SECONDARY TRAUMATIC WORKPLACE STRESS RISK FACTORS AND SYMPTOMS OF DEPRESSION IN B.C. ADULT PROBATION OFFICERS: CLINICAL AND ORGANIZATIONAL IMPLICATIONS

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Abstract

The aim of this investigation has been to examine the relationships among secondary traumatic stress workplace risk factors and symptoms of depression in probation officers. The results from over 167 adult probation officers who participated in *The Road Back to Wellness: Stress, Burnout and Trauma in Corrections* (Fisher, 2001), a 2-day live workshop coordinated through the Justice Institute of British Columbia was explored.

The intentions of the statistical exploration were to aid in data interpretation and to discover whether these variables were explainable in terms of any underlying predictors. This study is part of the journey for exploring, identifying and explaining factors related to secondary traumatic stress and depression. It is ultimately designed to assist the B.C. Community Corrections Branch in gaining insight from the results of the workshop as well as for targeting clinical and organizational interventions for managing work-related secondary traumatic stress and associated symptoms.

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Dedication

To my dearest friend Marina, thank you for your endless source of encouragement, inspiration and support. I dedicate this project those who have been impacted by trauma and depression, especially those who live in silence with the stigmatization. In this, I ultimately devote this effort to my late father, John Travers.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

CHAPTER I - INTRODUCTION

"**One of a parole officer's primary responsibilities is to analyze and assess risk while working to reintegrate offenders in the community safely.**" Case Management Supervisor, Toronto West Area Parole Office 1

The consequences of workplace stress pose potentially serious problems in corrections. Probation officers are exposed to both systemic stresses (i.e., job stress, burnout, discrimination and harassment) and traumatic stresses (i.e., primary and secondary traumatic stresses). These workplace stresses increase the risks for negative effects on individual officers and organizations. Exposure to secondary trauma or what is hearing about violent, brutal, and tragic events occurs often in the line of probation work. As Figley (1995a) puts it, "People can be traumatized without actually being physically harmed or threatened with harm. They can be traumatized simply by learning about a traumatic event." (p.51).

In particular, probation officers who work with violent and/or sex offenders are exposed to client disclosures and descriptions of their offences, as well as victim impact statements, police and court reports. Anyone who is capable of caring is inevitably affected by information of this nature. Being subjected to this kind of traumatic material may result in secondary traumatic stress effects. In addition, there is an inherent risk in probation work duties for physical injury, threats and stress in cases where an officer has actually been victimized by violence on the job. Whether an officer's perceptions of danger are real or suspected, these have a potentially harmful impact on the officer.

Unlike burnout and primary traumatic stress, secondary trauma effects can appear suddenly and unexpectedly. Eventually, the symptoms of secondary trauma may include those

found in Post Traumatic Stress Disorder (PTSD). Secondary trauma can also result in serious challenges to the officer's core meaning systems – their existential or spiritual beliefs (Fisher, 2000a; 2000b). Emotional and physical depletion are additional risks for the responsibility of 'caring' for clients.

As with other paramilitary occupations, the impact of trauma on officers is traditionally given little significance in corrections. Emotional response is often deemed weakness and those officers who experience the effects of psychological and emotional trauma may be stigmatized. (Fisher, 2001a; Fisher 2001b) Consequently, corrections' subculture may hinder an officer's willingness to seek ongoing personal care or to acknowledge more serious concerns as they arise, potentially compounding already existing stress effects.

Both the work conditions and the clients are stressful in probation work (Holgate & Clegg, 1991; Morgan et al., 2002): working with offenders and exposure to realities of violence, abuse, trauma, poverty, system failures, etc. may challenge an officer's previous belief system and frame of reference. The experience and knowledge gained from working with the offender population is specialized and most general members of society do not share associated knowledge. This may contribute to a sense of isolation in being a probation officer, and potentially have the impact of compounding existing stressors. Moreover, the work may be devalued by society given that officers deal with those who break the law.

Statement of the problem

Increased attention is being paid to the issue of workplace stress. Employees and employers are increasingly concerned about the impact of work-related stress on health, productivity, absenteeism and staff turnover rates. As such, stress-related symptoms, effects and

illnesses have resulted in direct and indirect costs to individuals, organizations and society. Personal consequences may be anxiety, depression, job dissatisfaction, interpersonal difficulties, burnout and physical illness or disease: stressful or traumatic events have the potential to alter a wide range of immunological activities. (Fisher, 2000a)

Occupational stress among criminal justice personnel, especially police has been discussed frequently in the research literature. The corrections and law enforcement fields are commonly believed to be highly stressful. An emerging body of work has consistently found the issue of worker stress in the criminal justice field to be a serious problem, however findings are inconsistent and ambiguous (Patterson, 1992). Comparatively little attention has been paid to the stressors specific to probation officers (O'Donnell & Stephens, 2001), the personal and organizational implications. Even less consideration has been paid to the potential risks, reactions, and prevention of harm from exposure to a client's traumatic material, which might naturally result from a probation officer's potential conflict between his or her professional role and relationship with the client.

Paralleling findings commonly identified in studies on police officers indicates that corrections personnel may also suffer from significant levels of stress, stress-induced illnesses, identity challenge, stigmatization and isolation. Probation officers are expected to simultaneously fill the frequently opposing roles of custodian and counsellor. They are professionally held responsible for both the conditions of a client's probation (and potential breach thereof), while assessing the risks to the general public as well as serving as an advocate for the client to reintegrate back into society.

Purpose of the study

Secondary traumatic stress is of particular interest to the field of probation work for several reasons. Little attention has been given to the extent probation officers are exposed to traumatic material; the support environment they experience, and how these systemic factors relate to depressive symptoms that may be associated with secondary traumatic stress. It would also be prudent for probation officers to be cognizant of the signs and symptoms of secondary traumatic stress and depression in themselves and colleagues. This could help ensure that agencies and organizations take appropriate steps to meet the needs of their officers and clients.

This study contributes to the ongoing investigation of secondary traumatic workplace stress risk factors and symptoms of depression specifically in probation officers. This is accomplished through the statistical analyses of the STS workplace risk and depression variables to be examined from the workshop results of those probation officers who voluntarily participated in this study. Implications for future investigations of the existing data, new research directions and potential clinical and organisational directions, specifically for the B.C. Community Corrections Branch are further discussed.

Delimitations

This study is limited in scope. Its limits are bound specifically to the population sample of probation officers for three primary reasons:

1. Probation officers have received scant attention in the research literature.
2. The nature of probation work may place an officer at risk for the effects of secondary traumatic stress.
3. The data has already been collected.

It would not be reasonable to attempt to explore all of the variables taken from the wellness workshop within the scope of this study. This study was intended to confirm or refute the prevalence of secondary traumatic risk variables suspected for being in relationship to symptoms of depression. The patterns of relationship among those variables under investigation were also explored. The intentions of this statistical exploration have been primarily twofold: to aid in data interpretation (as in which characteristics of the variables go together); and to discover whether these variables are explainable in terms of a much smaller number of underlying independent factors that may serve as predictors for STS effects and symptoms of depression under investigation.

Consequently, this study paves the way for continued exploration of the existing data and future research directions in the field. As such, it first serves to assist with promoting the identification of the underlying risk factors or explanatory constructs behind the variables investigated in this study. Further, it is the researcher's intention to generate a theory based on the results. Partnered with current research, it will target ideas around the prevention and intervention of individual and workplace risks for secondary trauma and depression, in particular as revealed through the exploratory factor analysis.

In the end, this study has aimed to be part of the journey for exploring, identifying and explaining factors related to secondary traumatic stress and depression specifically in the probation officers who participated, and more generally in those who work in related fields and may be deemed at risk. It is ultimately designed to assist the B.C. Community Corrections Branch in gaining insight from the results of the workshop, and potentially offers a means of

validation and/or recommendations around their current attitudes and practices in dealing with secondary traumatic stress and depression in their probation officers and workplace.

CHAPTER II – LITERATURE REVIEW

Traumatic stress studies have been present in the research literature only within the last fifteen years. A historical highlight that preceded this presence occurred in 1980 when the American Psychiatric Association's third edition of Mental Disorders (DSM-III) included the diagnosis of post-traumatic stress disorder (PTSD) for the first time. The inclusion offered a structure for which the symptoms associated with trauma could be examined, diagnosed and treated. However, the focus of the diagnostic criteria was on individuals who had actually experienced the event, and the assessment of secondary victims remained vague. Nonetheless, how individuals respond to indirect exposure to traumatic events has received increasing attention in the research literature. In particular, studies of those working in the field of law enforcement, medical professionals, social workers and psychotherapists have focused on secondary trauma, and moderating variables such as years in the field, age and level of education, to name a few.

In the latest edition DSM (American Psychiatric Association, 1994), the diagnostic criteria for PTSD includes a shift in wording to include a person who has "experienced, witnessed, or been confronted with an event or events that involve actual or threatened death or serious injury, or threat to the physical integrity of oneself *or others*" (APA, 1994, p. 27). This indicates a paradigm shift from viewing PTSD as affecting only the primary trauma victim to one in which secondary association or what may be deemed being in relationship and having knowledge of the traumatic event may place one at risk of developing symptoms with associated PTSD pathology. While the DSM-IV includes the secondary experiencing of trauma within the context of PTSD, clinicians and researchers in the field of traumatic stress have described those

who are distressed as a result of their work with traumatized clients as a distinct condition, secondary traumatic stress disorder or STSD (Figley, 1995; 1995a).

