victimization.

Personal trauma histories (Bober & Regehr, 2006; Brady et al., 1999; Dunkley & Whelan, 2006b.; Ortlepp & Friedman, 2002; Pearlman & Mac Ian, 1995) have been examined and debated in the literature. For example, some research indicates that counsellors with personal trauma histories are more likely to experience STS and its symptoms (Arvay & Uhlemann, 1996; Dunkley & Whelan, 2006b; Pearlman & Mac Ian, 1995). In a study of self-identified trauma counsellors ($n = 188$), Pearlman and Mac Ian found that participants with a personal trauma history showed more negative effects than those without a personal history of trauma (1995). However, these results contradict Schauben and Frazier's (1995) findings that counsellors with a history of trauma are *not* more distressed about seeing trauma clients than counsellors without a history of trauma. The study revealed that participants' symptomatology is not related to their own history of sexual victimization, but is related to the percentage of sexual violence survivors they counsel (Schauben & Frazier, 1995). Similarly, Ortlepp and Friedman (2002) found that both previous work and non-work related trauma was not significantly related to participants' level of STS.

The helper's level of experience has also been noted to affect the impact of STS (Adams & Riggs, 2008; Arvay & Uhlemann, 1996; Bober & Regehr, 2006; Pearlman & Mac Ian, 1995). For example, those with the least amount of experience in the field of trauma were found to be more likely to report traumatic stress (Arvay & Uhlemann, 1996). Trauma therapists who were the newest to the field of trauma counselling reported the most psychological difficulties (Adams & Riggs, 2008; Pearlman & Mac Ian, 1995). Arvay and Uhlemann (1996) suggest that inexperienced counsellors may be less knowledgeable about the difficulties of working with traumatized clients, and how to protect themselves.

Strategies for Reducing Counsellor STS: Protective Factors:

Coping strategies are another factor thought to affect the incidence of STS in counsellors (Arvay & Uhlemann, 1996; Bober & Regehr, 2006; Dunkley & Whelan, 2006b; Schauben & Frazier, 1995). Schauben and Frazier (1995) state the five most common coping strategies revealed in their study were: active coping (make efforts to do something about the problem), emotional support (talking with friends and family), planning (making a plan of action), instrumental support (seeking advice from co-workers and supervisors), and humour (laughing about the situation). These strategies were all associated with lower levels of STS symptoms. Getting exercise (61%), taking walks (33%), and obtaining support from friends (26%) or peers (24%) were the most commonly reported coping strategies in Arvay and Uhlemann's (1996) research. Only 10% of the participants reported that they sought personal therapy and only 1% obtained supervision as a means for self-care (Arvay & Uhlemann, 1996). It is unclear if the previous research results are due to intrinsic factors attributed to the counsellor, or if

supervision was not readily available to those counsellors.

Current research has revealed a deviation between counsellors' general beliefs about coping strategies in relation to the reduction of the impact of STS. Bober and Regehr (2006) studied participants who specialized in work with victims of violence and assessed whether or not participants believed in the strategies recommended for reducing STS, whether they engage in the recommended activities, and if doing so resulted in lower levels of STS.

The results of Bober and Regehr's (2006) research demonstrate a general belief in recommended strategies for reducing STS such as leisure activities, self-care activities, research and development, and supervision. However, managers and supervisors were more likely to believe in the benefits of supervision for reducing trauma than other counsellors, and were much more likely to dedicate time to engaging in supervision. No association was found between time allotted for supervision and counsellors' traumatic stress scores. Study results also revealed no evidence for using recommended coping strategies to protect against symptoms of acute distress and that hours per week spent working with traumatized people is the primary predictor of trauma scores, which is also consistent with both Ortlepp and Friedman (2002), and Schauben and Frazier's (1995) results. Considering these findings, the researchers recommend that organizations use a structural solution, instead of an individual solution, by reducing the degree to which counsellors' caseloads include trauma affected clients (Bober & Regehr, 2006; Ortlepp & Friedman, 2002).

Supervision has been identified as a coping strategy or as part of a counsellors' self-care in the STS literature as noted above (Arvay & Uhlemann, 1996; Bober &

Regehr, 2006; Christianson & Everall, 2008; Etherington, 2009; Pearlman & Saakvitne, 1995). It may be more useful however, to view supervision as not only a coping strategy, but also as a factor that stands alone as a protective influence against the impact of STS in counsellors, as the absence of appropriate supervision is suggested to increase the occurrence and intensity of STS (Arvay & Uhlemann, 1996; Dunkley & Whelan, 2006b; Pearlman & Mac Ian, 1995), despite research showing that supervision time did not help.

Etherington (2009) notes that even though there are those who might question the efficacy, usefulness and value of supervision, there appears to be a growing awareness of its value for counsellors working with trauma survivors. Supervision may occur in a variety of therapeutic settings and across a range of disciplines such as: "counsellors working with specialist-agencies that offer free, long term counselling for people who have been abused; counsellors working with people with disabilities, many of whom tell stories of historic and current abuse; teachers who are also counsellors and working therapeutically with abused children in schools and community contexts; victim liaison officers who work for the Probation Service supporting victims of serious crime such as rape, sexual abuse and murder; researchers working with issues of trauma and abuse; counsellors who work in general practice where time limited counselling creates its own difficulties; organizational counsellors who are dealing with workplace bullying and victimization; and with counsellors in private practice" (180).

Not all research supports the notion that supervision can play a mediating role in counsellors' STS. Dunkley and Whelan (2006b) examined a group of counsellors who had not been previously studied (telephone counsellors) to investigate the impact of STS and whether supervision has any protective influence. Dunkley and Whelan (2006b)

argue that much of the research on trauma has been done with face to face counsellors, and the need to study professionals working with a range of trauma clients in a variety of settings (such as telephone counselling and crisis hot lines) is justified, as they play an important role in this era of mental health services.

Dunkley and Whelan (2006b) hypothesized that participants would have higher levels of STS if they did not receive supervision, and those who did receive supervision would have lower levels if they perceived themselves as having a strong working alliance with their supervisor. The study also predicted that telephone counsellors who had a personal history of trauma would have higher levels of STS. About one quarter (27%) of the participants did not receive supervision and results of the study did not support the hypothesis that engaging in supervision would reveal lower STS levels, which is consistent with Bober and Regehr's (2006) results. Study results also provided evidence that a strong working alliance with one's supervisor was not correlated to PTSD symptoms, but did help to reduce disruptions in cognitive schemas, an expression of vicarious traumatisation (Dunkley & Whelan, 2006b).

Results of Dunkley and Whelan's (2006b) research should be taken with some reservation. Despite substantial variation in participants' descriptions of the types of supervision received, only a single item in the study measured whether or not participants received supervision (Dunkley & Whelan, 2006b). This may be problematic as the duration, intensity and frequency of participants' supervision is unknown. Therefore, the data may be skewed in favour of participants receiving supervision, when in fact they may not have received sufficient or appropriate supervision to protect them from the effects of STS. Furthermore, results of this study revealed low to average scores on the

vicarious traumatisation measures. This may be due to the fact that the instruments used in this study were designed to measure 'first-hand trauma', while the study proposed to measure 'second-hand trauma'. The low to average scores on vicarious traumatisation measures may mean that counsellors' stress was not substantial enough to be measured as primary trauma. Analysis also revealed the instruments were not correlated, signifying that two different constructs are being evaluated, an indication that validity may be questionable (Dunkley & Whelan, 2006b).

While empirical literature investigating the benefits of supervision are undeniably lacking, researchers and theorists strongly recommend that trainees and practicing therapists receive regular supervision (Arvay, 2001; Cerney, 1995; Hamilton, 2008; Pearlman & Mac Ian, 1995; Pearlman & Saakvitne, 1995; Schauben & Frazier, 1995). Sommer (2008) further comments that supervision practices that actively address STS have been strongly encouraged but are not always described in detail. Pearlman and Saakvitne (1995) generated some guidelines for trauma sensitive supervision which include four components: 1) A strong theoretical grounding in trauma therapy; 2) Attention to both the conscious and unconscious aspects of treatment; 3) A mutually respectful interpersonal climate and; 4) Educational components that directly address vicarious traumatization.

Trauma-therapy supervision needs to provide an atmosphere where the counsellor can discuss specific aspects of case management issues, case material, the therapeutic relationship, countertransference issues, and secondary traumatization (Pearlman & Saakvitne, 1995). The development of a trusting relationship between the counsellor and the supervisor over time is essential in order to serve as a model for the psychotherapy

relationship, as is the need to be alert to evidence of secondary traumatization in the supervisee (Pearlman & Saakvitne, 1995). Those who do not understand trauma issues can put both the clients and themselves at risk of harm. "Clients who have been abused in childhood, are extremely vulnerable to re-injury by therapists who do not understand their own responses to these clients" (Pearlman & Saakvitne, 1995, 2).

The types of supervision counsellors receive may vary depending on the need and circumstance of the supervisee, as well as the availability of supervision itself. Cerney (1995) notes that by seeking regular supervision or consultation much of STS can be avoided or its effects ameliorated. The supervisory process can help correct overidentification with the client, detect blind spots, analyze and understand the counsellor's overinvolvement or overextension, as well as evaluate and discuss alternative treatment procedures (Cerney, 1995). This type of case supervision is quite common, as is personal (one-on-one) supervision. Group supervision can also occur when working with trauma survivors and can be quite helpful. Group members can gain insight into their own cases, helping them to avoid countertransference clouding by listening to how other members handled a particular case. Also, group members often report that they gain insight into their own cases as they present them to the group (Cerney, 1995).

Pearlman and Saakvitne (1995) point out that supervision groups can come together within an organization, as at staff case conferences or clinical staff meetings, and that it is important to be mindful of the different roles and relationships that group members may have with one another. For example, supervisor/supervisee, staff/director, colleague/friend. As a result of these possible dual relationships, it is important to

normalize STS by formalizing the discussion about STS and countertransference in order to make group members feel safe enough to address these issues (Pearlman & Saakvitne, 1995). Regardless if it is a supervisor-directed or peer-directed supervision group, it is essential to be aware that group members may feel exposed and shamed while sharing their feelings. Supportive intervention in a way that normalizes their feelings and restores their connection to themselves and the group is required in such cases (Pearlman & Saakvitne, 1995).

Crutchfield and Borders (1997) looked at a peer-directed supervision group and a supervisor-directed supervision group to see which of the two models of peer supervision was most helpful to practicing school counsellors. Results of the study revealed that those in the peer-directed group found that support was the most helpful outcome of the supervision. Feedback on skills and techniques were cited as the most helpful outcome of supervision for the supervisor-directed group. The researchers suggest that in the absence of a trained supervisor, the focus is on collegial support. Whereas skill development and enhancement may occur in the presence of a trained supervisor, indicating that some combination of the two models may be the most effective approach for school counsellor supervision (Crutchfield & Borders, 1997).

An important aspect to supervision is the perception that the relationship between the supervisor and the supervisee is a positive, mutually respectful one. Fontes (1995) points out that the power imbalance and hierarchy inherent in the nature of the traditional supervisory relationship can add to the counsellor's feelings of powerlessness. This power imbalance and hierarchy is evidenced by tracing the word "supervision" back to its roots which is characterized as the communication of the vision of someone in a superior

position to someone in a lower position. Traditionally, a person in a "one-down" position receives supervision from a person of authority that sets the boundaries, tone and often the agenda of the session (Fontes, 1995). "In good supervision, the expected guidance and nurturing are forthcoming, and trust is not abused. In poor supervision, which many of us experience at some point in our careers, we may feel that our confidence is undermined and our power is taken away, rather than augmented, by the supervisory process. Even well-meaning supervisors can leave us feeling diminished as they impress upon us with their expertise, making us feel inadequate in comparison" (Fontes, 1995, 250).

For the most part, clinical supervision is a welcomed and positive aspect of professional counselling and has been defined as a focused, intensive, interpersonal relationship where the counsellor learns to apply a wider set of assessments and counselling methods to increasingly difficult cases with the help of the supervisor (Sutton & Page, 1994; as cited in Hamilton, 2008). Administrative supervision is typically experienced by school counsellors and is provided by a school administrator with no counselling training (Hamilton, 2008). Henderson and Lampe, (1992) note that administrative supervision is primarily concerned with the counsellors' effectiveness in building relationships, work ethic and habits, and appropriate use of time. Some would argue that administrative supervision is not enough and that despite the need, very little clinical supervision is being provided to practicing school counsellors (Crutchfield & Borders, 1997).

In spite of some of the ambiguities found in recent literature, engaging in supervision is thought to be a crucial component to counsellors' self-care (Arvay, 2001;

Hamilton, 2008; Pearlman & Saakvitne, 1995). Researchers and theorists advise that counselling is too demanding to do without supervision and should be understood as a counsellor's ethical responsibility to obtain supervision in order to maintain competence and deal with the ethical and moral obligations associated with the counselling profession (Arvay, 2001; Everall & Paulsen, 2004).

Ethical Implications

Certain ethical implications associated with the impact of STS on counsellors and the protective influence of supervision has emerged in recent literature (Everall & Paulsen, 2004). The Canadian Counselling Association (CCA, 2007) and the Canadian Psychological Association (CPA, 2000) Code of Ethics stipulate that responsible caring requires professionals to maintain their level of competence and actively demonstrate concern for the welfare of individuals. Counsellors who are unknowingly affected by STS may provide incompetent services as a result of one's diminished ability to function, which could place the client at risk of harm and may constitute a serious violation of a fundamental principle of ethical practice (CCA, Principle B), (Everall & Paulsen, 2004; Monroe, 1995; as cited in Hamilton, 2008).

Counsellors who do not recognize the personal impact of trauma counselling on the practitioner, may be in danger of not recognizing the effects of STS on counselling as an occupation, and the care given to clients (Pearlman & Saakvitne, 1995). Supervisors with knowledge about symptoms, effects and treatment approaches for STS are essential to the early detection and treatment of STS in counsellors (Arvay, 2001).

Risks to the School Counsellor:

As discussed previously STS can affect counsellors and others working with any traumatized population (Pearlman & Saakvitne, 1995) and it appears that school counsellors have not garnered as much attention in STS literature as other groups of counsellors. Many Canadian school boards require school counsellors to have professional training at the graduate level in educational psychology or other related fields (Alberta Education, 2007; British Columbia School Counsellors' Association, 2006; Ontario School Counsellors' Association, 2007 – as cited in Christianson & Everall, 2008). However some jurisdictions have limited requirements to obtain employment as a school counsellor. For example, a bachelor's degree in Education, a valid Manitoba teacher's certificate, and usually several years of teaching experience is required to obtain school counsellor employment in Manitoba. The Manitoba School Counsellors' Association (MSCA) website notes that the *proposed* certification of Manitoba school counsellors would require a 30-credit hour certificate, diploma or degree program in counsellor education (MSCA, 2002).

Current research reveals that even at the graduate level, many students do not have trauma-sensitive training. Adams and Riggs (2008) conducted a study that investigated the relationship between graduate student therapist trainees and trauma-specific training ($n = 129$). Study results revealed that 25% of trainees reported working with trauma clients with no prior formal training related to trauma. Of this sample, 35.6% of trainees reported training in the form of a semester course or multiple intensive workshops. Results further revealed that deficits in trauma-specific training are broadly associated with a pattern of vicarious trauma symptoms, and that compared to students

with no trauma-specific training, students with minimal training did not reveal any significant differences (Adams & Riggs, 2008). "Current findings suggest that one-time lectures or class discussions are not enough; rather, students need substantial trauma-specific training in the context of a full semester of coursework, or multiple intensive workshops in order to protect themselves against the potential negative impact of trauma counselling" (Adams & Riggs, 2008, 32).

Arvay (2001) points out that very few counsellor training programs provide training and information about psychological trauma and that training to address the risks involved for both the counsellor and the client is even less available. While many school counsellors are not typically trained as trauma counsellors, it is likely that they will encounter significant numbers of students who have trauma related experiences in their lives. Trippany, White Kress and Wilcoxan (2004) note, "counsellors in virtually all work settings work with clients who are survivors of trauma" (as cited in Sommer, 2008, 62). Similarly, counsellors in private practice, community agencies, and schools work with clients of a variety of ages who have directly experienced trauma (O'Halloran & Linton, 2000).

While there appears to be limited empirical literature providing evidence of school counsellors' encounters with survivors of trauma in their day-to-day case loads, there may be a rational explanation for this. Demographic data for all of the participants investigated are typically gathered and analyzed. Many previous studies do not have a category for the "School Counsellor" (Buchanan, Anderson, Uhlemann, & Horwitz, 2006). This may be interpreted in a few ways. First, school counsellors may not meet the requirements deemed by the researchers as fundamental to the population under

investigation, and are therefore not solicited for study participation. Second, the school

counsellor may not interpret their role in the school to be one that is involved with trauma

counselling, despite whether he/she has traumatized children on his/her caseload, and as a

result may choose not to participate in the study. Third, school counsellors may not be

included in research results for parsimonious purposes, particularly if "School

Counsellor" as an employment title, is represented by a small number of participants in

comparison with the rest of the sample who represent other occupations more well known

to counsel trauma survivors. Employment titles not typically reported (such as "School

Counsellor") may be collapsed into the category of "Other" in order to simplify the

demographic data analysis. It may be that school counsellors have participated in

research on STS, but are unintentionally overlooked in reported results.

Barwick (2000) notes that the role of the school counsellor has changed

dramatically in recent years and as a result, school counsellors face the same issues that

counsellors in other settings encounter, such as: bullying, bereavement, divisions in the

family, substance abuse, physical, emotional and sexual abuse, sexual and racial

harassment, unwanted pregnancy, and isolation (as cited in Christianson & Everall,

2008). School counsellors are likely to work therapeutically with abused children in the

school (Etherington, 2009) and are also likely to encounter a student suicide, if not a

client suicide, during their career (Christianson & Everall, 2008). "The welfare of the

students in counselling is clearly an important issue for school divisions and

administrators need to be aware of how both counsellors and students may be affected"

(Hamilton, 2008, 13).

Clearly, the Canadian school system is made up of a diverse array of students, from different races, cultures and backgrounds – some of which are also refugees from war-torn countries. Children exposed to varying degrees of trauma, such as cultural and language barriers, poverty, exposure to dangerous situations, family violence, physical, emotional, mental and sexual abuse, are living in circumstances that may compel them to disclose their traumatic experiences. Of this large number of documented child trauma survivors, some of them may seek out their school counsellor for help. A number of questions now need to be asked: 1) "Do school counsellors experience STS?" 2) "What is associated with STS among school counsellors?" And 3) "What predicts STS among school counsellors?" These questions will be the focus of this study about the presence and predictions of STS in Canadian school counsellors.

Chapter III: Methodology

Sample Description

  Participants in the current study were 57 school counsellors employed in various school divisions throughout provinces and territories of Canada. Contact of school counsellors was vetted through the senior administrators of these school divisions throughout the country. Letters were addressed to senior administrators requesting their permission to access school counsellors in their respective divisions (see Appendix C). Requests were sent to approximately 1529 Senior Administrators in school divisions across Canada. Administrative restrictions prevented direct access to school counsellors unless granted by senior administrators in their respective divisions. In some cases senior administrators provided a contact list for the author to access the counsellors and in other cases the senior administrators would reply and state they themselves would forward the materials to the school counsellors. As a result it is unknown exactly how many counsellors were informed about the study, and an accurate response rate cannot be determined.

  Given the number of Senior Administrators contacted, and the vast potential number of counsellors who could have participated across Canada (possibly in the thousands), the response rate was not as high as it was expected to be. It is not clear if this occurred because counsellors accessed declined to participate, or if the communication to the counsellors did not occur in the manner required to best facilitate their participation, which would necessitate that materials be forwarded accurately and in a timely manner. There were a number of instances where this did not occur. For example, in one division where permission to access counsellors was granted, an

administrative assistant forwarded the materials to counsellors in a PDF file format which does not allow for copying and pasting of any content in the document. As a result counsellors were unable to copy the Uniform Resource Locator (URL), also known as the World Wide Web address for the website, as it was quite lengthy making it difficult to copy manually. The error was immediately addressed by forwarding the materials a second time in a WORD format. Despite these efforts, three counsellors contacted the author to indicate that they could not copy the URL from the PDF file. The author also received numerous email responses from school divisions offering their apologies for not responding sooner. The majority of these responses also included a statement requesting that a research application for each corresponding division would be required if there is still interest in obtaining permission to access those counsellors. In total the author received 103 replies (14.85 %) from Senior Administrators, granting permission to contact counsellors in their divisions. Where primary researcher received permission to contact counsellors directly, contact was made immediately. Where primary researcher was granted permission and informed that the material would be forwarded to either school principals or counsellors directly, the time frame for which this would occur is unknown.

Measures

Demographic Data

To date, there are no known precise instruments developed to assess the impact of STS on Canadian school counsellors. A "Secondary Traumatic Stress Impact Questionnaire" (STSIQ) designed for this study was used to gather data (see Appendix B). Participants completed demographic components to the questionnaire developed by

the author based on variables typically used in social science research and discussed in counsellors' STS literature. These variables include gender, age, area of specialization, membership of a professioanal counselling organization, number of years of membership in said professional organization, overall population of student consumers of counselling services (ethnicity), students' level of schooling (i.e., early years, middle years, etc.) and students' presenting issues.

Protective Factors:

Protective factors are variables that may allow a counsellor freedom from being affected by STS. The STSIQ included significant indicators cited in prior research examining which factors may affect counsellors' level of risk to traumatic exposure and possible STS. A number of these factors appear to either mitigate or circumvent the effects that counselling survivors of trauma has on counsellors. Among these factors are Arvay and Uhlemann's (1996) profile of an at-risk counsellor which includes less than a masters degree level of training, employment in a community agency, less than ten years' experience, treatment of a high number of trauma clients on their caseload, feeling affected by their clients' traumatic material, and a reliance on non-professional and personal supports rather than clinical supervision or personal therapy.

While Arvay and Uhlemann's description of these variables is used to describe a profile of an at-risk counsellor, one could argue that these variables can be described as protective factors when reversing the meaning. For example, in the profile of an at-risk counsellor, having less than a masters degree level of training is considered to put counsellors at risk of the effects of STS. The reverse could be stated where having a masters degree level of training or more can act as a factor that may mitigate the effects

of counsellors' STS. The same could be said for the remaining factors included in the profile of an at-risk counsellor. More specifically, counsellors' protective factors appear to include having a higher number of counselling credit hours, the presence of trauma-specific training, a higher level of work experience, lower number of trauma clients on a counsellors' caseload, and the presence of supervision. As such, the corresponding components in the STSIQ were developed to reflect these variables.

Reliability & Validity:

The STSIQ draws from a reliable instrument, the Secondary Trauma Questionnaire (STQ), developed to assess STS across both therapist and non-therapist populations who have had extended contact with trauma survivors (Motta et al., 1999). As STS and PTSD are hypothesized to share many of the same symptoms, the STQ reflects the major PTSD criteria in the DSM-IV such as intrusive thoughts and imagery, emotional numbing and avoidance behaviours, hyper-arousal symptoms and psychosomatic complaints (Motta et al., 1999).

Participants are instructed to consider the traumatic life experiences of their clients and "write in the number that best describes how you think and feel about the experiences of those clients whom you identify as having traumatic life experiences." Participants respond to a 5-point likert scale (where 1 = Rarely/Never and 5 = Very Often). The STQ was evaluated within samples of therapists and students, demonstrating good internal consistency across samples (.75 for the therapist sample, and .88 for the student sample). The STQ is also significantly correlated with known measures of trauma used in the assessment of PTSD, across the different samples (correlations ranging from .33 to .56, $p < .01$), indicating its validity across samples (Motta et al., 1999). The range

of scores was not included in this article and there was no clinical cut-off reported. Similarly, other researchers have made note that there is difficulty determining the point at which counsellors and other helping professionals meet the clinical criteria for secondary trauma and that it is expected that the next level of measure development will offer norms and cut offs for symptom intensity, strengthening current assessment methodology (Zimering, Munroe, & Gulliver, 2003).

Finally the Coping Strategies Inventory (CSI) was used to explore strategies counsellors engage in to protect themselves from STS. More specifically, the CSI contains two sections; The CSI-Belief (CSI-B) section which identifies beliefs that trauma therapists hold regarding which coping strategies will lead to lower levels of secondary trauma, and the CSI-Time (CSI-T) section which identifies counsellors' time made available for engaging in coping strategies identified to assist in lowering levels of secondary trauma (Bober et al., 2006).

Analysis of each of the two sections (CSI-B & CSI-T) in the CSI revealed a set of subscales (Bober et al., 2006). The CSI-B has three sub-scales – leisure, self-care, and supervision, which together accounted for 55.9% of the variance and has reported internal reliability coefficients of .71 to .82. The CSI-T has four sub-scales – self-care, leisure, supervision, and research and development – which together accounted for 45.7% of the variance, and has reported internal reliability coefficients of .67 to .80. Bober et al. (2006) provided evidence that the underlying constructs were supported (despite the "somewhat disappointing" variance results) as there was a similar factor breakdown for both the CSI-B and the CSI-T (p. 79). One limitation of the CSI is that scores on this

instrument were not compared with scores on other known measures of coping strategies or coping styles, indicating that concurrent validity has not been assessed.

Excluded STSIQ Questions

As previously described the STSIQ asked participants to complete demographic questions based on variables typically used in social science research and discussed in counsellors' STS literature such as gender, age, area of specialization, membership of a professioanal counselling organization, overall population of student consumers of counselling services (ethnicity), students' level of schooling (i.e., early years, middle years etc.) and students' presenting issues. Some of the above variables were dropped from the analyses for various reasons.

The question asking participants to identify their "Area of specialization" was dropped from the analyses because the responses did not appear to yield any meaningful answers. There were a lot of common answers such as school counsellor, guidance counsellor, or specificities of which grade level counsellors provided services to, but not what the role of the participant was exactly. The question would have been more useful if it had been elaborated on. Another question that was dropped from the analyses was, "In addition to your role as a counsellor, do you hold another position? (if yes, please describe)". Many counsellors indicated they did not hold another position and a few stated they also taught classes. Some of the other replies were ambiguous, as it seemed they were describing their counsellor role as another position. For these reasons this question was dropped.

Questions inquiring about participants' membership in a professional counselling organization and the level of schooling of the consumers of counselling services were

also excluded from the analyses as they did not fit in a meaningful way into the primary questions guiding the statistical analyses, and were used as more of a point of interest for possible future research. Lastly, the purpose of the question, "What is the overall student population where you work" was to determine the overall *ethnic* population of students the counsellors provided services to. Of the 57 participants, 50 responded to this question and only 3 indicated a response related to ethnicity, all other responses were stated in numeric form (e.g., 1500 students). This question was not articulated in a way to best gather meaningful answers and in hindsight did not ask what was intended to be asked (for example, what is the overall ethnicity of the students in your school?) Due to the ambiguous nature of the question it was also excluded.

When investigating if counsellors engaged in supervision, participants were asked questions about supervision, and if supervision was available to them. In addition, there were three questions asked about supervision engagement: 1) "Do you engage in supervision?" 2) "How often do you engage in supervision?" and 3) "What type of supervision do you engage in?" The first question is dichotomous, and the variable is scored as such. The latter two questions are treated as continuous variables. The frequency of engagement in supervision was scored by evaluating each response to determine whether trends were present such as weekly, bi-weekly, and monthly supervision etc. The amount of supervision time was coded using the content of what the counsellors offered in their responses, the literature on supervision reviewed thus far, as well as what this author has come to consider appropriate amount of time spent engaging in supervision through personal experience with supervisors over the last 10 years, as

well as the author's own education, training, and clinical experience. The coding for amount of supervision times was done on a 5-point Likert scale and was as follows:

Blank = No Response (NR)

1 = Not Available (NA)

2 = A Few Times a Year

3 = Peer informal/As needed and Administrative As Needed

4 = Monthly (1-2 Times per Month)

5 = Regularly (Weekly, Bi-Weekly, or More).

Finally, the question, "How often do you engage in supervision", for the amount of supervision time variable, yielded the same responses as the question, "What type of supervision do you currently engage in?" Participants were supplied a variety of responses to choose from, with the instructions, "Please check any that apply". The responses were as follows: Administrative supervision (provided by a school administrator who is not a counsellor); Personal supervision (one-on-one with a trained counselling supervisor); Group supervision (supervisor-directed group supervision); Peer-group supervision (peer-directed group supervision; Other (Please describe). The answers reported for both of these questions were more relevant to the amount of supervision time variable than for type of supervision variable, and therefore the latter was excluded from the analyses. It may be of interest to note that the majority responding to the excluded question stated they were receiving administrative supervision. More specifically, 26 out of 40 participants who answered this question said they engaged in

administrative along with other types of supervision (65.0%), 13 of those 40 stated they

received only administrative supervision (32.5%). These responses were not included in

the statistical analyses and were manually calculated for interest sake.