The field of secondary traumatic stress has been exploratory in nature and knowledge has been largely generated from clinical experience, judgments and wisdom, rather than from empirical studies. Consequently, despite an expanding interest in secondary traumatization (probably most notably since September 11th, 2001 and the tragedy of the World Trade Centre attack), the literature is primarily theoretical in nature (Figley, 1995; McCann & Pearlman, 1990; Saakvitne & Pearlman, 1996). In addition, factors such as ethics in human subject participation, ongoing discussions over terminology and concepts, and comparative infancy of theory have played roles in this seeming lack of empirical research to date. Further, the call for research methodology that is specific to secondary traumatic stress has not been reviewed or identified.

Secondary traumatic workplace stress

Various terms associated with secondary traumatic workplace stress commonly appear in the research literature: compassion fatigue, compassion stress, secondary traumatic stress, vicarious traumatization, secondary victimization, co-victimization, and secondary survivor stress (Figley, 1995a). Through the semantic development of the actual naming of traumatic stress reactions, Figley (1995) also argued for a distinction between primary and secondary traumatic stress. The origins of secondary traumatic stress and secondary traumatic stress disorder (Figley, 1995a) are however, within the posttraumatic stress disorder construct.

Primary traumatic stress effects result from the experiencing of first-hand traumatic events (a 'traumatic event' may be considered any event that produces symptoms of traumatic stress). There is an emergent body of research that indicates there are fields of work where the

risk is higher for not only experiencing stress effects, but of further developing the pathological responses associated with primary trauma from secondary exposure. According to Figley (1995a), these pathological responses (or STSD) are distinguishable from secondary traumatic stress (STS) in that STSD is "a syndrome of symptoms nearly identical to Post Traumatic Stress Disorder (PTSD) except that exposure to knowledge (not actually experiencing) a traumatizing event is associated with the set of STSD symptoms" (p. 8).

As previously noted, various terminology has been used to describe the phenomenon of secondary traumatic stress (STS). It should also be noted that some researchers prefer the terms compassion fatigue and compassion stress because they believe that STS and STSD have derogatory connotations (Stamm, 1995). While other terms are used interchangeably, STS is considered by many researchers in the field to offer the most concise and clear description. For purposes of this study, secondary traumatic stress (*STS*) will be the operational definition for considering the impact of dealing with traumatic material second hand (e.g. effects from hearing about traumatic, violent or distressing events).

Depression: operationally defined

Paralleling findings commonly identified in studies on police officers, the literature also indicates corrections officers may actually suffer from higher levels of stress and stress-induced illnesses, such as depression. Beck (1967) defines depression as marked by feelings that the world is meaningless, the future hopeless, and the self worthless – this is the broad definition of depression that will be considered in this study. DSM IV (DSM IV, 1994) criteria of affective and somatic symptoms of clinical depression are also considered: sad mood; loss of interest and pleasure in life; changes in appetite; sleep disturbances; lack of energy; sense of slowing down,

restless or agitated; feelings of guilt; feelings of hopelessness; feelings of worthlessness or inadequacy; indecisiveness; thoughts that life is not worth living; thoughts of death; and suicidal thoughts.

Definition of client

Offender and client may be used interchangeably in the literature to mean the same. 'Client' however, is the professionally preferred and politically correct term used by the B.C. Community Corrections Branch to refer to those individuals on probation under the 'care' of a probation officer. Therefore, *client* is the term of reference used in this study.

The nature of workplace stress: broad theoretical perspectives

Workplace stress may be broadly categorized into systemic and traumatic workplace stress. When considering these categorical areas of job stress, it is important to view stress responses as following a basic pattern. The officer has been exposed to specific stresses, trauma or traumatic material, experienced these stressors in a unique way and then reacts to the challenges at hand with a set of responses. Consequently, it is important to bear in mind that although a large group of officers may be exposed to the same stress or challenge, reactions may vary radically among individuals. Demographic differences (age, years of service, socioeconomic and professional background, etc.) and personality types may affect not only an individual officer's orientation to their duties, but also his or her resiliency to job stressors. (Fisher, 2000a)

This study will consider three theoretical frameworks that factor characteristics of both the individual probation officer and job when examining levels of traumatic stress. Models have characteristically moved away from a dissected view of job stress that has historically focused on

the individual's perceived incompatibility with the job to embrace a more integrated view of this phenomenon in the workplace (Fisher, 2000a).

i. **Person-Environment Theory** (French &Kaplan, 1972; French, Kaplan & Harrison, 1982) essentially asserts that workplace stress results from an incompatibility between the probation officer and his or her environment. This person-environment incompatibility results in psychological strain and stress-related physical illness. It holds specific significance for paving the way for research on the effects of role ambiguity, role conflict and levels of control.

ii. **Transactional Process Theory** (Lasarus, 1994) expands on person-environment theory by considering how the individual officer perceives a specific stressor. Each officer's history, demographics, belief systems, and character traits will result in a potentially unique reaction to any given stressor.

iii. **Job-Demand Control Theory** (Karasek, 1979) focuses on the interactions between objective pressures of the work environment and the amount of decision control held by the officer through his/her job. Psychological distress is the outcome when very demanding tasks and/or roles - in particular those where the officer has little control or decision-making power.

Partnered with these models is a considerable body of research that has identified a range of workplace and individual risk factors. These factors may assist in forecasting degrees of officer resiliency and susceptibility to workplace stress (Fisher, 2000a; 2000b).

Workplace traumatic stress effects

Long-term impact from traumatic stress is now acknowledged as placing workers at risk for an array of serious effects and symptoms. For example, noteworthy rates of *STS* have been found in law enforcement personnel, emergency services workers, human services and medical staff (Follette, et al, 1994; Alexander et al., 1989; Dyregrov & Mitchell, 1992; Annscheutz, 1999; Genest, Levine, Ramsden & Swanson, 1990; McCammon, 1996; Raphael & Wilson, 1994). Researchers and clinicians acknowledge there are general categorical symptoms and effects of workplace traumatic stress. Symptoms fall generally into physical (e.g. fatigue, sleep difficulties), emotional (e.g. depression, anxiety), and behavioral (e.g. substance abuse) categories. Effects may be organizational (e.g. absenteeism, staff turnover) or interpersonal (e.g. withdrawal from clients and colleagues). Chronic, long-term exposure to secondary trauma can challenge an officer's frame of reference and core beliefs (Pearlman & Saakvitne, 1995), his or her ability to hold a sense of self that is consistent across time and the capacity to fulfill his or her own psychological needs, as well as susceptibility to burnout (Maslach, 1982).

Models of Secondary Traumatic Stress

This study will draw upon two broad theoretical models of secondary traumatic stress cited in the research and literature. (Toward the intention of simplicity, STS will also be the term used herein to embrace the consideration of both models.)

i. **Secondary Traumatic Stress (STS)** parallels the DSM IV criteria for Post Traumatic Stress Disorder or PTSD (Figley, 1995). As such, it includes the same criteria of diagnosis and expected clinical responses for primary traumatic stress – the essential difference being the second hand experience of the trauma.

ii. **Vicarious Trauma (VT)** also acknowledges the clinical PTSD symptoms, but accentuates the psychological and emotional effects of secondary trauma, and how individual responses to a traumatic event are viewed as coping or adaptive responses. (Pearlman & Saakvitne, 1995)

"Vicarious traumatization is a process not an event." (Saaktvine & Pearlman, 1996, p. 41) It is rather 'traumatization' that occurs through the direct exposure to content from a client, victim or other individual associated with a particular probation case or story. If officers are unable to assimilate or work through exposure to traumatic material that is maintained over time, they may also be on a pathway toward burnout (McCann & Pearlman, 1990).

A traumatized probation officer may encounter symptoms related to post-traumatic stress disorder (Figley, 1995; McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995). Based on the Diagnostic and Statistical Manual IV (DSM-IV) (1994) one of the criteria for Post Traumatic Stress Disorder (Or PTSD) is being "exposed to a traumatic event in which the individual experienced, witnessed or was faced with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others" (p. 428). The behaviors and emotions associated with STS are conceived as paralleling the pathological symptoms of PTSD.

An expanding body of research indicates that those in professions at risk are not only experiencing stress, but may also potentially develop pathological responses to second-hand exposure to trauma and traumatic material. These pathological responses which are different from STS are what Figley (1995a) refers to as Secondary Traumatic Stress Disorder (STSD). STSD is "a syndrome of symptoms nearly identical to Post Traumatic Stress Disorder (PTSD) except that exposure to knowledge, but not actually experiencing a traumatizing event, is

associated with the set of STSD symptoms" (p. 8). These symptoms include, but are not limited to: diminished affect and interest in otherwise significant activities; detachment/estrangement from others; sense of a shortened future; sleep difficulties; irritability; difficulty concentrating; hyper-vigilance; physiologic reactivity to cues; and survivor guilt. There have been studies that have examined the negative psychological outcomes for particular groups, especially the posttraumatic stress responses of avoidance, intrusion and hyper-vigilance (Arvay & Uhlemann, 1996; Steed & Bicknell, J., 2001; Fullerton & Ursano, 1997; Lyon, 1993; Steed & Downing, 1998; Ursano et al., 1996). While most of the literature is limited, and focuses primarily on those in the helping professions, such as psychotherapists and medical personnel who work with trauma victims, other professionals such as police officers, social workers, firefighters and corrections personnel (to name a few) are also at risk.

Secondary traumatic workplace stress risk factors: Challenges unique to probation officers

Examining STS from more of an ecological perspective might provide a framework for integrating STS risk factors with the professional and personal characteristics of probation officers within the context of their corrections community (Stephens, 1996). In examining any occupation for specific stress factors, it is important to consider the unique challenges faced, special nature and context of the profession (Lasarus, 1994; Karasek, 1979).

A probation officer working for B.C. Community Corrections (2003) is generally "responsible for supervising adult offenders in the community on court order through the management of risk, thus protecting the community from further offenses, safeguarding the interests of victims and the public, and directing offenders toward a non-criminal lifestyle".

(Retrieved March 18, 2003, from http://www.jibc.bc.ca/corrections/programs/public/adultProbationCareer.htm). Conceptually, the theme of officer responsibilities include reforming the offender toward a "non-criminal lifestyle" while simultaneously "protecting the community" have raised issues of controversy and debate within the field of probation work (Whitehead & Lindquist, 1992; Correctional Service of Canada, 2002; Hepburn & Albonetti, C., 1980; Jurik, 1985).

Province of British Columbia Ministry of Attorney General Probation Officer Job Description

Working in the corrections field carries additional sets of challenges not encountered in other fields. Individuals entering the criminal justice system recognize that verbal and minimal physical abuse from those in their care, custody, and control is a reality of the job. Probation officers in particular, are also responsible for collecting and analyzing documentation such as client files, reports completed by medical and mental health professionals, such as psychiatrists, psychologists, physicians, clinical counsellors, etc., criminal record searches and victim impact statements. Some probation officers also work alone or in one-person offices, but all work in isolation when meeting with clients. Clients include low to high-risk sexual offenders, violent offenders, mentally disordered offenders, and people who are prone to volatile behaviour. These duty-related factors may place an individual officer at risk for potentially developing symptoms associated with STS.

On occasions where reports are requested, probation officers will conduct interviews with clients, victims, and/or any other contacts concerned with a case file, for the purpose of assembling personal, social, health, correctional and court histories. They are further required to assess a client's risks and needs, and supervise while assisting a client in meeting and complying with the legal obligations of his or her community supervision orders. Probation officers are

expected to respond to the rehabilitative needs of a client through an array of interventions such as: enforcement, program delivery, interviewing, counselling, and liaison with and referral to other agencies.

Specialized supervision is necessary in cases of specific clients groups. For example, probation officers are obligated to develop an understanding of the cultural needs of clients and access the appropriate community resources to assist violent, sex and mentally disordered offenders. As appropriate, and within the boundaries of legislation and B.C. Community Corrections policy, probation officers may also be expected to offer notification and information to victims or the general public with respect to client status. (Province of British Columbia Ministry of Attorney General Job Description, 2002)

Compounding the unique stresses of probation work, officers also work within a subculture that places certain values, expectations and demands on the individual officer. Additionally, contact with dangerous clients and the criminal justice system may call into question previous views of society and life in general. Law enforcement culture in particular has traditionally denied the emotional and psychological impact of the work and has stigmatized officers who are affected (Violanti, 1996). While assumed to be similar, correctional subculture has not been well documented in the research literature.

Workplace risk factors therefore concern: workload; nature of the work; client population (inmate and client potential for violence and personal characteristics affect the level of risk); cumulative exposure to traumatic material (risk for secondary traumatic effects increases with length of service; the effect of this material is cumulative); inadequate relationships between colleagues and supervisors (negative work environment); social and cultural context; and role

conflict/ambiguity (constant changing between law enforcer and counsellor may create inner conflict). (Fisher, 2000a)

Individual risk factors for STS

Demographic distinctions (age, gender, years of service, etc.) also appear to play a role in the varying stress levels experienced by probation officers (Patterson, 1992). There are individual factors that place an officer at increased risk for STS. For example: officer personal history (personal histories of trauma can amplify the risk for secondary trauma effects); ethnicity; coping style (different coping styles may be better suited to stressful work situations); current life context (low stress levels in one's personal life can diminish the risk for STS effects); and training and professional history (officers who feel adequately trained to do their work experience fewer STS effects)(Fisher, 2001a). It is reasonable to presuppose that probation officers with limited training and/or experience will have an increased vulnerability to STS. In addition, a probation officer's skills, capacity, the context of role, client load, risk, as well as other factors will frequently contribute to increasing or decreasing stress levels. In particular, the novice probation officer who is just entering the field may be the most vulnerable, as well as those who have worked for a considerable length of time and been chronically exposed to traumatic material.

Another factor is the probation officer's personal trauma history (McCann & Pearlman, 1990). For some officers, there may also be expectations about the work, their professional identity and the meaning systems underlying their occupational choice that may impact STS responses. Therefore, individual attributes such as age, race and gender affect work perceptions

and experiences because individuals bring different orientations and worldviews that have bearing on their experiences (Van Voorhis et al., 1991). Furthermore, these attributes and beliefs as they exist historically and in the present, interacting with the individual perceptions of specific stressors may result in potentially unique psychological strain, and symptoms associated with STS and depression (Lasarus, 1994). In summation, overall there appears to be what might be deemed predisposing factors (e.g. as in a personal history of traumatization), contributing factors (e.g. isolation of the officer, inadequate training), precipitating factors (e.g. under personal stress, as in financial or divorce) and protective or preventive conditions designed to lessen risk (e.g. officer feels supported by peers and supervisors) that may impact the severity or act as buffers against the effects of STS.

Social/psychological influences (the political and social context of STS)

There is expanding acknowledgment in various professions of the risks for exposure to traumatic workplace stressors. Stressors are viewed as operating jointly with various social supports and coping mechanisms in determining an individual's level of occupational stress (Lasarus, 1994). More specifically, traumatic stress is a complex interaction between the individual officer (including demographic factors), the traumatic event or exposure, and the social and organizational context within which performance of the job occurs (Paton & Violanti, 1997; Cedric, 1999). In other words, the physical, intrapersonal, interpersonal and performance context of the work interacts with the challenges of the traumatic experience – all of which impact the character and potency of the experience (Dunning, 1994).

Violanti (1996) has cited various organizational and duty-related factors that cause distress in police officers: authoritarian structure, lack of participation in decisions affecting daily work tasks, lack of administrative support, a sense of futility in dealing with misery and death, exposure to human suffering which may necessarily alter an officer's frame of reference – to name a few. It is logical to assume from the law enforcement literature that a parallel cohesive subculture exists in corrections that has traditionally denied the emotional and psychological impact of the work and has stigmatized officers who are affected (Evans & Coman, 1992; 1993).

The research also suggests that such a disruption or loss of social support system is intimately associated with the inability to overcome the effects of psychological trauma (van der Kolk, 1987). It is therefore suggested that organizational interventions have a role to play in the management of work-related traumatic stress. Officer success in the probation organization might necessarily include the organization holding a vision that holds some consistency with that of the officer. Consequently, the structure of the agency will have a crucial role to play in addressing issues of traumatic stress and offering support. (Fisher, 2000b; O'Donnell & Stephens, 2001; Whitehead & Lindquist, 1992)

Predictors & Buffers of STS

Numerous individual and environmental job factors have already been mentioned that are predictors of individual risk for STS. Individual officer history, personality, coping style, current life context, training and professional history as well as accessibility to professional assistance can play into creating greater or less risk of vulnerability to STS effects. Environmental factors in probation work, such as workload, nature of the work and clientele base, cumulative exposure to

traumatic material, relationships with colleagues, social and cultural context and skilled supervision also place officer's at risk (Dignam et al., 1986; Fisher, 2000a; 2000b).

As previously mentioned, personal trauma histories can increase officer vulnerability (Follete et al., 1994; Pearlman and Mac Ian, 1995). Studies have found the same in disaster rescue responders, childcare and social workers (Dougall et al., 2000; Dane, 2000). Moreover, individuals will necessarily bring unique aspects of their personalities and styles – all of which may be deemed to be more or less adaptive to the stresses in probation work. The life context at a given time in the life of a probation officer may also compound the stress load (financially, conflict in personal relationships, illness or loss, etc.). Additionally, individuals are found to experience less stress when they feel adequately prepared for their job responsibilities. Research has also discovered that law enforcement and therapist professionals decreased their risks for STS through the education of trauma issues (Follete et al., 1994; McCann & Pearlman, 1990).

Current research

Contained by the limited empirical work including probation officers, a curvilinear effect of age on the symptoms of stress is among the most consistent findings. A study by King, Beckett and Hanlon (1989) suggests that stress-related effects for probation officers may include substance abuse, depressed mood, job discontent and low motivation. Considered over the longer term, King et al. (1989) predicted outcomes of depression, anxiety, interpersonal difficulties, burnout and physical illness. As with law enforcement, burnout in the corrections field has been theorized as a response to systemic stress factors – a process also conceived to be related to demographic differences such as age, career stage of the probation officer, etc. (Holgate & Clegg, 1991).

More recently, O'Donnell and Stephens (2001) examined the relationship between organizational, individual and job content stressors within a sample of 50 probation officers drawn from different geographical offices in New Zealand. The broader aims of this study were to determine the perceived sources and levels of stress experienced by the probation officers and to test predictions concerning the effects of organisational stressors using simple bivariate correlations, regression analyses and one-way ANOVA. Not surprisingly, measures demonstrated that stressors related to 'role boundary' and 'role conflict' were most strongly linked to all job strains identified in this study. Despite enlightening results herein, a larger sample may show more reliable differences and as well as provide a richer basis for justifying further investigation of probation officer stress.