Data Preparation

In the statistical analysis, counsellors' perception of the supervisory relationship

was treated as a dichotomous variable even though it was explored in the STSIQ using an

open-ended question. In order to treat the perception of the supervisory relationship as a

dichotomous variable each response was evaluated to determine whether the responses

seemed like a positive or negative relationship based on the content of what the

counsellors offered in their responses, the literature on supervision reviewed thus far,

what this writer has come to consider as positive or negative supervisory relationships

through personal experience with supervisors over the last 10 years, as well as writer's

own education and training achieved thus far.

Participant responses were reviewed and evaluated, and then grouped into 5

separate categories using a Likert scale based on the words they used such as "cursory",

"cordial", "supportive", "mutually respectful" and "transparent" to name a few. The

Likert scale is coded as: Not Supportive = 1, Fair = 2, Good = 3, Very Good = 4,

Excellent = 5). The scale can be broken down as follows:

N/A = No Answer/Not Applicable/No Response

1 = NOT SUPPORTIVE (the relationship is perceived/described as being negative,
unsupportive, uncaring, inadequate, or even non-existent).

2 = FAIR (the relationship is perceived/described as being somewhat supportive, but more often than not superficial, cursory, or ambivalent).

3 = GOOD (the relationship is perceived/described as being supportive, but more professional, pleasant, and cordial).

4 = VERY GOOD (the relationship is perceived/described as being supportive to very supportive, and is positive, trusting and comfortable.

5 = EXCELLENT (the relationship is perceived/described as being extremely supportive, mutually respectful, autonomous, transparent and trusting enough for open discussion about how the counsellor is affected by the work (including being negatively affected by client material).

*AMBIGUOUS ITEMS ARE TO BE LEFT UNCODED AND REMAIN BLANK.

A co rater (a work colleague, fellow therapist and former University of Manitoba research assistant) was solicited to code the individual responses based on the Likert scale definitions. The inter-rater reliability coefficient was .864. Based on the 44 cases the 2 individuals' inter rater agreement was very high.

Design

The main purpose of this study was to examine how school counsellors fit into the global picture of a secondarily traumatized counsellor. In order to understand this topic area more clearly three main questions were developed: 1) "Do school counsellors experience STS?" 2) What is associated with STS among school counsellors?" And 3) "What predicts STS among school counsellors?"

Based on the literature review, it is clear that children and youth in Canada experience unfortunate circumstances that lead to lingering traumatic effects. These same children and youth are some of the school children presenting for school counselling services. Given that at least some of these children are presenting as consumers of school counselling services, it can then be assumed that school counsellors are exposed to these consumers' traumatic material.

In order to determine if there is a presence of STS amongst this population, counsellors were identified as being affected by STS through self-identification of either a formal trauma diagnosis, a peer-identified trauma disorder, or obtaining a higher score on the STQ measure (STQ Total). More specifically, questions contained in the STSIQ to identify presence of STS included, "Have you been formally diagnosed by a psychiatrist, clinical psychologist, family physician or other related professional as suffering from a trauma disorder? (if yes, please specify)" and "Has another counsellor, co-worker, supervisor, or other person in a similar role ever identified you as suffering from a trauma disorder (if yes, please explain)". In addition to these two questions, participants filled out the STQ measure described previously and a total score was tallied for each participant. By using descriptive statistics and comparing the mean, school counsellors' severity of STS scores can be revealed. The number of counsellors formally diagnosed with a trauma disorder, or identified as having a trauma disorder by their peer, as well as the percentage of counsellors who score higher on the STQ was computed.

STS literature revealed numerous studies looking at the various factors thought to either increase a counsellor's susceptibility to STS or protect them against it. Factors that commonly appear in STS literature that also maintain a general consensus between

researchers in the agreement of their association to STS were compared to one another using correlational analyses to determine if there are any significant relationships to one another.

Given that there are a number of factors which are generally agreed upon in the literature to be associated with STS, in spite of some debate, a regression analysis was computed to see which factors predicted STS in school counsellors. Standard regression analyses were computed to explore general predictors for the total group (*N*). Higher organized regression analyses were used to test theories regarding factors' association to STS. This was done by computing analyses for not only the total group but for median split groups as well.

More specifically, these analyses examined how well supervision predicts coping strategies indentified by the CSI measure by looking at supervision time variables such as the amount of time spent engaging in supervision, the availability of supervision, how positive the supervisory relationship is perceived to be, and if the counsellor engages in supervision. Other variables that were thought to be associated with supervision that were examined in these analyses include the amount of counselling credit hours a counsellor has obtained, the counsellors' number of years of work experience, presence of trauma-specific training, the number of clients on the counsellors' caseload, as well as the number of trauma survivors on a counsellors' caseload.

These analyses also included multiple regression computations to examine how personal trauma, undiagnosed effects, and exposure to trauma, work to predict STS. More specifically, personal trauma was examined through the variables formal trauma

diagnosis and peer identified trauma disorder. Undiagnosed effects were examined through trauma-specific training, and exposure to trauma work was examined through the variables number of clients and number of trauma clients.

Finally, these analyses also look at how well supervision and coping strategies predict STS. Factors involved in the supervision equation include supervision availability, engagement in supervision, amount of time spent engaging in supervision, and perception of the supervisory relationship. The CSI time (Time Total) and belief (Belief Total) scores were also used to examined how well they predict STS.

Procedures

Once permission to access school counsellors in their corresponding divisions was established, survey information was expressed to them via a "Letter of Invitation to School Counsellors" which was forwarded to them electronically (see Appendix D). Information forwarded to counsellors included in the letter of invitation contained: an introduction to the primary researcher and an explanation of why the individual was being contacted; an introduction to the concept of counsellor stress; emphasis of the importance of research conducted in the area of human services including a statement of how valuable counsellors' input is and how the special qualities of the school counsellor make it possible to do this difficult but rewarding work; an expression of the need to highlight some of the areas where assistance can be provided to make the position of school counsellor more manageable and less stressful; an invitation to participate in the survey and the link to STSIQ questionnaire and corresponding forms; a statement of the importance of confidentiality and direction to the informed consent form; as well as an opportunity to confidentially enter a draw to win a gift card to "The Keg" upon survey

completion. In order to avoid any association between counsellors and their survey responses, participants were instructed to send a separate email to the author indicating their wishes to be included in the gift card draw. Of the total number of participants who completed the survey, 14 wished to be entered into the draw for the gift card and one individual was randomly selected.

The "Informed Consent Form" (Appendix A) was appended to the letter of invitation (Appendix D) so that potential participants had a copy, as the one contained on the website was not a printable form. Once participants entered the link to the survey the informed consent form is presented first and contains information such as: a general explanation of informed consent; an explanation of the purpose of the proposed research; an explanation of the study's procedures; including a disclaimer alerting participants to potential distress they may experience as a result of participating in the survey; guidance to a "Counselling Resource List" containing the contact information to for agencies and organizations that provide counselling support to help deal with any negative emotional responses resulting form working as a school counsellor, or as a result of recalling difficult situations while participating in the study (See Appendix E); a guarantee of participants' confidentiality, as well as instruction of how to obtain feedback and/or a summary of the results.

Participants were then instructed that continuance past the informed consent form was considered assent to participate in the study. Participants were also apprised of their right to withdraw from the study at any time or refrain from answering any questions without prejudice or consequence. As previously mentioned, potential participants were offered a chance to be entered into a draw for a $50.00 gift card upon survey completion.

On the survey webpage, immediately below the informed consent form is a copy of the "Counselling Resource List", followed by the survey itself.

An on-line survey was created using Google Documents. The STSIQ was loaded into the Google Documents program by using the survey "forms feature" which allows for cutting and pasting of a word document into a blank form. Forms were customized by the author, as the survey program allows each question to be created in a variety of different formats typically found in surveys (such as multiple choice or open ended questions, for example). Writer created the STISIQ web survey to exactly reflect the STSIQ. To distribute the survey, either an email can be generated that sends the link to the survey form, or it can be "embedded" which displays a URL that can be copied and pasted into e-mails, used on a web page, or included in an invitation such as the "Letter of Invitation to School Counsellors" (Appendix D), as was done in this case.

Counsellors gained access to the survey by clicking on the URL located in the "Letter of Invitation to School Counsellors" (Appendix D), or alternatively, cutting and pasting the URL into their web browser which automatically opened the webpage containing the survey. Counsellors who participated in the study completed questions inquiring into demographic information, self-reported secondary trauma exposure, views and experiences of supervision, as well as beliefs about and time spent engaging in coping strategies.

Once participants completed the survey, Google Documents collects all responses and stores them in a completely anonymous password protected Google Documents Spreadsheet accessible only by the Google account holder (this author), whereby participants were coded only by a time stamp number and no identifying information

from participants could be linked to that number. As per Canadian Psychological

Association guidelines, data collected will be kept under password protected computer

and locked files, retained for seven years, and then disposed of by deleting and closing all

computer files and/or web pages, as well as by shredding all related paper material. Also,

personally identified material, such as email correspondence will be destroyed in the

manner described above upon completion of thesis defence. Furthermore, the informed

consent form assures that there will be no deception as a means of conducting the

research, and only the author, research supervisor and research co-rater will view

questionnaire results or portions of research results (see Appendix A).

Chapter IV: Results

<u>Sample Description</u>

All of the school counsellors who participated in the STSIQ ($n = 57$) completed the STQ portion of the survey and most provided demographic information ($n = 54$). The average ages of participants ranged from 24 to 66 years with a mean of 41.76 years. Eighty-seven per cent of participants were female and 13% were male. Forty-eight per cent of participants held a Masters, 35% held Bachelor degrees, 13% held a Certificate or Applied diploma, and only one individual held a Doctoral degree. The mean number of years working as a school counsellor was 7.46 ($SD = 5.59$; range = 1 to 28 years; $n = 53$) and a large number of participants had some form of trauma-specific training (83.7%). A summary of the demographic descriptions of sample participants is contained in Table 1. It should be noted that the number of school divisions, as well as provinces and territories represented in the results of the data is unknown, as there was no specific question exploring these two domains of this population of school counsellors.

The number of clients reported on a school counsellors' caseload ranged from 10 to 600, with a mean of 141.68 (median = 100.00, $SD = 102.41$, $n = 53$). The mean number of trauma-affected clients on school counsellors' caseload was 57.63). Eighteen per cent of participants had received a formal diagnosis by a psychiatrist, clinical psychologist, family physician or other related professional as suffering from a trauma disorder, and 8.9% stated that another co-worker, supervisor, or other person in a similar role had identified them as suffering from a trauma disorder.

Supervision was available to 40.4% of respondents and, of those counsellors, 59.6% stated they engaged in supervision. For participants who responded to the question asking how often they engaged in supervision, 36.7 % either do not engage, or it is not available to them, 2.0% engage a few times a year (3-4 times), 30.6% engage in "peer", "informal" or " as needed" types of supervision, 4.1% engage monthly, and 26.5% engage weekly, bi-weekly, or more (see Table 2).

Respondents completed the STQ measure and the mean level of STS reported was 35.28 (median = 34.00, *SD* = 13.06, range = 20 to 79, *n* = 57). Responses to both sections of the CSI were also computed in order to determine total scores for beliefs (CSI-B) and time spent engaging in coping strategies (CSI-T). The mean score for CSI-B was 50.11 (median = 51.00, *SD* = 12.29, range = 36 to 70, *n* = 57). The mean score for CSI-T was 39.93 (median = 42.00, *SD* = 10.78, range = 25 to 65, *n* = 57). Two variables (number of credit hours in counselling and counsellors' perception of their relationship with their supervisors were unable to be included in these analysis due to missing data (see Table 3).

Demographics:

Pearson's product-moment correlation coefficients indicated significant relationships between demographic indices involving work experience and variables associated with STS in the literature (see Table 4). Age of school counsellors was positively correlated with years of work experience ($r = .510$, $p = .000$), and counsellors' work experience was correlated with presence of trauma training ($r = .289$, $p = .046$). Meaning, the more work experience that a school counsellor has, the more likely they

will have obtained some type of trauma-specific training. Consistent with this are the results for the Independent samples *t*-test, which also revealed significant differences between counsellors with and without trauma-specific training when comparing counsellors' work experience, $t(46) = 2.05$, $p = .046$). More specifically, counsellors who had trauma-specific training were more likely to have more years of work experience (see Table 5).

<u>Total Group</u>

Secondary Trauma Questionnaire and Coping Strategies Inventory:

The scores for the 20-item STQ measure were computed to create a total trauma score (STQ Total). The STQ was significantly associated with both the CSI Total Beliefs ($r = .420$, $p = .001$) and CSI Time Total ($r = .495$, $p = .000$). These relationships can be interpreted to mean that the more beliefs in and time spent engaging in coping strategies, the more likely counsellors are to score higher on the STQ. These results suggest that despite the greater counsellors' belief that coping skills are helpful and the more time spent engaging in those activities, the more likely they are to be affected by STS. The CSI-B and CSI-T sections were correlated significantly with one another ($r = .762$, $p = .000$), demonstrating good internal consistency and reliability between the CSI subscales.

Forward Stepwise Regression analysis was used to predict overall severity of STS symptoms on the STQ for the school counsellor group. This statistical model selection procedure is typically used in cases where there is a large number of potential explanatory variables, and no underlying specific theory on which to base the model selection such as in this study. "The Forward selection method selects the predictor at

each stage that (a) adds the most to the prediction of the criterion, and (b) reaches some specified probability level to enter the equation" (Clark, 1992, 9.8). To enter the equation, it was required that a variable lead to an increase in variance accounted for R^2 by 2% or more and be significant at the $p </= .05$ level. Variables in the initial analysis included number of peer-identified trauma disorder, formal trauma diagnosis, trauma-specific training, number of clients on a caseload, and number of traumatically affected clients on a caseload.

The final equation of the STQ regression analysis computed to predict the overall severity of STS symptoms on the STQ contained only one variable, peer-identified trauma disorder, and yielded a multiple R of .226 ($F = 11.674$, $p = .001$) accounting for 11.85% of the total variance in STS symptom scores (see Table 6). Formal trauma diagnosis did not reach the required significance level ($p = .098$) and was therefore excluded.

Gender:

Gender was correlated with age ($r = -.276$, $p = .043$) meaning that female counsellors tended to be younger than male counsellors. Independent samples *t*-tests revealed significant differences when comparing binary variables with continuous demographic indices and variables associated with STS. Despite the fact that the mean ages appear similar, the contrast in the ages of women (40.64) compared to men (49.29) confirm that men were on average, older. Tests for significant differences between genders also revealed that men were more likely to be older than their female counterparts, $t(52) = 2.07$, $p = .043$ (see Table 7 for results for means and standard deviations for *t*-tests).

Results comparing counselling credit hours reveal that women were more likely to have a higher number of counselling credits than men, $t(26) = 2.75$, p. 011.

Gender was also correlated with the variable supervision engagement ($r = -.337$, $p = .013$), suggesting that females tend to engage in supervision more than males. The results for Pearson's Chi-Square Test revealed similar significant relationships between these binary variables. The Chi-Square analysis comparing females and males on the variable of engagement in supervision revealed significant results ($X^2 = 6.116$, $p = .013$). That is, females were more likely than their male counterparts to engage in supervision, and only one male that responded to this question stated that he did engage in supervision.

Gender was also correlated to supervisory relationship ($r = .330$, $p = .035$). While this correlation is fairly weak, significant differences were also seen between males' and females' perceptions of their relationship with their supervisors. Participant responses were coded on a 5-point Likert scale where 1 represents that the relationship is perceived/described as being negative, unsupportive, uncaring, inadequate, or even non-existent, and 5 represents the relationship as being perceived/described as extremely supportive, mutually respectful, autonomous, transparent, and trusting enough for open discussion about how the counsellor is affected by the work (including being negatively affected by client material). More specifically, male counsellors were more likely to view their relationship with their supervisors as being "Fair" (the relationship is perceived/described as being somewhat supportive, but more often than not superficial, cursory, or ambivalent) $t(39) = 2.19$, $p = .035$, where females viewed the relationship as "Good" (the relationship is perceived/described as being supportive, but more

professional, pleasant, and cordial) to "Very Good" (the relationship is perceived/described as being supportive to very supportive, and is positive, trusting and comfortable) .

Comparisons between the means for gender, and amount of time spent engaging in supervision, and the CSI-T, reveal trends in the results. Results demonstrated that men spend less time in supervision, $t(46) = 1.77$, $p = .084$, and also tend to spend less time devoted in coping strategies, $t(52) = 1. 98$, $p = .053$. Both of these trends can be considered as somewhat consistent with the result of men's perspective of their supervisory relationships, as engaging in supervision is often considered to be a coping strategy, and as reported above, men were less likely than their female counterparts to engage in supervision, and were also less likely to view their supervisory relationship positively.

Peer-identification of a Trauma Disorder and Formal Trauma Diagnosis:

Peer-identified trauma disorder was highly correlated with formal trauma diagnosis ($r = .508$, $p = .000$) suggesting that co-worker and peer identification of a counsellors' trauma disorder was quite accurate. More specifically, if a counsellor received a peer-identified trauma disorder, they were also quite likely to have a formal trauma disorder diagnosis. Chi square analysis further revealed that counsellors who do not have a formal trauma diagnosis were very unlikely to have a peer-identified trauma disorder ($X^2 = 14.454$, $p = .000$). Summaries of the results for the independent tests of significance for formal trauma diagnosis and peer-identified trauma disorder across the dependent measures are presented in Tables 8 and 9.

Counsellors' trauma-specific training was negatively related to peer-identified

trauma disorder ($r = -.346$, $p = .016$), meaning that those counsellors who indicated they

had been identified by a peer or co-worker as suffering from a trauma disorder are less

likely to have received trauma-specific training. Chi square analyses provide similar

results, also revealing that counsellors who had trauma-specific training were very

unlikely to have a peer-identified trauma disorder ($X^2 = 5.760$, $p = .016$). That is, for

counsellors with trauma-specific training, the majority were unlikely to have a peer-

identified trauma disorder, although some did (25%).

Peer-identified trauma disorder was negatively correlated with time spent in

supervision ($r = -.290$, $p = .043$), meaning that the more time spent engaging in

supervision the less likely they were to have a peer-identified trauma disorder. The

amount of time spent engaging in supervision was coded on a 5-point Likert scale, where

1 represents supervision is unavailable, or participants do not engage in same, and 5

represents regular engagement in supervision (weekly, bi-weekly or more).

Results for tests of significance between peer-identified trauma disorder and

amount of time spent engaging in supervision provide evidence supporting the

correlational analyses, revealing considerable differences between these variables, $t(45) =$

8.22, $p = .000$. Counsellors with a peer-identified trauma disorder are more likely to

spend time engaging in "peer informal", "as needed", or "administrative as needed"

supervision, which on the 5-point Likert scale described above, falls in the middle of the

scores (3 of 5). That is, these counsellors spend more than "a few times a year (3 to 4

times a year)" and less than "monthly (1 to 2 times a month)" engaging in supervision.

More specifically counsellors without a peer-identified trauma disorder appear to have as

needed peer or administrative supervision. Further results for peer-identified trauma disorder in relation to counsellors' perception of their supervisory relationship also reveal significant differences, $t(39)$ 2.72, $p = .010$. That is, counsellors who did not have a peer-identified trauma disorder appear to have a more positive view of their supervisory relationship.

Coping Strategies:

The two sections of the CSI (CSI-B and CSI-T) yielded total scores for each section (Belief Total and Time Total) which were analyzed to determine if there are relationships between demographic indices and other factors related to STS. Belief Total was positively associated with counsellors' credit hours ($r = .384$, $p = .040$); however, the *n* for this correlation was low (29) suggesting a very robust finding despite the moderate strength of the correlation. Belief Total was also highly negatively correlated with both formal trauma diagnosis ($r = -.366$, $p = .006$) and peer-identified trauma disorder ($r = -.554$, $p = .000$). That is, these relationships can be interpreted to mean counsellors who have higher beliefs in coping strategies are less likely to have either a formal trauma diagnosis or a peer-identified trauma disorder. Comparison of means between Belief Total score and both formal trauma diagnosis, $t(10) = 1.69$, $p = .124$) and peer-identified trauma disorder, $t(5) = 2.04$, $p = .110$, demonstrates that significant differences were not observed (see Tables 8 and 9).

Time Total also had a negative relationship with peer-identified trauma disorder ($r = -.425$, $p = .001$). The results can be interpreted to mean that the more time spent engaging in coping strategies, the less likely the counsellor would be to have a peer-

identified trauma disorder. The relationship between Time Total and formal trauma diagnosis did not reach the level of significance ($r = -.209$, $p = .123$).

Further significant results were revealed when looking at the relationships between total amount of time spent engaging in coping strategies (Time Total) and time spent in supervision ($r = .460$, $p = .001$), and Time Total and counsellors' perception of the supervisory relationship ($r = .467$, $p = .002$). That is, counsellors who spend more time engaging in coping strategies are likely to spend more time engaging in supervision, and to view their relationship with their supervisor as being more positive and supportive.

Forward Stepwise Multiple Regression Analysis was then used to further predict Time Total. To enter the equation, it was required that a variable lead to an increase in variance that accounted for R^2 by 2% or more and be significant at the $p = </= .05$ level. Variables in the initial analysis included supervision availability, engagement in supervision, amount of time in supervision, perception of the supervisory relationship, counsellor credit hours, level of education, years of work experience, trauma-specific training, number of clients, and number of trauma affected clients.

The final equation of the regression analysis computed to predict the amount of time counsellors spend engaging in coping strategies contained only one variable, amount of time spent engaging in supervision, and yielded a multiple R of .496 ($F = 14.740$, $p = .002$) accounting for 7.98% of the variance in Total Time scores (see Table 10).

Supervision:

The amount of time spent in supervision was significantly correlated with a number of related factors examined to look at supervision. There was a strong

relationship between time spent in supervision and clinical supervision available in the current work setting ($r = .537$, $p = .000$). Comparison between the means provide similar results. Counsellors who had supervision available to them, were more likely to spend time engaged in it, $t(47) = 4.36$, $p = .000$ (see Table 11).

Time spent in supervision was also highly correlated to engagement in supervision ($r = .829$, $p =. 000$). Comparisons between the means revealed similar results. That is, counsellors who stated they engaged in supervision were more likely to spend higher amounts of time in supervision $t(47) = 10.69$, $p = .000$. Significant differences were revealed when comparing counsellors' engagement in supervision with number of trauma survivors on their caseload, $t(46) = 1.36$, $p = .187$, as well as with counsellors' perception of their supervisory relationship, $t(40) = 1.69$, $p = .099$.

Clinical supervision available in the current work setting and engagement in supervision are also correlated to one another ($r = .385$, $p = .003$) suggesting that if supervision is available, counsellors are likely to engage in it. Chi-Square analysis provides results consistent with the product-moment correlation computed for these two variables ($X^2 = 8.445$, $p = .004$), signifying that if a counsellor has supervision available to them the more likely they were to engage in it. In other words, if counsellors have clinical supervision available to them in their current work setting, they are more likely to engage in it, even if they are engaging in supervision outside of their place of work (see Table 12 for results for means and standard deviations for t-tests).

Forward stepwise regression analysis used to predict overall severity of STS symptoms from variables associated with supervision and coping revealed no effects.

Variables used in this equation were Time Total, engagement in supervision, supervision availability, perception of the supervisory relationship, Belief Total and time spent engaging in supervision.

Median-Split Groups

Initial statistical analyses were computed for the school counsellor population based on the STQ Total Score. It was determined that STQ Total Scores needed to be dichotomized by using a median-split analysis in order to simplify interpretation of study results. In doing so, the median split transformed the many values in the STQ variable into two categories. One of these categories included scores above the median (34.0) and the other included all scores below the median. Median-Split analyses were computed in order to determine if there were associations and differences between counsellors who scored lower on the STQ (0-33) with those who scored higher on the STQ (34-79).

Peer-identification of a Trauma Disorder and Formal Trauma Diagnosis:

Counsellors in the low STQ group whose peers identified them as having a trauma disorder were quite likely to have a formal trauma diagnosis ($r = .553$, $p = .004$) and were less likely to have trauma-specific training ($r = -.465$, $p = .025$). For the low group median-split correlation summaries, see Table 13). Counsellors in the high STQ group who were identified by their peers as being affected by a trauma disorder were likely to have a high number of trauma survivors on their caseload ($r = .402$, $p = .042$). Counsellors in the high STQ group with a higher amount of trauma survivors on their caseload were also likely to have a formal trauma diagnosis ($r = .398$, $p = .044$). For the high-group median-split correlation summaries, see Table 14).

Forward stepwise regression analysis predicted overall severity of symptoms on the STQ based on variables associated with personal trauma, undiagnosed effects or exposure to trauma work and revealed no effect for the low STQ group (0-33) but revealed good prediction for the high STQ group (34-79). Variables in the initial analysis included peer-identification of a trauma disorder, formal trauma diagnosis, trauma-specific training, number of clients, and number of trauma-affected clients. The final equation contained only one variable, peer-identification of a trauma disorder, yielding a multiple R of .234 ($F = 6.416$, $p = .019$) accounting for 11.54% of the variance in the STQ scores (see Table 15). Based on these results it appears that peer-identification of a trauma disorder is the best predictor of high STQ scores, a finding that is consistent with STQ regression analysis computed to predict the overall severity of STS symptoms for the total group.

Coping Strategies:

Counsellors who hold more positive beliefs in coping strategies, as outlined in the CSI measure, are also quite likely to spend more time engaging in those coping strategies regardless if they scored low or high on the STQ measure ($r = .486$, $p = .012$ and $r = .477$, $p = .009$, respectively). Similarly, counsellors in both the low and high STQ groups who spent more time engaging in strategies outlined in the CSI to help with coping against STS were quite likely to view their supervisory relationship more positively ($r = .455$, $p = .050$ and $r = .489$, $p = .018$, respectively) and were also very likely to indicate that they spend a longer amount of time engaging in supervision ($r = .523$, $p = .009$ and $r = .424$, $p = .035$, respectively).

Computations for Independent *t*-tests did not reveal any statistically significant differences although there were some factors that approached statistical significance which is suggestive of some trends in the data. More specifically, there were no differences between the low STQ group (0-33) and the high STQ group (34-79) on all variables analyzed (see Table 16). The variable time spent engaging in coping strategies (CSI-T) was approaching significance, $t(28.29) = -1.621, p = .111$.

Regression analysis were computed to predict CSI Time Total based on variables associated with supervision time, positive supervisory relationships and other variables typically associated with rationale for spending time engaged in coping strategies. Variables in the initial analysis for both the low and high STQ groups included supervision availability, engagement in supervision, time spent in supervision, perception of the supervisory relationship, counsellor credit hours, education level, years of work experience, trauma-specific training, number of clients, and number of trauma affected clients.

The final equation of the regression analysis predicting CSI Time Total for the low STQ group contained only one variable, engagement in supervision, and yielded a multiple *R* of .698 ($F = 13.835, p = .010$) accounting for 8.63% of the variance in Time Total scores for the low STQ group (see Table 17). The final equation of the regression analysis for the high STQ group did not reveal any effects. There was a trend in the analyses for the variable supervision availability which was approaching significance ($p = .112$).

Supervision:

Counsellors in the low STQ group were quite likely to engage in supervision if they stated clinical supervision was available to them in their current work setting ($r = .573$, $p = .002$), and were also highly likely to spend a longer amount of time engaging in supervision ($r = .704$, $p = .000$). Counsellors in both the low and high STQ groups also indicated that if they engaged in supervision they are also very likely to spend a longer amount of time in supervision ($r = .819$, $p = .000$ and $r = .843$, $p = .000$, respectively). Counsellors in the high STQ group who indicated they spend more time engaging in supervision, are quite likely to view their relationship with their supervisor positively ($r = .567$, $p = .009$). These results are consistent with the total group supervision results, and also provide further evidence of good internal consistency and reliability for factors associated with supervision.

Gender was significantly correlated with amount of time spent in supervision ($r = .427$, $p = .038$) and engagement in supervision ($r = .508$, $p = .006$) for counsellors in the high STQ. Meaning that females in the high STQ group were more likely to engage in supervision and spend a longer amount of time in supervision than males. Significant results were not revealed for the low STQ group of counsellors. Independent samples *t*-tests and Chi-square analyses did not reveal any significant differences or relationships for any of the median split analyses. Results for regression analysis predicting overall severity of STS symptoms on the STQ from variables associated with supervision and coping were computed and also revealed no effects for both the low and high STQ groups.