Moran et al. (2001) conducted a study with the aim of developing an economical self-report questionnaire (Vulnerability Depression Questionnaire or VDQ) that was aimed at determining which cognitive and interpersonal vulnerability factors operate for predicting the onset of clinical depression, as well as offering a more cost effective method for screening larger populations in risk assessment. The researchers in this study assumed there to be an array of psychosocial factors to be implicated in risk for depression. Generally, those demographics associated with gender, age, marital status, socio-economic status, lack of social support, childhood maltreatment, and a combination of cognitive and personality risk factors such as introversion, dysfunctional attitudes, negative self-esteem and poor coping style were examples of the factors under consideration.

Moran et al.'s (2001) study was conducted over the span of a year. Three separate contacts were made with the resulting target population of 104 women who were based in the community in North London, England. Participants for this study were recruited via the patient

lists of general practitioners in the region. An initial screening using the Personal Health Questionnaire (PHQ; Simpson, 1984) was sent to determine depression-free suitability, as well as target a group to include working-class mothers and single mothers of any social class. Once suitability was determined, screening progressed with the intention of obtaining a final sample with participants who rated vulnerable on at least one vulnerability factor (based on their VDQ scores).

The analysis of data in this study (Moran et al., 2001) involved an investigation of the inter-correlations of the VDQ questionnaire items and a factor analysis with a resulting presence of two factors – categorized as self-attribute and role-performance items. It was concluded from this study that women with the greatest risk had both psychological and interpersonal vulnerability. The greatest risk of depression onset seemed to be the recipe of a hostile and unsupportive environment with personal sensitivity to a crisis or life-altering event.

This study presents some enlightening results, especially in supporting the theory that vulnerability to depression is best considered as the interface between interpersonal and intrapersonal circumstances. The primary limitations however, concern questions around the longevity of depression vulnerability and cross validation of the PDQ, in particular to male populations that remain unanswered.

Summary

All occupations may be associated with stress. Nevertheless, it is reasonable to assert that certain occupations are uniquely more stressful than others. It may also be argued that individual and organizational responses to stress impact outcomes. In particular, probation officers working directly with violent offenders or sex offenders cannot reasonably disregard the

cruelty of their clients. At least, it may be argued that anyone with the capacity for feeling will be impacted by the disturbing nature of offender stories often uncovered through probation work. The officer essentially bears witness (whether through direct client or victim testimonials, reading of reports or a combination thereof) to the torment his or her client inflicted on the victim(s).

The evidence is clear: work in the corrections field is highly stressful. Even so, what is not clear is how specific workplace and individual risk factors relate to symptoms associated with traumatic stress, depression and compromised health. More research is needed. Specifically, given the isolating, sometimes conflicting nature of a probation officer's role (case in point: the obligation to attend to a client's reintegration into society, through the promotion of a "crime-free lifestyle", yet acting also as the enforcer of probation conditions and court orders, while simultaneously protecting victims and the general public), attention is certainly warranted for examining the extent of probation officers' exposure to traumatic material; the nature of their client population; the support environment they experience and how these systemic ingredients may be related to depressive symptoms.

"When we understand the factors that contribute to vicarious traumatization, we are better able to address and minimize its' effects, individually and organizationally" (Pearlman & Saakvtine, 1995, p. 295-296). This study will contribute to ongoing investigation of secondary traumatic workplace stress risks and symptoms of depression in probation officers, aim to uncover underlying predictors, and address the clinical and organizational implications for officers at risk. Clinical implications are aimed at working with individual officers and potentially groups of officers in distress from a counselling or therapeutic perspective. Organizational implications will be directed toward how the B.C. Community Corrections Branch addresses probation officer STS in their organization, and possible training issues or practice frameworks

that might alleviate some of the traumatic stress experienced by doing probation work. It is further intended to assist with discovering a smaller set of underlying factors that will assist B.C. Community Corrections in subsequent workshops with their officers. Future studies might also evaluate how probation officers cope with job-related stressors, as well as investigate the efficacy of stress/burnout reduction strategies and techniques.

Research questions

1. What were the general demographics of the probation officers who participated in this study?
2. What were the measures of central tendency and variability, and what percentage of probation officers reported experiencing higher distress levels for the work-related secondary traumatic risk variables?
3. What were the measures of central tendency and variability, and what percentage of probation officers reported experiencing depressive symptoms "consistently"? "Fairly often"? "Never or rarely"? (Further, were there specific clinical symptoms reported as experienced more and/or less consistently than others?)
4. What are the inter-correlations among the STS risk variables?
5. What are the inter-correlations among the symptoms of depression variables?
6. What are the inter-correlations among the STS and depression variables, and what are the patterns of relationship that emerge?
7. Which, and to what degree are the variables related to any underlying, influential factors or constructs inferred from the exploration of this data? (More specifically, how many

different factors are needed to explain the pattern of relationships among these variables? What is the nature of those factors? How well do the hypothesized factors explain the observed data?)

CHAPTER III – METHODOLOGY

This chapter presents a description of the design and procedures used to examine the research questions. All demographics, secondary traumatic workplace risk variables and symptoms of depression were taken from a larger questionnaire design as part of the delivery of the two-day live, *The Road Back to Wellness: Stress, Burnout and Trauma* (Fisher, 2000a) workshop. Part of the workshop involved a series of self-report questionnaire measures utilized in this study.

The variables explored in this study consisted of a depression checklist (DSM-IV; American Psychiatric Association, 1994) and a combination of measures largely derived from the work of Pearlman and her colleagues (McCann & Pearlman, 1990; Pearlman & Saakvitne 1995; Saakvitne & Pearlman, 1996) as well as from the research and practice with criminal justice professionals of Patricia Fisher (Fisher, 2000a; 2000b; 2001a; 2001b), the clinical and consulting psychologist who developed and delivered the workshop program through the B.C. Community Corrections Branch.

Method

Participants

Data for this study was taken from the initial questionnaire results of over four hundred and fifty Corrections personnel from the B.C. Community Corrections Branch. Probation officers were then isolated as the target population. The participants were those who voluntarily participated in the live 2-day workshops *The Road Back to Wellness: Stress, Burnout and Trauma* facilitated through the Justice Institute of B.C., and were delivered throughout the

province of British Columbia during 2001. Adult probation officers who participated were at the time, working with B.C. Community Corrections in one of over sixty local probation offices throughout the province. The workshops were provided offsite for individual probation offices throughout the province, generally at local hotel and convention facilities. These facilities were arranged and coordinated by the regional offices and provincial headquarters of the B.C. Community Corrections Branch.

Procedure

Participants for this research volunteered to provide copies of the self-report component with the full understanding the results were being used in academic research, reports, and also with the protection of confidentiality. The questionnaires were part of the workshop format. Participants were guided through the questionnaire completion phase by a trained facilitator. The informed consent form was reviewed and participants were invited to take part in the research component. Workshop facilitators explained the research component of the program, clearly emphasizing that participation in the research component was strictly voluntary.

Participation in the workshop spanned a two-day period, approximately seven hours a day, with periodic breaks including a meal break. Completion of the questionnaire and informed consent forms took place during a ninety-minute interval in the afternoon of the first day of the workshop. The workshop was structured to allow for direct, sensitive communication by the facilitator. The introductory component consisted of a clear outline of what was to be expected throughout the process of the two days.

Facilitators communicated with the group to directly address issues of confidentiality and rules of safety for the group as well as introducing the informed consent piece to those who

wished to volunteer to participate in the research component. Discussions of any concerns around these issues were permitted throughout the workshop process – their willingness to share those results with the research program was expressed by the facilitators as secondary to the primary goal represented by their personal reflections of the self-report outcomes.

Those who volunteered signed in prescribed sequence, the consent form and three sets of self-report questionnaires and scoring charts provided in envelopes. Participants kept the original. Carbon copies were sealed into the envelopes supplied, and collected by the facilitator. Facilitators couriered completed sets to Patricia Fisher, the clinical psychologist who developed and coordinated the program.

Measures

1. Demographic variables examined: gender, age, years of service, caseload (including type of client, risk level), financial stress and perceived adequacy of training received.

2. Dependent variables examined: depression symptom checklist reported as ranging from 0-2 (0 to mean "never or rarely", 1 to indicate "fairly often" and 2 to denote "consistently"), and secondary traumatic stress workplace risk variables (nature of the corrections population, exposure to traumatic material, and support environment) measured on a likert distress level scale between 0 – 5 (generally ranging from a 0-1 being low, and 4-5 indicating high).

Data collection

Generally, workshop facilitators working in two person teams gathered the data. These were twelve individual Community Corrections staff (senior probation officers) representing the five regions of the province. Prior to the program rollout, the facilitators received specialized and intensive training from Dr. Fisher to provide the workshops, administer the self-report

questionnaires, and facilitate the research component. Facilitators received ongoing supervision and consultation throughout the program rollout.

Analysis

The questions raised in this study called for an exploration of the patterns of relationships among the variables. Given the number of dependent variables investigated and the purpose of this study, a number of analytic procedures were followed. First, the standard measures of central tendency and variability were calculated. These operations provided a descriptive account for all variables and an examination of any extreme scores. Exploratory factor analysis of the STS and depression measures was conducted to help address construct validity (specifically, as related to the three questionnaire labels attached to the STS variables under investigation) and identify important underlying constructs that were theoretically better representatives of explaining the reported STS effects and symptoms of depression than the original variables taken from the workshop. Analysis took place using the statistical program NCSS.

Descriptive statistics were initially performed to gather the general demographic information about this probation officer sample and the frequency of the variables under investigation. In particular, which STS variables were reported with the highest distress levels, the lowest, and similarly which depression variables were reported as more consistently present? Which ones were reported as "never"? Following this exploration, further analysis included investigating the relationships among the variable groupings and among all of the variables investigated in this study. Moreover, it was hypothesized that these variables represented linear combinations of some underlying sources or factors.