The results for Pearson's Chi-Square Test did not reveal any significant relationships between the low and high STQ groups on the binary variables gender (X^2 = .090, p = .764), counselling credit hours (X^2 = 21.791, p = .241), trauma-specific training (X^2 = .004, p = .950), trauma diagnosis (X^2 = .016, p = .901), peer-identified trauma disorder (X^2 = .305, p = .580), supervision availability (X^2 = .144, p = .705), engagement in supervision (X^2 = .144, p = .705), and supervisory relationship (X^2 = 3.811, p = .432).

Chapter V: Discussion

Summary of the Results

      The purpose of this study was to determine if there is a presence of STS amongst Canadian school counsellors, to examine what is associated with their STS, and to determine what predicts STS among this population. There is a general consensus in the literature that working with traumatized individuals has at the very least, potential to cause negative effects in counsellors and practitioners providing services to this population. What the literature is less clear about is how the school counsellor fits into the global picture of a secondarily-traumatized counsellor. There is literature available that speaks to the existence of child-trauma survivors, but not directly about children as consumers of school counselling services, and how their traumatic experiences may affect counsellors providing their services. The current study sought to explore these areas of school counsellors' potential STS in more detail.

Total Group

      The demographic characteristics of school counsellors across Canada were observed and revealed that male counsellors were older than female counsellors, and female counsellors were more likely than their male counterparts to engage in supervision and were more likely to have a higher number of counselling credits than men. The results also revealed that the more work experience the counsellor had, the more likely they had obtained trauma-specific training, and were also less likely to have obtained a peer-identified trauma disorder.

The primary goals of the study, to determine if there is a presence of STS amongst Canadian school counsellors, to examine what is associated with STS among school counsellors, and to determine what predicts STS among school counsellors, was accomplished through the use of two measures, the STQ and the CSI, as well as a survey questionnaire (STSIQ), designed to explore if and how indicators reviewed in the STS literature are associated with counsellors' STS, and whether those indicators can predict counsellors' STS.

In this study, school counsellors were identified as being affected by STS through self-identification of either a formal trauma diagnosis, peer-identified trauma disorder, or obtaining a higher score on the STQ. The relationship between counsellors' formal trauma diagnosis and peer-identified trauma disorder was very strong, revealing repeated results for all statistical analyses, indicating that in comparison to individuals who formally diagnose traumatic stress, counsellors' peers were quite accurate at identifying their co-workers as being affected by traumatic stress. Significantly, study results also found that the best predictor of STS on the STQ measure was peer-identification of a trauma disorder. In other words, if peers identified the counsellors as being affected by traumatic stress, they were likely to score as being more affected by STS.

To this authors' knowledge, there is no similar research on peer-identification of a trauma disorder. Considering the robust nature of the results surrounding this variable, at the very least future research would benefit from further inquiry into the area of peer-identification of a trauma disorder, such as how common an occurrence this practice is, what are the outcomes of this practice, and how does it affect the treatment of those identified as suffering from a trauma disorder. Future research would need to further

examine counsellors' collegial relationships and determine how it came to be that they were identified by their peers as suffering from a trauma disorder. It is possible that some of the counsellors could have told their peers about their diagnoses, and then peers further corroborated signs and symptoms seen in their coworkers.

Results of the current study provided a picture of indicators associated with STS among school counsellors. The two sections of the CSI (CSI-B and CSI-T) were used to determine if there was association between counsellors' beliefs in coping strategies and corresponding time spent engaging in those coping strategies. Results for the CSI demonstrate good internal consistency and reliability, as the two sections of this measure have a strong relationship.

Counsellors who held stronger beliefs in the coping strategies (CSI-B) were less likely to have either a formal trauma diagnosis or a peer identified trauma disorder. Results further revealed that the more time counsellors spent engaging in coping strategies (CSI-T), the less likely they were to have a peer-identified trauma disorder. These relationships can be interpreted to mean counsellors who have higher beliefs in coping strategies are less likely to have either a formal trauma diagnosis or a peer-identified trauma disorder because they take the time to engage in the coping strategies they believe help.

The results of this study also found that counsellors who had supervision available to them, were likely to spend more time engaging in supervision, and those who stated they did engage in supervision, were more likely to engage in higher amounts of time spent in supervision. Similarly, counsellors who spend more time engaging in supervision

were more likely to view their relationship with their supervisor as being more positive and supportive.

In addition, results of the current study also provided a picture of what predicts STS among school counsellors. Forward Stepwise Regression analysis was used to predict overall severity of STS symptoms on the STQ for the school counsellor group using the variables formal trauma diagnosis, peer-identified trauma disorder, trauma-specific training, number of clients on a caseload, and number of traumatically affected clients on a caseload. These analyses generated a final equation containing only one variable, peer-identified trauma disorder. Based on these results, it appears that peer-identification of a trauma disorder is a very good predictor of STS, which is consistent with results supporting that there is a presence of STS amongst Canadian school counsellors reported above. More specifically, counsellors who identified themselves as having peer-identification of a trauma disorder were likely to score as being more affected by STS on the STQ measure.

Median Split Groups

Median Split analyses were used to separate counsellors' scores on the STQ in order to explore the differences between counsellors who scored low on the STQ (0-33) and those who scored high on the STQ (34-79). In order to explore what predicts STS in school counsellors, three main scopes of inquiry were used: 1) How does personal trauma, undiagnosed effects, or exposure to trauma work predicts STS? 2) How does supervision predict coping? 3) How do supervision and coping predict STS?

Do Personal Trauma, Undiagnosed Effects, or Exposure to Trauma Work Predict STS?

Counsellors in the high STQ group who were identified by their peers as being affected by a trauma disorder were likely to have a high number of trauma survivors on their caseload and were also likely to have a formal trauma diagnosis. Regression analysis also demonstrated that of the variables associated with personal trauma, undiagnosed effects or exposure to trauma work, peer identification was the best predictor for the high STQ group (34-79).

Counsellors in the high STQ group who were identified by their peers as being affected by a trauma disorder were also likely to have a high number of trauma survivors on their caseload. These results are consistent with previous research that maintains that counsellors' symptomatology is related to the percentage of trauma survivors to whom they provide service (Brady et al. 1999; Schauben & Frazier, 1995). While this study did not investigate participants' personal trauma histories due to concern of research restrictions on potential participants, there is still much debate about this area of research. Some research has found that counsellors with personal trauma histories are more likely to experience STS (Arvay & Uhlemann, 1996; Dunkley & Whelan, 2006b; Pearlman and Mac Ian, 1195). Other researchers assert that participants' symptomatology is not related to their own trauma history. For example, in Schauben and Frazier's (1995) research, sexual victimization was not related to participants' symptomatology, but is related to the percentage of trauma survivors they counsel. Similarly other research found that both previous work and non-work related trauma was not significantly related to participants' STS (Ortlepp & Friedman, 2002).

How does Supervision Predict Coping?

Regression analysis computed to predict the amount of time counsellors spend

engaging in coping strategies revealed that amount of time spent engaging in supervision

is the best predictor for total group. Results of this study also demonstrated that

counsellors who hold more positive beliefs in coping strategies outlined in the CSI

measure, are also quite likely to spend more time engaging in those coping strategies

regardless if they scored low or high on the STQ measure. Similarly, counsellors in both

the low and high STQ groups who spent more time engaging in strategies outlined in the

CSI to help with coping against STS were quite likely to view their supervisory

relationship more positively, and were also very likely to indicate that they spend a

longer amount of time engaging in supervision. These results are consistent with previous

research that asserts that there is a general belief in recommended strategies for reducing

STS such as leisure activities, self-care activities (both of which fall into the coping

strategies category), and supervision (Bober & Regehr, 2006).

In a review of literature, Zimering et al., (2003) note that while theorists such as

Figley (1995) and McCann and Pearlman (1990) "have written extensively on the

phenomena of secondary traumatization, the level of corroborative data is not

commensurate with the sophistication of existing theories" (2). These researchers further

point out that at that time, only 17 peer-reviewed articles on secondary traumatization

were found, 12 of which mostly contained descriptive data (Zimmering et al., 2003).

While the empirical literature on STS, including the positive benefits of

supervision to assist in mediating STS are lacking, these results can be interpreted to

mean that school counsellors in this study who take the time to engage in supervision, are more likely to take the time to engage in other coping strategies. This may be due to the fact that supervision is often seen as a coping strategy or as part of a counsellors' self-care, rather than a separate construct. Previous research has suggested that the absence of appropriate supervision increases the occurrence and intensity of STS (Arvay & Uhlemann, 1996; Dunkley & Whelan, 2006b; Pearlman & Mac Ian, 1995). Research needs to be conducted to examine both the presence and absence of supervision in order to have more concrete results that better convey the role of supervision in counsellors' STS, as the absence of appropriate supervision is suggested to increase the occurrence and intensity of STS.

How do Supervision and Coping Predict STS?

Results for regression analyses predicting overall severity of STS symptoms on the STQ from variables associated with supervision and coping were computed and revealed no effects for both the low and high STQ groups. However, results for tests of association and differences between the means revealed results that are consistent with the total group supervision results. More specifically, counsellors in the low STQ group who had clinical supervision available to them in their current work setting were quite likely to engage in it, and were also highly likely to spend a longer amount of time engaging in supervision. Counsellors in both the low and high STQ groups also indicated that if they engaged in supervision they are also very likely to spend a longer amount of time in supervision. Finally, counsellors in the high STQ group who indicated they spend more time engaging in supervision are quite likely to view their relationship with their supervisor positively.

This may be due to the fact that many counsellors who score high on STQ measure are experiencing enough distress that they feel the need to engage in supervision in order to manage their negative emotions associated with their clients' traumatic material. It may be further argued that this counsellor groups' supplementary amount of time spent engaging in supervision allows for the cultivation of the necessary environment for a trusting, mutually respectful relationship to grow between the counsellor and their supervisor, possibly resulting a more positive view of the supervisory relationship.

Limitations

Canada has many different school boards and divisions, and every province and territory organizes and runs them quite differently. Despite the effort put forth requesting access of counsellors in Canada, the response rate was low. It should also be noted that subjects did not answer all questions and therefore some variables had missing cases. Furthermore, the STSIQ did not include a question that was specific to where participants lived and where their school divisions were. As a result, comparisons cannot be made between across provinces. Study results would have been enhanced if provinces with known graduate school requirements could be compared to provinces without such requirements.

Another possible limitation to this research involves the variable trauma-specific training. The survey contained one question for this variable, "Have you participated in trauma-specific training? (if yes, please describe)". Of the counsellor group, 49 responded to this question and 8 did not. Of the 49 who did respond, 41 (83.7%) stated

they had participated in trauma-specific training and 8 (16.3%) stated they did not and of those 49 who responded, 36 specified what type of training they felt they had obtained.

As previously mentioned Adams and Riggs (2008) found that one quarter of their sample of trainees reported working with trauma clients with no formal training related to trauma. Furthermore, their results revealed that deficits in trauma-specific training are broadly associated with a pattern of vicarious trauma symptoms, and that compared to students with no trauma-specific training, students with minimal training did not reveal any significant differences (Adams & Riggs, 2008). The researchers assert that one-time class lectures are not enough and that students require substantial trauma-specific training in the context of a full semester of coursework, or multiple intensive workshops to adequately protect themselves from STS.

While many participants indicated that they had received trauma-specific training (36), it is unclear how intensive the various training was. Common responses for those participants who chose to describe their trauma-specific training as they saw it, included Critical Incident Stress Debriefing or Management (a workshop conducted during a four to five day conference), Threat-Risk Assessment (a two-day workshop for both level one and level two participants), Applied Suicide Intervention Skills Training (a two-day skills building workshop), and Non-Violent Crisis Intervention Training (a two-day workshop), among others. Not only would these workshops not be equivalent to a full semester of coursework, or multiple intensive workshops, but they are also not clearly "trauma-specific training", however one participant did state that they had completed "a counselling course where there was a focus on trauma and recovery". There were a number of other responses provided, however these responses are ambiguous in that it is

not clear how trauma-specific the training was, or how intensive, time-wise, it was (a few days or weeks, or a semester's worth etc.).

As a result of these ambiguities, it is would be wise to take the responses associated with the trauma-specific training with some caution. For future research it would be important to provide the participants with some direction of how to be more specific with their responses to that variable. For example, participants could be asked to complete a question designed to treat trauma-specific training as a continuous variable in order to determine if they had received a one-time class lecture, a two-day workshop, multiple intensive workshops or a full semester of coursework. This type of questioning would certainly assist in covering the various types of training commonly taken by counsellors. It would also be helpful to tease out the trauma content of the above types of training as many of them were likely not focused completely on trauma, but rather touch on the topic and focus more on crises.

Another possible limitation that arose during interpretation of study results was that it appears two of the questions are ambiguous. The question on the STSIQ, "What is the overall student population where you work", was intended to determine the overall *ethnic* population of students the counsellors provided services to. Participants generally responded using a numerical value rather than offering the ethnicity of the majority of clients. It would have been useful to see if there was an association between the students that the participants indicated and children and youth who have been suggested in the literature review to be faced by traumatic circumstances.

Another item that appears to be ambiguous involves the supervision availability question. Results revealed that 40.4% stated that supervision was available to them and 59.6% stated they engaged in it. These results can be interpreted to mean that the number of participants who stated they engaged in supervision was greater than the amount of supervision reported as available to them. In other words, it appears that school counsellors were engaging in supervision more than supervision was actually available to them. However, upon further investigation, the question addressing supervision availability appears to be ambiguous as it is specific to "clinical supervision" available to counsellors in their "current work setting", whereas the question addressing supervision engagement, "Do you engage in supervision", is more general in nature.

More specifically, there are at least two ways that the supervision availability question could have been interpreted. First, respondents could have interpreted it to mean that while they did not have clinical supervision available to them, they were engaging in some other type of supervision such as administrative supervision, and therefore stated "No" to the supervision availability question, and "Yes" to engaging in supervision. Second, respondents may have felt they did have clinical supervision available to them, but not in their "current work setting", and therefore responded "No" to this question. Similarly they may have responded "Yes" to engaging in supervision, because it is available to them elsewhere (e.g., graduate students who are actively employed as school counsellors also completing a practicum component outside of their work setting, where they do receive clinical supervision).

It would also be important to further investigate the types of supervision available to school counsellors, such as the differences between "administrative supervision" and

"clinical supervision". In addition to the three questions pertaining to supervision discussed above, this study also used the CSI measure to investigate counsellors' beliefs in coping strategies recommended to assist with counsellor stress (CSI-B), and time spent in those recommended coping strategies (CSI-T). Both subscales of this measure included two items that specifically addressed supervision and two items that appear related more to a consultative meeting, rather than clinical supervision. For example, the CSI-B subscale includes the following items: 1) "Case discussions with colleagues"; 2) "Case discussions with management". Similarly, the CSI-T subscale includes the following items: 1) "Discussing cases in team meetings"; 2) "Case discussion with management". These appear to be more consultative in nature rather than supervisory.

The content validity of the CSI measure was examined using a focus group with a combined 40 years of trauma-related clinical experience, grouping the resulting subscales (the CSI-B and the CSI-T) into factors deemed to be highly consistent with recommendations in the literature about healthy coping strategies for trauma counsellors (Bober & Regehr, 2006). For the CIS-B, three factors emerged: leisure, self-care, and obtaining supervision. For the CSI-T, four factors emerged: leisure, self-care, supervision, and research and development. It appears that of the factors that emerged for the CSI subscales, the items that seem to be more consultative than supervisory would only fit into the supervisory factor category. For example, "Case discussion with management" would not correspond naturally with "leisure, self-care, or research and development".

This could be problematic for a few reasons. First, while the CSI examines counsellors' coping strategies, including supervision, the type of supervision is not clear.

When investigating counsellors' supervision, it is important to know whether it is clinical or consultative in nature. Second, as in the current study, counsellors could read the indicators for the CSI and then answer specific questions relating to clinical supervision. This could also be problematic in that if respondents made assumptions about what supervision entails based on the CSI measure, their answers to specific questions about their own supervision could be skewed. For example, counsellors could state they engage in clinical supervision when receiving administrative supervision. Due to this, these results should be interpreted with caution.

Implications for Future Research

The fact that earlier results showed that peer-identified trauma disorder was highly associated with formal trauma diagnosis, and that counsellors who identified themselves as having peer-identification of a trauma disorder were likely to score as being more affected by STS on the STQ measure, contributes to a sense of assurance that even though school counsellors are not trained to diagnose STS symptomatology, they were quite accurate in identifying STS in their peers. Further research will need to be conducted in this area of counsellor STS; however, it may be that, in time, an accurate means for referral for services could begin at the peer level in the employment setting. Furthermore, the implications for peer supervision could be quite significant especially in the setting where formal supervision and clinical diagnoses are not readily available.

Prospective research would benefit from further inquiry into the area of peer-identification of a trauma disorder, such as how common an occurrence this practice is, what are the outcomes of this practice, and how does it affect the treatment of those

identified as suffering from a trauma disorder. Currently there is no one way of managing the supervision of school counsellors across Canada and the vast differences in divisions within provinces, territories and cities, as well as individual divisions within cities. That being said, there would clearly be a benefit to have a general consensus among practicing school counsellors and their governing bodies as to how to best protect school counsellors from the effects of STS.

Future research in this area would also benefit greatly from looking at some of the variables proposed in this study to play a mediating factor in counsellor STS such as trauma-specific training and supervision. Due to the ambiguities related to some of the questions surrounding these factors, conclusive determinations cannot be made, however the results can be used to further the investigation into this area. Future research would benefit from including questions more specific to trauma-specific training and supervision. Considering that supervision is thought to be such a crucial piece to counsellors' training and on-going professional development and emotional health, it seems imperative that this factor be more of a focus in prospective research. More specifically, it would be important to further investigate the types of supervision available to school counsellors, such as the differences between "administrative supervision" and "clinical supervision" in order to get a clearer understanding of counsellors' supervision.

Implications for Education and Training

The review of literature presented in this report, as well the results of this study, bring to light some valuable recommendations for education and training of school counsellors. One of the key foundational components to school counsellor education

needs to include formal trauma-specific training. Previous research has revealed that deficits in trauma-specific training are related to patterns of secondary trauma symptoms and students need to have substantial trauma-specific training (Adams & Riggs, 2008). In light of this, graduate programs would be wise to include courses focused on formal trauma-specific training. This trauma-specific training should be part of course requirements, rather than elective components to the program, as many students, even at the graduate level, do not have trauma-sensitive training. Formal trauma-specific training should include information about psychological trauma and should address the risks involved for both the counsellor and the client (Arvay, 2001).

Supervision adds another layer to the picture of prospective graduate counsellor training programs. If they have not already, program requirements should include a thorough supervisory process. In addition, graduate programs would be judicious by including trauma-sensitive supervision. Researchers suggest that trauma-sensitive supervision should include educational components that directly address STS, and be conducted by a supervisor with a strong theoretical grounding in trauma therapy, who can create a mutually respectful interpersonal climate where secondary traumatization can be addressed, while remaining alert to evidence of STS in the supervisee (Pearlman & Saakvitne, 1995). Finally, it appears that graduate programs are not equipping students to conduct supervision. Many counsellors and therapists, upon gaining further experience in their careers, will act as supervisors themselves. Graduate students could benefit greatly from the inclusion of training to conduct supervision in their course of study.

Conclusion

Previous research has provided a profile of counsellors at-risk, identifying factors that are likely to coincide with their STS. While there are factors that are generally recognized in the literature as contributing to STS, some factors appear to garner more attention from researchers and theorists. Supervision has been identified as an important part of counsellor training (Corey, 2001; Martin, 2000; Yalom, 1995) and equally important to practicing counsellors. It appeared that despite the general consensus in the literature for the importance of supervision, only some counsellors actually engaged in it. In the current study, counsellors were quite engaged in supervision; however, it appears that much of this supervision is informal peer or administrative in nature, rather than clinical, and occurred on as needed basis.

The results of this study revealed that many of the school counsellors who participated in this research do engage in supervision, especially if it is available to them (59.6%). Some research in the trauma field has provided support that supervision and other self-care activities do not affect counsellors' STS. This study found that counsellors were not necessarily protected from STS if they spent time using coping strategies, but were much less likely to be affected by STS if they engaged in supervision, especially if it was individual. In general, participants indicated that approximately 41 per cent of their caseload was made up of students who were affected by trauma. Results for the amount of trauma survivors present on a counsellors' caseload showed counsellors in the high STQ group who were identified by their peers as being affected by a trauma disorder were likely to have a high number of trauma survivors on their caseload.

Another factor that is commonly discussed in the STS literature is the percentage of trauma clients a counsellor sees. Given the introduction of managed care in counselling and the ever-increasing demand for free counselling services, heavier client caseloads are seen more frequently. Considering that lack of supervision and a high number of trauma survivors counselled are two factors that have been cited as major contributors to counsellor STS, it is logical that these two factors are also noted to have a negative influence on the school counsellors. More clearly, engaging in regular supervision and ensuring that one's caseload does not have an excessively high representation of trauma survivors, would likely reveal lower incidences of counsellor STS.

Although there is not as much empirical research available on the protective influences of level of work experience and amount of education and training, these factors are thought to increase counsellor STS when lacking in their background. Similarly, literature indicates that counsellors not provided with trauma-specific training, are more likely to be impacted by STS. Results of this study were mainly consistent with the theories above, indicating that counsellors who have more work experience tend to have trauma-specific training. Counsellors with trauma-specific training were also less likely to have a peer-identified trauma disorder.

Peer-identified trauma disorder played a large role in the results of the study. Peers were quite accurate at identifying counsellors' trauma disorders as seen with the highly significant results when comparing to a formal trauma diagnosis and to the outcomes of the STS measure, the STQ. That is, if peers identified the participant as suffering from a trauma disorder, they were very likely to have a formal trauma diagnosis

and were also likely to have higher scores on the STQ. This is an interesting result and one that is worth examining further considering that supervision is not available to all school counsellors, but almost all school counsellors have peers, and could then use peer supervision in the absence of individual supervision. In addition to this, the governing bodies that assume responsibility over counsellors in their respective divisions may need to ensure that appropriate research is being conducted especially in the area of counsellor STS.

As previously suggested, it would be beneficial to have a general consensus among practicing school counsellors and their governing bodies as to how to best protect school counsellors from the effects of STS. It may be that one external governing body maintain legislation over not only counsellors' qualifications, and membership to a professional association, such as the Canadian Counselling and Psychotherapy Association, but also to perhaps govern counsellors' clinical supervision, making it a mandatory component to their professional development and employment requirements. These governing bodies would be well advised to follow guidelines for trauma-specific training and trauma-sensitive supervision as previously discussed, including educational components that directly address psychological trauma and STS, and specific supervisor requirements that include a strong theoretical grounding in trauma therapy, the ability to create a mutually respectful interpersonal climate where secondary traumatization can be addressed, and a focused attentiveness for evidence of STS in the supervisee.

School counsellors are one group of helpers for whom STS research does not appear readily available. Trauma therapy literature indicates that processing of traumatic experiences needs to be handled with exceeding caution, and if done too quickly before

the client is ready, a great deal of damage can be done to that client (Rothschild, 2010). Counsellors who are unknowingly affected by STS may also pose a danger to their clients by inadvertently not being present with their client, and thereby missing important signals that could quite literally, affect their health and well being.

The results of this study are meaningful in that, at the very least they provide the reader with enough information to begin important discussions about school counsellors and the effects of STS they experience. Discussions which should be aimed at determining if counsellors are supported in the manner which is not only sufficient enough to protect them from STS, but also to protect the children who are the consumers of these counselling services. This support can come in many forms such as supervision, training and education in the area of trauma, as well as peer and group support. The focus of research in this area would benefit from shifting from determining if school counsellors are affected by STS, to what is the best way to protect counsellors from STS, and in turn, protect the emotional health of school children.

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Table 1

Demographic Profile of Counsellor Respondents

Variable	N	%	SD
Gender			
Male	7	13.0	.339
Female	47	87.0	
Age	54	41.76	10.62
Education*			
1	1	1.9	.805
2	7	13.0	
3	19	35.2	
4	26	48.1	
5	1	1.9	
Work experience	53	7.46	5.59
Trauma training			
Yes	41	83.7	.373
No	8	16.3	

*Note. *(Certificates/Degrees: 1 = < formal education; 2 = Certificate or Applied; 3 = Bachelor; 4 = Masters; 5 = Doctoral).*

Table 2

Counsellors' Perceptions of Supervision

Variable	N	%
Supervision availability		
Yes	23	40.4
No	34	59.6
Supervision engagement		
Yes	34	59.6
No	23	40.4
Supervision time*		
1	18	36.7
2	1	2.0
3	15	30.6
4	2	4.1
5	13	26.5
Supervisory relationship**		
1	3	7.1
2	6	14.3
3	11	26.2
4	10	23.8
5	12	28.6

Note. *1 = No response/supervision not available; 2 = A few times a year (3-4 times); 3 = Peer informal, as needed, as needed administrative; 4 = Monthly (1 – 2 times); 5 = Regularly (weekly, bi-weekly, or more).

**1 = Not Supportive; 2 = Fair; 3 = Good; 4 = Very Good; 5 = Excellent (See Appendix D).

Table 3

Counsellors' Levels of Trauma Symptoms (STQ) and Coping (CSI)

Variable	%	*SD*	Range
STQ Total	35.28	13.06	20-79
CSI-Belief total	50.11	12.29	36-70
CSI-Time total	39.93	10.78	25-65

Note. N = 57.

Table 4

Correlations of Counsellors' Trauma Variables

Variables	1	2	3	4
1. Age	-			
2. Gender	-.276*	-		
3. Work experience	.510***	.012	-	
4. Counselling credits	.122	.271	-.084	-
5. Trauma training	.216	-.023	.289*	-.366
6. Number of clients	-.063	-.072	.083	-.122
7. Trauma clients	.224	-.265	-.027	-.063
8. FormalDx	-.052	-.016	-.043	-.064
9. PeerID	-.039	-.170	-.165	-.146
10. Supervision availability	-.103	.068	-.151	.084
11. Engagement in supervision	-.091	.337*	-.133	.027
12. Supervision time	-.106	.252	-.042	.202
13. Supervisory relationship	-.102	.330*	-.102	.030
14. Education level	.204	.032	.260	.118
15. STQ total	.053	.009	-.014	-.114
16. Belief total	-.116	.153	-.071	.384*
17. Time total	.158	.265	.046	.019

Table 4

Continued

Variables	5	6	7	8
5. Trauma training	-			
6. Number of clients	-.082	-		
7. Trauma clients	-.044	.109	-	
8. FormalDx	.100	.111	.086	-
9. PeerID	-.346*	.194	.137	.508***
10. Supervision availability	.125	.184	.173	.179
11. Engagement in supervision	.248	-.034	-.228	-.007
12. Supervision time	.074	.189	-.158	-.122
13. Supervisory relationship	.166	.068	-.036	-.118
14. Education level	-.004	.141	.041	.150
15. STQ total	-.057	.229	.021	-.060
16. Belief total	.149	.210	.091	-.366**
17. Time total	.207	.133	-.057	-.209

Table 4

Continued

Variables	9	10	11	12
9. PeerID	-			
10. Supervision availability	-.007	-		
11. Engagement in supervision	-.133	.385**	-	
12. Supervision time	-.290*	.537***	.829***	-
13. Supervisory relationship	-.095	.192	.258	.388*
14. Education level	-.104	-.002	-.184	-.007
15. STQ total	-.111	-.181	-.007	.055
16. Belief total	-.554***	-.139	-.090	.222
17. Time total	-.425***	-.045	.125	.460***

Table 4

Continued

Variables	13	14	15	16
13. Supervisory relationship	-			
14. Education level	-.010	-		
15. STQ total	-.159	.015	-	
16. Belief total	.269	-.131	.420***	-
17. Time total	.467***	.001	.495***	.762***

Note. FormalDx = Formal trauma diagnosis. PeerID = Peer-identified trauma

*p < .05. **p < .01. ***p </= .001

Table 5

Differences between Counsellors with and without Trauma-specific Training

Variable	Trauma Training (n = 41)		No Training (n = 8)			
	%	*SD*	%	*SD*	*t*	*p*
Age	42.80	10.38	36.88	8.46	1.52	.136
Work experience	8.40	5.91	4.00	2.73	2.05	.046
Counselling credit hours	51.85	60.99	153.83	218.63	1.13	.308
Number of clients	143.31	83.92	166.25	188.35	.34	.745
Number of trauma clients	57.42	99.19	68.43	70.94	.28	.782
Supervision time	2.76	1.61	2.43	1.90	.48	.632
Supervisor relationship	3.55	1.21	3.00	1.41	.99	.328
Education level	3.37	.77	3.38	1.06	.03	.977
STQ Total score	36.00	10.96	37.75	14.64	.39	.698
CSI-Belief total score	52.76	7.48	49.63	9.52	1.04	.305
CSI-Time total score	41.66	6.52	37.75	9.11	1.45	.153

Table 6

Forward Stepwise Multiple Regression Predictors of Counsellors' STQ Total Score for

the Total Sample

	Unstandardized Coefficients		Standardized Coefficients		
Model	*B*	Std. Error	*Beta*	*t*	*p*
1 Constant	88.125	15.017		5.868	.000
Peer-identified trauma	-26.125	7.646	.475	3.417	.001

Excluded Variables			
Model	*Beta In*	*t*	*p*
Trauma training	-.036	-.036	.806
Formal trauma diagnosis	-.237	-.237	.098
Number of clients	.135	.976	.365
Number of trauma clients	.167	1.128	.266

Note. R² = .226 for step 1 (p < .001).