The first step in the exploratory factor analysis was to determine if any of the measured variables in the STS and depression groupings appeared unnecessary and could thus, be

eliminated. This decision was based on findings from the correlation matrices and the more advanced procedures that followed. The next step was to analyze the results beginning with a factor number selection mathematically based on the number of measured variables within the grouping, the researcher's intuitive sense of the data, the method chosen and her understanding of the research in existence at the time this study was undertaken.

Once the number of measured variables to be used was determined, the next step in this part of the analysis was for the researcher to make a judgment on how many factors to extract from the measured variables. The general aim of deciding how many factors to retain was to reproduce as much information in the measured variables with as few factors as results and sound judgment would dictate. The following were three core determinants in that decision process: the position of the factors in the scree plot; the proportion of variance accounted for by the individual factors (the criterion was generally reflected in eigenvalues with a value of 1.0 or higher); and the overall interpretability of those factors to be retained. In addition, it was the researcher's intention to assess the validity and 'fit' of the STS constructs previously established by the questionnaire design.

Given that factor analysis is purely a statistical technique indicating, which, and to what degree, variables relate to underlying and undefined factors, the substantive meaning that was attached to each retained factor was based on the careful examination of what the high loading variables measure, and the judgment of the researcher. Essentially, the interpretation named was founded on what the variables had in common, and how well they were perceived as predictors of the variables. This process was also based on test criteria of: a minimum of three variables loading per factor; simplicity of structure, as in all input factors loading on to a specific construct exhibited one-way moderate to high loading coefficients of .40 or higher and very low

complementary loading on other factors; and variables that loaded high on each factor subscribed to the same concept that was distinctly different from those shared and measured by the variables supporting the other factors.

Factors or constructs were named based on their reasonable capacity to identify all variables that loaded high on it. The researcher then looked at the predominant common theme, concept, or content that each of the variables contributed. Critically, the overall aim of the interpretation was for all observed variables that loaded highly on a particular factor to share the same thematic or conceptual perspective.

To summarize, this analysis included:

1. Participant demographics.
2. Descriptive correlations, inter and cross-correlations among the measured STS risk and symptoms of depression variables.
3. Exploratory factor analysis among the following variables: STS workplace risk measures and symptoms of depression.

Limitations

Given the large sample size for this study, results may be generalized to other professions, particularly in the criminal justice field. The primary contextual limitation of the data collection method itself and paradoxically, perhaps also a strength, is the workshop format of 'live' self-reporting. Even though participants individually completed questionnaires, the physical environment for this was within the context of a peer dynamic. It may be reasonable to assume that individual honesty may have been compromised within a collective environment, especially one that is suspect for having a subculture that traditionally discourages disclosure of emotions.

It is further conceivable that peers may directly or indirectly influence individual officers throughout the discussion periods of the workshop.

Factor analysis does not instruct the researcher in what substantive labels or meaning to attach to the underlying factors. Given that the factors are actually hypothetical or explanatory constructs decided upon by the researcher, their reality in the individuals of the probation officer sample used in this study is always open to argument. What was stated is to claim that if the factors were real, then they would account for the correlations discovered within the sample, or otherwise stated, they were the latent or unobserved, hypothetical, underlying constructs deduced from the correlations between the measured variables investigated in this study that were taken from the wellness workshop. While the data will serve as a quantitative indicator of the patterns of relationship and substantive meaning among specific secondary traumatic stress risk variables, demographics and symptoms of depression, further research will need to be explored - perhaps continued exploratory and/or confirmatory factor analysis with the existing larger data set, utilizing the results from this study in more advanced procedures (such as multiple regression) or using a qualitative approach.

Implications

Findings from this study are applied in generating a theory of predictors based on the identification of the factor structure for the set of variables investigated. The method of factor analysis was also undertaken to specifically address construct validation of the observed variables. This is further taken to assist in developing a profile for at risk probation officers as well as for targeting clinical and organizational interventions for managing work-related STS and symptoms suspected to be associated. Given that the participants were informed that the data

was concerned with identifying mechanisms and themes associated with employee stress, and that the research component was designed to assist in identifying sources of stress and to allow B.C. Community Corrections managers to focus on specific stress reduction strategies, the results have meaning for practicing probation officers – individually for those who participated, and more generally as an educational and clinical tool for informing about the risks of STS, depression and underlying influences discovered through this study.

It is anticipated that the B.C. Corrections Branch will take a keen interest in the results of this study by reviewing current organizational policies around these issues, and working toward continued acknowledgement of STS, and implementing preventive measures against its effects. The decision to utilize an exploratory factor analysis approach was also intended to help identify a smaller number of factors to aid in not only the interpretation of this portion of the results from the workshop, but also for potentially developing a more precise, cost- effective instrument to be considered for similar workshop purposes used by the B. C. Community Corrections Branch in the future. To this end, it was also intended to offer a logical direction for future analysis of the larger data set.

Given that the field of secondary traumatic stress is comparatively new, STS is primarily theoretical in nature. This study aims to make a theoretical contribution to the underlying nature of secondary trauma and symptoms of depression, most specifically to the probation officers in this study. The results may have meaning for probation officers in general, and implications for those working in the corrections and law enforcement field who may be at risk for secondary traumatic stress effects.

CHAPTER IV – RESULTS

A total of over 450 questionnaires from B.C. Community Corrections personnel were returned for the research component of the 2-day live workshop, *The Road Back to Wellness: Stress, Burnout and Trauma in Corrections* (Fisher, 2000a). Three hundred and fifty-nine of those were considered usable for the initial data entry. Participants ranged from client supervisors (those working directly within B.C.'s adult correctional facilities), management, to administrative personnel. From those three hundred and fifty-nine entries, a total of 167 adult probation officers were isolated for this study. Some probation officer entries were missing values for responses to some of the variables being examined. This may have been due to basic human error in the completion of the response or a level of discomfort in responding. Omitted responses were not included in the investigation of those respective variables; it was nonetheless, valid to utilize them for other statistical procedures.

Toward the intention of simplicity, this chapter has been organized to sequentially address the results under the research questions posed in this study. Essentially what follows are: demographic descriptions of the participants and a review of the statistical procedures used in the analysis of the questions concerning the STS workplace risk and depression symptom variables under investigation. A summary will then conclude this chapter.

The demographics or personal attributes of the probation officers included "age", "gender", "caseload", "years of service", "risk level of clients" (low, med, high), "specialized clients" (sex offender, violent, etc.), "financial stress" and " adequate job training". A total of nine STS workplace risk variables from the self-report questionnaire were examined. These measures were: "the inmates/clients are hostile and demanding", "the inmates/clients are violent offenders" and "the inmates/clients are sex offenders", "you hear about the crimes and stories of

abuse, assault, violence, etc. directly from inmates/clients", "you read the reports and file materials about the crimes and victim impact statements", "you have been working in the field for some time and have been exposed to lots of traumatic material", "workplace does not recognize stress effects of secondary trauma", "not able to discuss distress with colleagues and coworkers" and "not able to discuss distress with supervisors or management". Levels of perceived distress for each of these variables were reported on a scale from 0 to 5 with 0 – 1 indicating "low", 2-3 an indicator of "moderate", and 4-5 an indication of "high".

The symptoms of depression measures consisted of a symptoms checklist (DSM-IV, American Psychiatric Association, 1994). In response to the depression variables, participants were asked to consider the two weeks prior to participating in the workshop as an indicator of prevalence for gauging the symptom statements. . From a list of 14 items, the officers responded on a scale from 0 - 2 (0 indicated "never", 1 "fairly often" and 2 "consistently") consisting of: "I feel depressed most of the day or others see me as depressed", "I don't seem to feel much pleasure in anything through the day", "My appetite has changed (e.g., either I have lost interest in food, or I am eating more than normal)", "I am having problems with sleep (e.g., either difficulty falling asleep, staying asleep, or early waking or I am oversleeping)", "I feel a lack of energy and a general sense of fatigue", "I feel either slowed down or restless and agitated", "I feel a sense of worthlessness or inadequacy", "I have feelings of guilt", "I have feelings of hopelessness", "I am having difficulty concentrating and holding attention", "I feel indecisive and have difficulty making decisions", "I am having thoughts that life is not worth living", "I am having thoughts of death or suicide without a plan", and " I am having suicidal thoughts and a plan is forming".

Question 1: What were the general demographics of the probation officers who participated in this study?

Of the 167 probation officer questionnaires incorporated in the statistical analysis, 44% of the participants were female and 56% were male. Twenty four percent reported being in a primary relationship (those respondents who left this variable blank were assumed to have responded as "no"), 39% had children and approximately 50% reported experiencing financial stress. The average age of the probation officers was 40.5 years (SD = 9.14) with a range from 22 to 59 years of age. Average years of service were within a strata range from 5 to 10 years.

The average probation officer caseload was 71 clients (SD = 19.51) with a range numbering from a minimum of 25 to a maximum of 120. The average risk level for clients was medium to high with 16% or 26 out of the 167 participants recorded as carrying a specialized client load, in all cases this was noted as referring to sex offenders. (All other responses to "client type" were of a "mixed/generic" category.) Sixty-three percent of the probation officers also indicated that they did not feel they were adequately trained for their job.

Question 2: What were the measures of central tendency and variability, and what percentage of probation officers reported experiencing higher distress levels for the work-related secondary traumatic risk variables?