Table 7

Differences between Male and Female Counsellors

Variable	Males (*n* = 7)		Females (*n* = 47)			
	%	SD	%	SD	t	p
Age	49.29	12.19	40.64	10.03	2.07	.043
Work experience	7.29	4.79	7.49	5.74	.09	.930
Counselling credit hours	19.33	23.34	99.30	131.80	2.75	.011
Number of clients	161.43	117.96	139.98	101.72	.51	.613
Number of trauma clients	120.00	235.54	48.93	42.92	.74	.494
Supervision time	1.60	1.34	2.91	1.59	1.77	.084
Supervisor relationship	2.25	.96	3.62	1.21	2.19	.035
Education level	3.29	.76	3.36	.82	.23	.818
STQ Total score	36.29	12.53	36.60	11.45	.06	.948
CSI-Belief total score	48.71	7.68	52.19	7.70	1.12	.270
CSI-Time total score	36.00	5.45	41.91	7.60	1.98	.053

Table 8

Differences between Counsellors with and without a Formal Trauma Diagnosis

Variable	Trauma Diagnosis ($n = 41$)		No Diagnosis ($n = 8$)			
	%	SD	%	SD	t	p
Age	40.38	8.88	41.91	11.07	.37	.712
Work experience	6.71	4.39	7.41	5.73	.31	.760
Counselling credit hours	64.50	59.67	86.75	132.28	.33	.746
Number of clients	168.13	82.37	139.68	106.87	.79	.434
Number of trauma clients	77.83	70.60	54.85	93.56	.58	.568
Supervision time	2.38	1.60	2.90	1.63	.84	.404
Supervisor relationship	3.17	1.84	3.58	1.16	.75	.458
Education level	3.63	.52	3.29	.843	1.09	.282
STQ Total score	33.90	22.39	35.91	10.30	.28	.787
CSI-Belief total score	40.50	21.67	52.24	8.30	1.69	.124
CSI-Time total score	35.20	18.98	41.07	8.11	.96	.361

Table 9

Differences between Counsellors with and without Peer-Identification of a Trauma

Disorder

Variable	Peer Identification ($n = 41$)		No Peer Identification ($n = 8$)			
	%	SD	%	SD	t	p
Age	40.00	12.00	41.78	0.75	.28	.783
Work experience	3.67	2.08	7.54	5.62	1.18	.243
Counselling credit hours	19.50	2.12	88.50	127.43	.75	.459
Number of clients	221.67	180.02	136.61	97.89	1.40	.169
Number of trauma clients	116.00	135.77	55.20	89.48	.93	.359
Supervision time	1.00	.00	2.93	1.60	8.22	.000
Supervisor relationship	3.00	.00	3.55	1.28	2.72	.010
Education level	3.00	1.00	3.36	.80	.75	.458
STQ Total score	31.00	31.80	36.00	10.16	.35	.744
CSI-Belief total score	28.40	26.08	52.27	7.92	2.04	.110
CSI-Time total score	25.40	23.59	41.45	7.86	1.51	.203

Table 10

Forward Stepwise Multiple Regression Predictors of Counsellors' Amount of Time Spent
Using Coping Strategies for the Total Sample

	Unstandardized Coefficients		Standardized Coefficients		
Model	*B*	Std. Error	*Beta*	*t*	*p*
1 Constant	30.441	15.017		10.475	.000
Time spent in supervision	3.123	.813	.704	3.839	.002

Excluded Variables			
Model	*Beta In*	*t*	*p*
Supervision availability	-.097	-.457	.655
Engagement in supervision	.129	.331	.745
Supervisory relationship	.015	.063	.950
Counselling credit hours	-.033	-.166	.871
Level of education	-.008	-.043	.966
Years of work experience	.033	.166	.871
Trauma training	-.245	-1.37	.194
Number of clients	.167	.885	.391
Number of trauma clients	-.052	-.274	.788

Note. R² = .496 for step 1 (p < .002).

Table 11

Differences between Counsellors with and without Supervision Availability

Variable	Peer Identification ($n = 41$)		No Peer Identification ($n = 8$)			
	%	SD	%	SD	t	p
Age	40.35	11.05	42.59	10.43	.75	.460
Work experience	6.34	5.00	8.09	5.87	1.09	.279
Counselling credit hours	94.75	110.29	74.29	131.96	.44	.664
Number of clients	164.76	127.42	126.53	80.75	1.34	.186
Number of trauma clients	75.75	129.79	44.68	41.51	1.19	.241
Supervision time	3.85	1.50	2.10	1.29	4.36	.000
Supervisor relationship	3.76	1.18	3.29	1.31	1.24	.223
Education level	3.35	.75	3.35	.85	.01	.990
STQ Total score	32.43	15.20	37.21	11.22	1.36	.178
CSI-Belief total score	48.04	16.49	51.50	8.37	1.04	.302
CSI-Time total score	39.35	14.18	40.32	7.93	.332	.741

Table 12

Differences between Counsellors who Engage in Supervision and those who do not

Engage in Supervision

Variable	Engage ($n = 41$)		No Engage ($n = 8$)			
	%	SD	%	SD	t	p
Age	40.94	11.23	42.87	9.80	.66	.513
Work experience	6.82	5.16	8.30	6.12	.96	.341
Counselling credit hours	85.47	108.78	78.92	143.24	.14	.890
Number of clients	138.88	108.42	145.95	94.96	.24	.808
Number of trauma clients	40.50	31.08	81.60	132.20	1.36	.187
Supervision time	3.96	1.04	1.29	.72	10.69	.000
Supervisor relationship	3.75	1.18	3.07	1.33	1.69	.099
Education level	3.23	.85	3.52	.73	1.35	.184
STQ Total score	35.21	14.30	35.39	11.30	.05	.959
CSI-Belief total score	49.21	13.79	51.43	9.81	.67	.507
CSI-Time total score	41.03	12.49	38.30	7.58	.94	.354

Table 13

Correlations of Counsellors' Trauma Variables for the Low STQ Group

Variables	1	2	3	4
1. Gender	-			
2. Work experience	-.219	-		
3. Counselling credits	.236	-.136	-	
4. Trauma training	-.169	.319	-.473	-
5. Number of clients	.026	.195	-.232	-.265
6. Trauma clients	-.319	-.115	-.034	.083
7. FormalDx	.109	-.215	-.159	-.163
8. PeerID	.060	-.187	-.198	-.465*
9. Supervision availability	.038	-.098	.055	.115
10. Engagement in supervision	.149	-.246	.026	.224
11. Supervision time	.061	.031	.305	.065
12. Supervisory relationship	.201	.371	-.192	.464
13. Education level	-.158	.200	-.030	-.371
14. Belief total	.151	.005	.546*	.061
15. Time total	.190	.196	.080	.213

Table 13

Continued

Variables	5	6	7	8
5. Number of clients	-			
6. Trauma clients	.350	-		
7. FormalDx	.250	-.142	-	
8. PeerID	-.254	.000	.553**	-
9. Supervision availability	.289	-.059	-.050	-.167
10. Engagement in supervision	.060	-.214	-.169	-.230
11. Supervision time	.309	-.056	-.267	-.232
12. Supervisory relationship	.348	-.068	.055	-.201
13. Education level	.119	.065	.175	-.089
14. Belief total	.185	.296	.013	-.025
15. Time total	.347	-.244	.163	.009

Table 13

Continued

Variables	9	10	11	12
9. Supervision availability	-			
10. Engagement in supervision	.573**	-		
11. Supervision time	.704***	.819***	-	
12. Supervisory relationship	.169	-.209	.150	-
13. Education level	.058	-.089	.006	.048
14. Belief total	-.064	-.031	.108	.053
15. Time total	.381	.349	.523**	.455*

Table 13

Continued

Variables	13	14	15
13. Education level	-		
14. Belief total	-.303	-	
15. Time total	-.234	.486*	-

Note. FormalDx = Formal trauma diagnosis. PeerID = Peer-identified trauma

*p < .05. **p < .01. ***p </= .001

Table 14

Correlations of Counsellors' Trauma Variables for the High STQ Group

Variables	1	2	3	4
1. Gender	-			
2. Work experience	.198	-		
3. Counselling credits	.290	.071	-	
4. Trauma training	-.107	.267	.177	-
5. Number of clients	-.108	.006	.007	.268
6. Trauma clients	.324	.128	.289	.290
7. FormalDx	-.076	.070	-.074	-.055
8. PeerID	-.283	-.171	-.102	-.273
9. Supervision availability	.091	-.191	.026	.134
10. Engagement in supervision	.508**	-.049	.054	.273
11. Supervision time	.427*	-.093	.019	.088
12. Supervisory relationship	.351	-.297	.279	.038
13. Education level	.171	.303	.337	-.331
14. Belief total	.158	-.152	.254	.267
15. Time total	.324	-.068	-.028	.202

Table 14

Continued

Variables	5	6	7	8
5. Number of clients	-			
6. Trauma clients	.331	-		
7. FormalDx	.042	.398*	-	
8. PeerID	-.345	.402*	.236	-
9. Supervision availability	.155	.152	.208	-.213
10. Engagement in supervision	-.109	-.204	-.019	-.348
11. Supervision time	.156	.005	.000	-.343
12. Supervisory relationship	.050	.143	-.173	.041
13. Education level	.157	.240	.133	-.116
14. Belief total	.268	-.002	-.157	-.256
15. Time total	.046	.268	.111	.027

Table 14

Continued

Variables	9	10	11	12
9. Supervision availability	-			
10. Engagement in supervision	.072	-		
11. Supervision time	.375	.843***	-	
12. Supervisory relationship	.201	.336	.567**	-
13. Education level	-.050	-.263	-.008	-.034
14. Belief total	.221	.151	.370	.393
15. Time total	.035	.331	.424*	.489*

Table 14

Continued

Variables	13	14	15
13. Education level	-		
14. Belief total	-.037	-	
15. Time total	.151	.477**	-

Note. FormalDx = Formal trauma diagnosis. PeerID = Peer-identified trauma

*p < .05. **p < .01. ***p </= .001

Table 15

Forward Stepwise Multiple Regression Predictors of Counsellors' STQ Total Scores for the High STQ Group

	Unstandardized Coefficients		Standardized Coefficients		
Model	B	Std. Error	Beta	t	p
1 Constant	81.381	14.795		5.501	.000
Peer-identification of a trauma disorder	-19.381	7.651	.484	-2.533	.019

Excluded Variables			
Model	Beta In	t	p
Trauma training	-.064	-.316	.755
Formal trauma diagnosis	-.220	-1.134	.270
Number of clients	-.034	-1.64	.871
Number of trauma clients	.101	.475	.640

Note. R² = .234 for step 1 (p < .019).

Table 16

Differences between Counsellors' Low and High STQ Scores

Variable	Low STQ Scores (0-33)		High STQ Scores (34-79)			
	%	SD	%	SD	t	p
Age	40.27	10.05	43.14	11.12	.99	.325
Work experience	6.88	5.25	8.02	5.94	.74	.465
Number of clients	121.16	65.91	160.00	124.90	1.39	.170
Number of trauma clients	41.77	33.73	51.81	46.98	.84	.408
Education level	3.35	.75	3.36	.87	.05	.961
CSI-Belief total score	48.18	15.97	51.97	8.70	1.15	.257
CSI-Time total score	37.61	12.46	42.17	8.50	1.62	.111

Table 17

Forward Stepwise Multiple Regression Predictors of Counsellors' Amount of Time Spent Using Coping Strategies for the Low STQ Group

Model	Unstandardized Coefficients		Standardized Coefficients		
	B	Std. Error	Beta	t	p
1 Constant	59.533	5.461		10.902	.000
Engagement					
In supervision	-13.933	3.746	-.835	-3.720	.010

Excluded Variables			
Model	Beta In	t	p
Supervision time	.345	.766	.478
Supervision availability	-.406	-1.927	.112
Supervisory relationship	.311	1.434	.211
Counselling credit hours	.157	.662	.537
Education level	-.304	-1.482	.199
Work experience	.224	.987	.369
Trauma training	.003	.010	.993
Number of clients	.030	.119	.910
Number of trauma clients	-.052	-.192	.855

Note. R^2 = ..698 for step 1 (p < .010).

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APPENDIX A: Informed Consent Form

Research Project Title: *The Presence of Secondary Traumatic Stress (STS) in School Counsellors*

Researcher(s): Andrea D. Moore; Dr. Glen McCabe (Supervisor)

This informed consent form is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. The official copy of this informed consent form containing the University of Manitoba's letterhead was emailed to you in order to enable you to the ability to print a copy for your records and reference. If you would like more detail about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand any accompanying information.

Purpose of the research:

Counsellors experience regular work-related stress associated with the demand of helping individuals with their emotional needs. Sometimes when a client discloses details of traumatic life experiences, the counsellor in turn can experience their own set of emotional responses. The purpose of this research is to examine these counsellor experiences. As a participant in this study, you will be asked questions about difficult situations you may have encountered in your counselling role, your work with students who have experienced traumatic events, and your perceptions about the difficult aspects of your work.

Procedures:

Potential participants will be contacted by Senior Administrators of their school divisions such as School Board Chairs, School Superintendents and/or School Principals inviting them to participate in the proposed study. Participants will be forwarded a "Letter of Invitation" that contains the URL to a web page for entrance into the survey. The informed consent form appears first followed by the "Counselling Resource List". The next page is the electronic copy of the Secondary Traumatic Stress Impact Questionnaire

(STSIQ). The STSIQ is a brief statement type of questionnaire which also invites participants to offer commentary on experiences with trauma survivors, and how these experiences affect them both personally and professionally. The questionnaire should take approximately 15 minutes to fill out.

Once participants have read and understood what their involvement in the research study entails, they will be informed that continuance past informed consent page will be considered their assent to participate in the study. Once participants are ready to move on to the survey page, they can begin immediately by scrolling down to the first section of the STSIQ. When participants have finished the survey they will then be prompted to click on the word "Submit". There will be no deception as a means of conducting this research and no recording devices are to be used in this research study.
Some of the questions asked throughout the survey may cause participants more distress than what you might normally experience in the conducts of your everyday life, as you will be asked to recall details of difficult situations associated with your work. *If you are experiencing any negative emotional responses as a result of your work as a school counsellor, or as a result of recalling difficult situations while participating in this study, please see the "Counselling Resource List" (following this informed consent form) for agencies and organizations that provide counselling support to help deal with these issues.*

Confidentiality:

To guarantee participants' anonymity and that no two respondents can be distinguished from one another only the answers to survey questions will be automatically forwarded to the primary researcher. This assures that no identifying information is linked to any individual participant responses. Furthermore, as per Canadian Psychological Association guidelines, data collected will be kept under locked computer file protected by password that only primary researcher has access to. Data will be retained until study is completed (as determined by binding of thesis study), and then disposed of by deletion of all pertinent computer files located either on device hard drive, or on an external zip drive. Only the primary researcher, research supervisor (Dr. Glen McCabe), a co-rater from the Graduate Department recruited to assist with recording participants' responses, and the web server hosting site (which adheres to strict confidentiality procedures and guidelines) will have the ability to view the raw data. All individuals involved directly with the research will have read and signed confidentiality agreements in order to assist with the research.

Feedback:

A summary of the research results will be made available to participants upon request. Furthermore, participants are also encouraged to offer their own feedback based on their experience as a participant of this study. This may be done by calling or e-mailing the primary researcher or research supervisor at the contact information provided below, and requesting study results or offering feedback. The survey also has a section (Section E) whereby participants can also offer commentary and feedback if they choose.

Your continuance past the signature portion of this form indicates that you have understood to your satisfaction the information regarding participation in the research project and agree to participate as a subject. In no way does this waive your legal rights nor release the researchers, sponsors, or involved institutions from their legal and professional responsibilities.

You are free to withdraw from the study at any time, and/or refrain from answering any questions you prefer to omit without prejudice or consequence. If you decide that you do not wish to answer a question, you may move on to the next one. If you decide that you do not wish to continue to participate in the study, you may either send your form blank, or close your webbrowser. Your continued participation should be as informed as your initial consent, so you should feel free to ask for clarification or new information throughout your participation (through the contact information provided below). [Andrea D. Moore (primary researcher) **surpant_@hotmail.com** (204) 999-9940; Dr Glen McCabe (supervisor) **glen_mccabe@umanitoba.ca** (204) 474-7111]. This research has been approved by the Education/Nursing Research Ethics Board (ENREB). If you have any concerns or complaints about this project you may contact any of the above-named persons or the Human Ethics Secretariat at 474-7122, or e-mail **margaret_bowman@umanitoba.ca**.

Please print a copy of this consent form to keep for your records and reference.
Participant's Signature _____   Date _____
Researcher's Signature _____   Date _____

Appendix B
Secondary Traumatic Stress Impact Questionnaire (STSIQ)

Counsellors experience regular work-related stress associated with the demand of helping individuals with their emotional needs. Sometimes when a client discloses details of traumatic life experiences, the counsellor in turn can experience their own set of emotional responses. This questionnaire includes a number of responses that counsellors may experience as a result of providing services to their clients in a therapeutic setting. Please think about your personal experiences as a counsellor and complete all sections (A to F) regardless of how you reply to each individual question.

SECTION A

Gender: _____

Age: _____

Area of specialization: _____

Years of work experience as a school counsellor: _____

SECTION B *(please answer all questions):*

How many credit hours in counsellor training have you obtained? _____

Please check all that apply and provide name of your degree/certificate:

- ❑ Certificate/Applied Diploma: _____
- ❑ Undergraduate Degree:_____
- ❑ Masters Degree: _____
- ❑ Other (Please describe): _____

Have you participated in trauma-specific training? (if yes, please describe) _____
_____

In addition to your role as a counsellor, do you hold another position? (if yes, please describe) _____

Are you a member of a professional counselling organization? (circle)   Y/N

If so, which organization? _____

How long have you been a member of that organization? _____

SECTION C *(please answer all questions):*

What is the overall student population where you work? _____

What level of schooling do you provide counselling for (please check all that apply):

- ❑ Early Years

- ❏ Middle Years
- ❏ Senior Years
- ❏ Adult Education
- ❏ Other (Please specify): _____

How many clients do you estimate that you have provided counselling services to in the last 2 years?_____

Please check off any of the following if they have been a presenting issue for a client that you are providing service to:

- ❏ Sudden loss of a close loved one
- ❏ Witness/survivor of a natural disaster
- ❏ Witness/survivor of a fatal car crash
- ❏ Witness/survivor of a violent death
- ❏ Witness/survivor of a murder
- ❏ Incest
- ❏ Rape
- ❏ Childhood sexual abuse
- ❏ Domestic/family violence
- ❏ Physical, mental or emotional abuse
- ❏ Other (Please specify):
  _____

Of the clients that you have provided services to in the last two 2 years, how many do you estimate are affected by the traumatic life experiences as outlined above?_____

SECTION D: Secondary Trauma Questionnaire

(For the complete version of the STQ, please see "Appendix B Reference" below for Motta, Kefer, Hertz, & Hafeez, 1999).

SECTION E

Have you been formally diagnosed by a psychiatrist, clinical psychologist, family physician or other related professional as suffering from a trauma disorder (if yes, please specify)? _____.

Has another counsellor, co-worker, supervisor, or other person in a similar role ever identified you as suffering from a trauma disorder (if yes please explain). _____

_____.

Is clinical supervision available to you in your current work setting? (circle)

Y/N

Do you engage in supervision? (circle)   Y/N

How often do you engage in supervision? (Please specify):

_____

What type of supervision do you currently engage in? (Please check any that apply):

- ❑ Administrative supervision (provided by a school administrator who is not a counsellor).
- ❑ Personal supervision (one-on-one with a trained counselling supervisor).
- ❑ Group (supervisor-directed group supervision)
- ❑ Peer-group (peer-directed group supervision,
- ❑ Other (Please describe):

    _____

How would you describe your relationship with the supervisor you currently work with? *(Please offer commentary regarding your relationship with your supervisor. Use any additional paper you require):*

(Please offer commentary, if you wish, regarding your professional experience with trauma and traumatized clients on a more personal level. Use any additional paper you require):

SECTION F (Please fill out the following section):
Beliefs

COPING STRATEGIES INVENTORY

(For the complete version of the STQ, please see "Appendix B Reference" below for

(Bober, Regehr & Zhou, 2006).

Appendix B References:

Arvay, M. (2001). Secondary traumatic stress among trauma counsellors: What does the
Research say? *International Journal for the Advancement of Counselling, 283-293, 23.*

Bober, T., Regehr, C., & Zhou, Y. (2006). Development of the Coping Strategies
Inventory for Trauma Counsellors. *Journal of Loss and Trauma, 11,* 71-83.

Collins, S., Long, A. (2003). Working with the psychological effects of trauma:
Consequences for mental health-care workers – a literature review. *Journal of
Psychiatric and Mental health Nursing, 10*, 471-424.

Motta, R., Kefer, J., Hertz, M., & Hafeez, S. (1999). Initial evaluation of the secondary
trauma questionnaire. *Psychological Reports, 1999,* 997-1002.

UNIVERSITY
OF MANITOBA

APPENDIX C

School Superintendent Letter of Permission

May 15th, 2010

Mr./ Mrs. Doe

Title

Organization

Address

City, MB POSTAL

Dear Mr./ Mrs. Doe,

I am currently finishing my graduate thesis work to complete my Masters Degree at the University of Manitoba, Faculty of Educational, Administration, Foundations and Psychology (EAF&P) in the Counsellor Education Program. I am writing to seek approval in order to access the counsellor population in your school division. Ethics approval to conduct my study from the Education/Nursing Research Ethics Board (ENREB) at the University of Manitoba has been obtained (Protocol #E2009:139, see attached).

The focus of my research is on school counsellors and whether Secondary Traumatic Stress (STS) exists amongst this population. The purpose of this research is to identify the presence of STS and some of the conditions that may contribute to this phenomenon in school counsellors.

Barwick (2000) notes that the role of the school counsellor has changed dramatically in recent years and as a result, school counsellors face the same issues that counsellors in other settings encounter, such as: bullying, bereavement, divisions in the family, substance abuse, physical, emotional and sexual abuse, sexual and racial harassment, unwanted pregnancy, and isolation (as cited in Christianson & Everall, 2008). School counsellors are likely to work therapeutically with abused children in the school (Etherington, 2009) and are also likely to encounter a student suicide, if not a client suicide, during their career (Christianson & Everall, 2008). "The welfare of the students in counselling is clearly an important issue for school divisions, and administrators need to be aware of how both counsellors and students may be affected" (Hamilton, 2008).

It appears that school counsellors have not garnered as much attention in STS literature as other groups of professionals such as community counsellors and trauma counsellors. Through this research it may be possible to reveal the special qualities of the school counsellor that make it possible to do this difficult but rewarding work, as well as to highlight some of the areas where assistance can be provided to make the position of school counsellor more manageable and less stressful.

Attached is the "Letter of Invitation to School Counsellors" inviting them to participate in an on-line survey and providing them the URL for same. The survey will take approximately 15 minutes to complete, is confidential and completely anonymous. No identifying information can be linked to any individual school counsellor, school or school divisions. Please feel free to view the survey.

If you could please forward the "Letter of Invitation to School Counsellors" to the counsellors in your division on my behalf, it would be greatly appreciated. Further, if you could send me an e-mail reply indicating if you agree to forward the letter, it would enable me to get a sense of how many schools I may have access to.

If you prefer to have Principals from your respective school divisions forward the "Letter of Invitation to School Counsellors" on your behalf, there is an alternative letter attached (School Principal Letter of Permission). This letter is addressed to School Principals requesting that he/she contact individual school counsellors in their respective schools and provide them with the invitation to counsellors described above. If you are choosing this option, all of the attachments contained in the email to you will need to be forwarded to your division Principals. Yours assistance with this matter is greatly appreciated. If you have any questions or comments please feel free to contact me. I would like to Thank-you for taking the time to read this letter and for your potential assistance with my research.

Sincerely,

Andrea D. Moore

University of Manitoba

EAF&P

Grad Student/BAHons. Psych.

Cell: (204) 999-9940

Home: (204) 783-9893

Surpant_@hotmail.com

References:

Etherington, K. (2009). Supervising helpers who work with the trauma of sexual abuse.

   British Journal of Guidance & Counselling, 179-194, 37.

Hamilton, M. (2008) Compassion fatigue: What school counsellors should know about

   Secondary Traumatic Stress. *The Alberta Counsellor, 9-21*, 30.

Christianson, C., & Everall, R. (2008). Constructing bridges of support: School

   counsellors' experiences of student suicide.

Appendix D

Dear School Counsellors,   September 10, 2010

I am currently finishing my graduate thesis work to complete my Masters Degree at the University of Manitoba, Faculty of Educational, Administration, Foundations and Psychology (EAF&P) in the Counsellor Education Program. I am looking for interested individuals who provide counselling services to students, to participate in the questionnaire designed for my research.

Counsellors experience regular work-related stress associated with the demand of helping individuals with their emotional needs. Sometimes when a client discloses details of traumatic life experiences, the counsellor in turn can experience their own set of emotional responses. The purpose of this research is to examine these counsellor experiences.

As you are aware, research conducted in the area of human services is highly important. With your valuable input it may be possible to reveal the special qualities of the school counsellor that make it possible to do this difficult but rewarding work, as well as to highlight some of the areas where assistance can be provided to make the position of school counsellor more manageable and less stressful. I hope you will find the time in your busy schedules to provide your input. The survey will take approximately 15 minutes to complete. If you can find the time to participate, your contribution is important and will be much appreciated.

If you are interested in participating in this important area of counsellor research, please copy and paste this URL into your webbrowser to enter the survey: www.spreadsheets.google.com/viewform?formkey=dFk0M1RsZW1ldml3LVFsdk5TSi1iN3c6MQ. This website contains the informed consent form that will provide more details of the study. **As well, there is a copy of the informed consent form appended to this letter for you to print off to keep for your records.**

In order to maintain confidentiality as well as to Thank-you for your assistance with this research, please send a separate email to the primary researcher with your contact information in order to be entered into a draw to win a $50.00 gift certificate to "The Keg" once you have completed the survey. As the survey responses are sent anonymously to the primary researcher, your submission to be entered into the draw for the gift certificate will in no way be linked to any study responses. If you have any questions or concerns, please feel free to contact either myself or the research supervisor. No indentifying information will be linked to participants and all survey responses will kept confidential.

Sincerely,

Andrea D. Moore,

Primary Researcher
(Graduate Student, EAF&P)

COUNSELLING RESOURCE LIST

Manitoba Teachers Society (MTS)

Education Assistance Program (EAP)

McMaster House

191 Harcourt Street

Winnipeg, MB R3J 3H2

(204) 837-5801 (800) 378-8811

MTS, Brandon EAP

Room 28, 144-6th Street

Brandon, MB R7A 3N2

(204) 571-2080 (800) 555-9336

Aurora Family Therapy Centre

University of Winnipeg

Sparling Hall

2nd Floor, 515 Portage Avenue

Winnipeg, MB R3B 2E9

(204) 786-9251

University of Manitoba Student

Counselling & Career Centre

Fort Gary Campus

474 University Centre

Winnipeg, MB R3T 2N2

(204) 474-8592

Bannatyne Campus

S207 Basic Medical Sciences Building

Health Sciences Centre

Send mail to:

Fort Gary Campus address (above)

(204) 789-3857 (204) 474-8592

Klinic Community Health Centre

870 Portage Avenue

Winnipeg, MB R3G 0P1

(204) 784-4059

FOR IMMEDIATE ASSISTANCE, PLEASE CALL:

Klinic 24-Hour Crisis Line: (204) 786-8686

Toll free: (888) 322-3019

TTY: (204) 784-4097

Manitoba 24-Hour Suicide Line: (877) 435-7170

Mobile Crisis Service: (204) 940-1781

Questions and Concerns may be directed to Andrea D. Moore (primary researcher) andreamoore@mts.net (204) 783-9893; Dr Glen McCabe (supervisor) glen_mccabe@umanitoba.ca (204) 474-7111 of the Faculty of Educational Administration, Foundations and Psychology, University of Manitoba.