For the STS risk assessment variables undertaken for examination in this study, a total of 162 or 97% of the participants responded to the distress level measurements. Table 1 follows indicating the mean, standard deviation and range with which the participants reported distress levels for each of these items.

Table 1

STS Risks (Mean, SD & Range)

Item	M	SD	Range (0-5)
Clients hostile/demanding	2.94	1.31	0 – 5
Clients are violent offenders	2.81	1.29	0 – 5
Clients are sex offenders	1.66	1.71	0 – 5
Hear about crimes, stories, etc	3.33	1.42	0 – 5
Read reports, files about crimes, etc	3.47	1.34	0 – 5
Working for some time, lots of exposure	3.15	1.61	0 – 5
Workplace does not recognize STS	2.59	1.58	0 – 5
Unable to discuss with colleagues	1.52	1.24	0 – 5
Unable to discuss with supervisors	2.08	1.54	0 – 5

To summarize, the probation officers in this study generally reported "moderate" distress levels for STS variables (overall average = 2.62). "Read reports, files about crimes, etc.", "hear about crimes, stories, etc." and "working for some time, lots of exposure to traumatic material" showed the highest mean scores ranging from 3.47 to 3.15. The lowest average distress level was "unable to discuss with colleagues" (1.52). This may be reflective of a general sense of perceived ability to discuss work stress with colleagues, or the peer dynamic context under which these responses were given. Interestingly, the mean for "unable to discuss distress with supervisors" was higher, and the overall perception of B.C. Community Corrections recognition of STS effects was highest among the last three variables in Table 1.

Participants overall reported the highest distress levels for "you hear about the crimes and stories of abuse, assault, violence, etc. directly from inmates/clients", "you read the reports and file materials about the crimes and victim impact statements", and "you have been working in the field for some time and have been exposed to lots of traumatic material". The average distress level for these STS risk measures was 3.32. Given the nature of probation work, it is not

surprising that participants show as having moderately high distress levels for the direct and indirect exposure to graphic, traumatic material through the course of their duties.

Table 1.1 follows (p. 38-40) showing the frequency distribution for each STS risk variable. Again, distress levels were reported in the range from 0 to 5 (0 being lowest, as in no distress, and 5 the highest).

Table 1.1

STS Risk Frequencies

Variable Distress Level	Count	Cumulative Count	Percent	Cumulative Percent	Graph of Percent
Clients are hostile/demanding					
0	6	6	3.68	3.68	
1	19	25	11.66	15.34	
2	33	58	20.25	35.58	
3	43	101	26.38	61.96	
4	43	144	26.38	88.34	
5	18	162	11.04	99.39	
	1	163	0.61	100.00	
Clients are violent offenders					
0	8	8	4.91	4.91	
1	21	29	12.88	17.79	
2	31	60	19.02	36.81	
3	47	107	28.83	65.64	
4	44	151	26.99	92.64	
5	11	162	6.75	99.39	
	1	163	0.61	100.00	
Clients are sex offenders					
0	57	57	34.97	34.97	
1	35	92	21.47	56.44	
2	24	116	14.72	71.17	
3	16	132	9.82	80.98	
4	12	144	7.36	88.34	
5	18	162	11.04	99.39	
	1	163	0.61	100.00	

(STS Risk Frequencies)

Variable Distress Level	Count	Cumulative Count	Percent	Cumulative Percent	Graph of Percent
Hear about crimes, stories, etc					
0	8	8	4.91	4.91	|
1	11	19	6.75	11.66	||
2	23	42	14.11	25.77	|||||
3	39	81	23.93	49.69	|||||||
4	40	121	24.54	74.23	|||||||
5	41	162	25.15	99.39	|||||||
	1	163	0.61	100.00	
Read reports, files about crimes, etc					
0	3	3	1.84	1.84	|
1	13	16	7.98	9.82	|||
2	21	37	12.88	22.70	|||||
3	39	76	23.93	46.63	|||||||
4	40	116	24.54	71.17	|||||||
5	46	162	28.22	99.39	|||||||||
	1	163	0.61	100.00	
Working for some time, lots of exposure to traumatic material					
0	11	11	6.75	6.75	||
1	23	34	14.11	20.86	|||||
2	20	54	12.27	33.13	||||
3	28	82	17.18	50.31	|||||
4	37	119	22.70	73.01	|||||||
5	43	162	26.38	99.39	|||||||
	1	163	0.61	100.00	
Workplace does not recognize STS					
0	15	15	9.20	9.20	||||
1	37	52	22.70	31.90	|||||||
2	27	79	16.56	48.47	||||||
3	24	103	14.72	63.19	|||||
4	39	142	23.93	87.12	|||||||
5	20	162	12.27	99.39	||||
	1	163	0.61	100.00	

(STS Risk Frequencies)

Variable Distress Level	Count	Cumulative Count	Percent	Cumulative Percent	Graph of Percent
Unable to discuss with colleagues					
0	37	37	22.70	22.70	
1	57	94	34.97	57.67	
2	30	124	18.40	76.07	
3	25	149	15.34	91.41	
4	10	159	6.13	97.55	
5	3	162	1.84	99.39	
	1	163	0.61	100.00	
Unable to discuss with supervisors					
0	26	26	15.95	15.95	
1	46	72	28.22	44.17	
2	28	100	17.18	61.35	
3	26	126	15.95	77.30	
4	23	149	14.11	91.41	
5	13	162	7.98	99.39	
	1	163	0.61	100.00	

The frequency distributions of the STS risk variables as illustrated in Table 1.1 reflects moderately high distress level frequencies, especially for clients who are hostile and demanding, and/or violent offenders. It is possible that the lower frequency of reported distress results for sex offenders is an indication and reflection of the lower percentage of probation officers from this study who carry sex offenders as part of their caseload (16% as reported in the background information section of the questionnaire). "Read reports, files about crimes, etc." shows as having the greatest reported frequency of moderate to high distress levels. It was highest overall, as over 70% of the participants reported a 3, 4 or 5 – with 5 having the highest percentage of 28.22%.

Question 3: What were the measures of central tendency and variability, and what percentage of probation officers reported experiencing depressive symptoms "consistently", "fairly often" and "never or rarely"?

Of the 167 probation officers who participated, 160 or 96% completed this section of the questionnaire component of the workshop. What follows are 2 tables (Table 2 and 2.1) illustrating measures of central tendency and variability (mean, standard deviation and range), and frequency distributions for each of the depression variables.

Table 2

Depression Measures (Mean, SD & Range)

Item	M	SD	Range (0-2)
Depressed most of the day	0.22	0.44	0 – 2
Little pleasure through day	0.24	0.49	0 – 2
Appetite has changed	0.35	0.56	0 – 2
Sleep difficulties	0.71	0.70	0 - 2
Lack of energy/sense of fatigue	0.75	0.70	0 - 2
Slowed down or restless & agitated	0.50	0.62	0 - 2
Sense of worthlessness or inadequacy	0.21	0.40	0 - 1
Feelings of guilt	0.30	0.54	0 - 2
Feelings of hopelessness	0.19	0.44	0 - 2
Difficulty concentrating	0.36	0.54	0 - 2
Indecisive/difficulty making decisions	0.31	0.51	0 - 2
Thoughts life is not worth living	0.07	0.28	0 - 2
Thoughts of death/suicide no plan	0.06	0.24	0 – 1
Thoughts of death/suicide with plan	0.01	7.91	0 - 1

Table 2.1

Depression Checklist (Frequencies)

Variable How Often	Count	Cumulative Count	Percent	Cumulative Percent
Depressed most of day				
0 = never	127	127	78.88	78.88
1 = fairly often	31	158	19.25	98.14
2 = consistently	2	160	1.24	99.38
	1	161	0.62	100.00
Little pleasure through the day				
0 = never	127	127	78.88	78.88
1 = fairly often	28	155	17.39	96.27
2 = consistently	5	160	3.11	99.38
	1	161	0.62	100.00
Appetite has changed				
0 = never	111	111	68.94	68.94
1 = fairly often	42	153	26.09	95.03
2 = consistently	7	160	4.35	99.38
	1	161	0.62	100.00
Sleep difficulties				
0 = never	69	69	42.86	42.86
1 = fairly often	68	137	42.24	85.09
2 = consistently	23	160	14.29	99.38
	1	161	0.62	100.00
Lack energy; fatigue				
0 = never	64	64	39.75	39.75
1 = fairly often	72	136	44.72	84.47
2 = consistently	24	160	14.91	99.38
	1	161	0.62	100.00
Slowed down or restless and agitated				
0 = never	91	91	56.52	56.52
1 = fairly often	58	149	36.02	92.55
2 = consistently	11	160	6.83	99.38
	1	161	0.62	100.00
Feel sense of worthlessness or inadequacy				
0 = never	127	127	78.88	78.88
1 = fairly often	33	160	20.50	99.38
	1	161	0.62	100.00

(Depression Checklist (Frequencies))

Variable How Often	Count	Cumulative Count	Percent	Cumulative Percent
Feelings of guilt				
0 = never	119	119	73.91	73.91
1 = fairly often	34	153	21.12	95.03
2 = consistently	7	160	4.35	99.38
	1	161	0.62	100.00
Feelings of hopelessness				
0 = never	132	132	81.99	81.99
1 = fairly often	25	157	15.53	97.52
2 = consistently	3	160	1.86	99.38
	1	161	0.62	100.00
Difficulty concentrating; holding attention				
0 = never	107	107	66.46	66.46
1 = fairly often	48	155	29.81	96.27
2 = consistently	5	160	3.11	99.38
	1	161	0.62	100.00
Indecisive; difficulty making decisions				
0 = never	115	115	71.43	71.43
1 = fairly often	41	156	25.47	96.89
2 = consistently	4	160	2.48	99.38
	1	161	0.62	100.00
Thoughts that life is not worth living				
0 = never	150	150	93.17	93.17
1 = fairly often	9	159	5.59	98.76
2 = consistently	1	160	0.62	99.38
	1	161	0.62	100.00
Thoughts of death or suicide without a plan				
0 = never	150	150	93.17	93.17
1 = fairly often	10	160	6.21	99.38
	1	161	0.62	100.00
Suicidal thoughts and a plan is forming				
0 = never	159	159	98.76	98.76
1 = fairly often	1	160	0.62	99.38
	1	161	0.62	100.00

In summary, Table 2 and 2.1 illustrate the frequency and variability of depression items reported by the probation officers who participated in this study. "Sleep difficulties", "lack of energy and a sense of fatigue" and "slowed down or restless and agitated" show the greatest frequencies for how often (as in "fairly often") they reported experiencing these symptoms over the 2 week period prior to participating (42.24%, 44.72% and 36.92% respectively). The mean scores for these three items were also respectively, 0.71 (SD = 0.70), 0.75 (SD = 0.70) and 0.50 (SD = 0.62).

The last three items of the depression measures in Table 2.1 were reported most frequently as "never" experiencing the symptoms (those being "thoughts that life is not worth living", "thoughts of death or suicide without a plan" and "thoughts of death or suicide with a plan forming"). This is significant as far as determining the level of suicidal thoughts at the time of participation for this particular group. The results generally demonstrate low reported levels of a sense of hopelessness. Nonetheless, it is also noteworthy that some of the participants were in significant difficulty as indicated by their responses to these last three items. Fourteen out of the one hundred and sixty-one officers or 9% of those officers who responded to these items reported these symptoms as at least "fairly often". One officer reported "consistently" experiencing these three suicide-related symptoms, and another reported having thoughts of suicide with a plan forming "fairly often".

Question 4: What are the inter-correlations among the STS workplace risk variables?

An inter-correlation statistical procedure was used to help identify which of the variables was most closely related using Pearson R's correlation coefficient, and an alpha level of .05. For

instance, it seemed reasonable that variables 4, 5, and 6 in Table 3 (p. 45) would be inter-correlated given the plausibility that they are related to each other. This step in the analysis was used to help see relationships among the variables as well as determine which variables should be included in advanced statistical procedures undertaken in this study. Table 3 follows showing the results using correlation matrices. Cronbach's alpha and standardized alpha were applied to show an estimation of the internal consistency and homogeneity of variances, or test reliability among the measures (scores of 0.70 or higher are considered acceptable).

Table 3

Pearson Product-Moment Inter-Correlations Among STS Variables

Variable	1.	2.	3.	4.	5.
1. Clients hostile	1.000000	0.714096	0.065353	0.523273	0.575265
2. Clients are violent	0.714096	1.000000	0.243087	0.537615	0.576374
3. Clients are sex offenders	0.065353	0.243087	1.000000	0.068973	0.154245
4. Hear stories of violence	0.523273	0.537615	0.068973	1.000000	0.861962
5. Read reports of violence	0.575265	0.576374	0.154245	0.861962	1.000000
6. Long exposure to STS	0.466294	0.527549	0.083938	0.668399	0.709156
7. Work doesn't recog. ST	0.296326	0.295742	0.053524	0.309596	0.315826
8. Can't discuss w colleag.	0.127427	0.144562	0.113892	0.244469	0.252259
9. Can't discuss w super.	0.204697	0.231746	0.158638	0.284910	0.258167

Cronbachs Alpha = 0.825926 Standardized Cronbachs Alpha = 0.834387

	6.	7.	8.	9.
1. Clients hostile	0.466294	0.296326	0.127427	0.204697
2. Clients are violent	0.527549	0.295742	0.144562	0.231746
3. Clients are sex offenders	0.083938	0.053524	0.113892	0.158638
4. Hear stories of violence	0.668399	0.309596	0.244469	0.284910
5. Read reports of violence	0.709156	0.315826	0.252259	0.258167
6. Long exposure to STS	1.000000	0.378980	0.350456	0.382809
7. Work doesn't recog. ST	0.378980	1.000000	0.526371	0.650595
8. Can't discuss w colleag.	0.350456	0.526371	1.000000	0.563500
9. Can't discuss w super.	0.382809	0.650595	0.563500	1.000000

Cronbachs Alpha = 0.825926 Standardized Cronbachs Alpha = 0.834387

Table 3 indicates that there is an extremely high positive correlation among the measures. As might be expected, the most significantly correlated pairing is "hearing about crimes and stories of violence, assault, etc." and "reading reports and file materials, victim impact statements" etc. This table also shows a high correlation between the years an officer has worked in the field and the other variables in this category. The lowest correlation found among the STS variable grouping was between "clients are sex offenders" with "clients are hostile and demanding" and "clients are violent offenders".

Question 5: What are the inter-correlations among the symptoms of depression variables?

Tables 4, 4.1, 4.2 and 4.3 show the correlations using Pearson R's correlation coefficient and .05 alpha level among the depression measures used in this study. Similarly to Table 3, Cronbach's Alpha is also shown.

Table 4

Pearson Product-Moment Inter-Correlations Among Depression Variables

Variable	1.	2.	3.	4.
1. **Depressed most of day**	**1.000000**	0.591888	0.396269	0.363503
2. **No pleasure in day**	0.591888	**1.000000**	0.489611	0.341546
3. **Appetite changed**	0.396269	0.489611	**1.000000**	0.366608
4. **Sleep difficulties**	0.363503	0.341546	0.366608	**1.000000**
5. **Lack energy/fatigue**	0.439882	0.371804	0.526322	0.465641
6. **Slowed or restless**	0.533085	0.467885	0.411450	0.429271
7. **Worthlessness/inadequacy**	0.446066	0.537141	0.397698	0.318934
8. **Feelings of guilt**	0.504842	0.385400	0.269498	0.372338
9. **Feelings of hopelessness**	0.488277	0.507466	0.433922	0.322038
10. **Difficulty concentrating**	0.346937	0.332450	0.322664	0.257680
11. **Indecisive**	0.338513	0.355013	0.235843	0.314479
12. **Thoughts life not worth living**	0.387636	0.475511	0.207317	0.262828
13. **Death/suicide, no plan**	0.397416	0.451212	0.299028	0.179389
14. **Suicide with plan forming**	0.139983	0.283203	0.233147	0.145517

Cronbachs Alpha = 0.871768 Standardized Cronbachs Alpha = 0.880508

Table 4.1

Pearson Product-Moment Inter-Correlations Among Depression Variables

Variable	5.	6.	7.	8.
1. **Depressed most of day**	0.439882	0.533085	0.446066	0.385400
2. **No pleasure in day**	0.371804	0.467885	0.537141	0.385400
3. **Appetite changed**	0.526322	0.411450	0.397698	0.269498
4. **Sleep difficulties**	0.465641	0.429271	0.318934	0.372338
5. **Lack energy/fatigue**	**1.000000**	0.647097	0.293136	0.295408
6. **Slowed or restless**	0.647097	**1.000000**	0.310181	0.441786
7. **Worthlessness/inadequacy**	0.293136	0.310181	**1.000000**	0.427636
8. **Feelings of guilt**	0.295408	0.441786	0.427636	**1.000000**
9. **Feelings of hopelessness**	0.381344	0.399213	0.477532	0.408751
10. **Difficulty concentrating**	0.437789	0.500305	0.257642	0.245313
11. **Indecisive**	0.141979	0.191098	0.155577	0.101778
12. **Thoughts life not worth living**	0.218423	0.235918	0.375872	0.360378
13. **Death/suicide, no plan**	0.277350	0.290346	0.251267	0.142014
14. **Suicide with plan forming**	0.141979	0.191098	0.155577	0.101778

Cronbachs Alpha = 0.871768 Standardized Cronbachs Alpha = 0.880508

Table 4.2

Pearson Product-Moment Inter-Correlations Among Depression Variables

Variable	9.	10.	11.
1. **Depressed most of day**	0.488277	0.346937	0.338513
2. **No pleasure in day**	0.507466	0.332450	0.355013
3. **Appetite changed**	0.433922	0.322664	0.235843
4. **Sleep difficulties**	0.322038	0.257680	0.314479
5. **Lack energy/fatigue**	0.381344	0.437789	0.388768
6. **Slowed or restless**	0.399213	0.500305	0.382161
7. **Worthlessness/inadequacy**	0.477532	0.257642	0.238008
8. **Feelings of guilt**	0.408751	0.245313	0.342212
9. **Feelings of hopelessness**	**1.000000**	0.308269	0.208062
10. **Difficulty concentrating**	0.308269	**1.000000**	0.500680
11. **Indecisive**	0.208062	0.500680	**1.000000**
12. **Thoughts life not worth living**	0.557937	0.209008	0.204244
13. **Death/suicide, no plan**	0.414320	0.208477	0.198446
14. **Suicide with plan forming**	0.145276	0.239668	0.262191

Cronbachs Alpha = 0.871768 Standardized Cronbachs Alpha = 0.880508

Table 4.3

Pearson Product-Moment Inter-Correlations Among Depression Variables

Variable	12.	13.	14.
1. **Depressed most of day**	0.387636	0.397416	0.139983
2. **No pleasure in day**	0.475511	0.451212	0.283203
3. **Appetite changed**	0.207317	0.299028	0.233147
4. **Sleep difficulties**	0.262828	0.179389	0.145517
5. **Lack energy/fatigue**	0.218423	0.277350	0.141979
6. **Slowed or restless**	0.235918	0.290346	0.191098
7. **Worthlessness/inadequacy**	0.375872	0.251267	0.155577
8. **Feelings of guilt**	0.360378	0.142014	0.101778
9. **Feelings of hopelessness**	0.557937	0.414320	0.145276
10. **Difficulty concentrating**	0.209008	0.208477	0.239668
11. **Indecisive**	0.204244	0.198446	0.262191
12. **Thoughts life not worth living**	**1.000000**	0.589194	0.266975
13. **Death/suicide, no plan**	0.589194	**1.000000**	0.307148
14. **Suicide with plan forming**	0.266975	0.307148	**1.000000**

Cronbachs Alpha = 0.871768 Standardized Cronbachs Alpha = 0.880508

Tables 4, 4.1, 4.2 and 4.3 show the inter-correlations among the depression variables. While this shows evidence of varying degrees of positive correlation between all fourteen variables, "depressed most of the day" shows as correlated significantly with "no pleasure in the day", "slowed or restless and agitated", "feelings of hopelessness" and "thoughts of death or suicide with no plan". "Slowed down or restless and agitated" was strongly correlated with "lack of energy and fatigue" and "difficulty concentrating". Perhaps not surprisingly, "lack of energy and fatigue" was also highly correlated with "appetite has changed" and "sleep difficulties".

Question 6: What are the inter-correlations among the STS and depression variables, and what are the patterns of relationship that emerges?

To help offer a more complete understanding of the STS risk variables that may show as being in relationship to symptoms of depression in probation officers, the decision was made to compute the correlations between the STS measures and depression variable groups prior to running the factor analysis. The correlation matrices in Tables 5, 5.1 and 5.2 reflects the findings, again using Pearson R's correlation coefficient, an alpha level of .05, and showing the Cronbach's Alpha scores.

Table 5

Pearson Moment Correlations Among Depression and STS Measures

Variable	Clients hostile	Clients violent	Clients sex offenders
Depressed most of day	0.148270	0.066680	-0.100841
No pleasure in day	0.047749	0.066615	0.058850
Appetite has changed	0.187343	0.182129	-0.036415
Sleep difficulties	0.072838	0.090551	-0.035630
Lack energy/fatigue	0.225257	0.116885	0.023776
Slowed down or restless	0.188408	0.184388	0.053452
Worthlessness/inadequacy	-0.031529	-0.053673	0.002735
Feelings of guilt	0.043406	-0.017913	-0.108606
Feelings of hopelessness	0.045689	0.012328	-0.044692
Difficulty concentrating	0.087991	0.100553	0.005413
Indecisive	0.113365	0.145820	-0.033994
Life not worth living	0.002112	0.026907	-0.060909
Death/suicide, no plan	0.020330	0.046319	0.001845
Suicide with plan forming	0.067479	0.076226	-0.032186

Cronbachs Alpha = 0.810169 Standardized Cronbachs Alpha = 0.870397

Table 5.1

Pearson Moment Correlations Among Depression and STS Measures

Variable	Hear about crimes	Read reports/files	In field long time
Depressed most of day	0.096067	0.105188	0.144184
No pleasure in day	0.078016	0.072280	0.094791
Appetite has changed	0.193087	0.208878	0.196228
Sleep difficulties	0.103403	0.081682	0.179062
Lack energy/fatigue	0.290828	0.225756	0.147932
Slowed down or restless	0.223597	0.193409	0.198953
Worthlessness/inadequacy	0.023411	0.019962	0.052809
Feelings of guilt	0.078886	0.045217	0.070792
Feelings of hopelessness	0.088423	0.113599	0.184559
Difficulty concentrating	0.131966	0.143116	0.144760
Indecisive	0.133772	0.090386	0.020726
Life not worth living	0.075847	0.004023	0.082524
Death/suicide, no plan	0.165857	0.169140	0.177251
Suicide plan forming	0.096137	0.093847	-0.005397

Cronbachs Alpha = 0.810169 Standardized Cronbachs Alpha = 0.870397

Table 5.2

Pearson Moment Correlations Among Depression and STS Measures

Variable	Doesn't recog. STS	Discuss/supervisors	Discuss/colleagues
Depressed most of day	0.144184	0.128869	0.139524
No pleasure in day	0.094791	0.152451	0.208349
Appetite has changed	0.196228	0.256258	0.253273
Sleep difficulties	0.179062	0.121262	0.144956
Lack energy/fatigue	0.147932	0.136479	0.234849
Slowed down or restless	0.198953	0.229096	0.257257
Worthless/inadequacy	0.052809	-0.010370	0.102026
Feelings of guilt	0.070792	0.031786	0.148183
Feelings of hopelessness	0.184559	0.092962	0.169706
Difficulty concentrating	0.144760	0.118292	0.078357
Indecisive	0.020726	-0.050204	0.019776
Life not worth living	0.082524	0.034321	0.114523
Death/suicide, no plan	0.177251	0.115414	0.114318
Suicide plan forming	-0.005397	0.128652	-0.001673

Cronbachs Alpha = 0.810169 Standardized Cronbachs Alpha = 0.870397

The correlation matrices displayed in Tables 5, 5.1 and 5.2 reveals both positive and negatively statistically significant relationships. Specifically, "clients are hostile" was significantly correlated with "lacking energy and fatigue", and to a lesser degree with "sleep difficulties", "slowed down or restless" and "depressed most of the day". "Clients are violent" was notably correlated with "appetite has changed", "slowed down or restless" and "indecisive". "Clients are violent offenders" was correlated significantly only with "appetite has changed" and "slowed down or restless". Curiously, "clients are sex offenders" was negatively correlated with "depressed most of the day" and "feelings of guilt". This might be due to the fact that those officers who work with sex offenders and reported increased distress at working with this type of client are likely to experience less frequent feelings of guilt.

Another grouping of significantly correlated variables: "hear about crimes and stories of abuse, assault, violence, etc. directly from the clients" was markedly correlated with "lack energy/fatigue", "slowed down or restless", "appetite has changed" and "thoughts of death or suicide with no plan". The variable "read reports and file materials about the crimes and impact statements" was significantly correlated with "lack of energy/fatigue", "appetite has changed" and "thoughts of death or suicide without a plan". It may be reasonable to assume that higher levels of distress experienced by probation officers through continuous exposure to traumatic material (directly from the client and through written materials, such as reports, files and impact statements) may also be related to decreased energy, fatigue, changes in eating patterns and thoughts about death.

"You have been working a long time in the field and have had lots of exposure to traumatic material" correlated positively with "slowed down or restless", "appetite has changed", "feelings of hopelessness", "sleep difficulties", "difficulty concentrating" and "thoughts of death or suicide without a plan". Again, as with the previous aforementioned STS variable, an officer's

long term (as in many years in the field), repeated exposure to traumatic material may also be linked with increased changes in eating patterns, sense of hopelessness, difficulties with sleep (whether lack of, or oversleeping), problems with concentration and thoughts of death.

The last three STS variables in Table 5.2 correlated positively with a number of the depression variables. The "work doesn't recognize STS" showed statistical significance with the following measures: "slowed down or restless", "appetite has changed", "sleep difficulties", "feelings of hopelessness" and "thoughts of death or suicide without a plan". It seems reasonable to expect distress associated with an officer's perception of the workplace not acknowledging effects of traumatic stress, to be positively correlated with the depression variables shown in these results.

"Unable to discuss distress with colleagues" showed significant positive correlation with "appetite has changed", " slowed down or restless" and "no pleasure in the day". "Unable to discuss distress with supervisors" was notably correlated with "slowed down or restless", "appetite has changed", " lack energy/fatigue", "no pleasure in the day" and "feelings of hopelessness". Again, given the nature of probation work, and what we suspect about the subculture within corrections work (Violanti, 1996), it is valid to expect there to be some relationship between distress levels experienced by an officer's inability to discuss his or her distress with colleagues or supervisors with symptoms of fatigue, changes in eating habits, a sense of hopelessness and decreased pleasure in one's work day.

Question 7: Which, and to what degree are the variables related to any underlying, influential factors or constructs inferred from the exploration of this data? (More specifically, how many different factors are needed to explain the pattern of relationships among these variables? What is the nature of those factors? How well do the hypothesized factors explain the observed data?)

This study called for an exploratory factor analysis of the STS and depression measures to help identify any important underlying constructs that were better representatives of explaining the reported STS effects and symptoms of depression than the original variables taken from the workshop. Tests were run individually for the STS and depression groupings to determine if any of the measured variables were not required. This decision was based on findings from the correlation matrices and the more advanced procedures that followed.

In light of the significantly low correlations and communality within their grouping, and extremely low factor loadings in the initial tests, the following two variables were eliminated at this stage of the analysis: "clients are sex offenders" from the STS measures and "having suicidal thoughts with a plan forming" from the depression measures. In partnership with the results from the correlation matrices and initial factor loadings run, it was deemed reasonable to assume that both of these observed variables scored low in association for these reasons: the relatively low number of probation officers carrying sex offenders as part of their caseload, and the fact that only one participant indicated consistently having suicidal thoughts with a plan forming.

The next step after making the decision to remove the two aforementioned variables was to make a judgment on how many factors to extract from the measured variables. With both groupings, the initial decision was to extract the number of factors equal to at least half the number of variables. In both cases, scree plots; eigenvalues where the criterion was generally a

value of 1.0 or higher, or a notable measure difference between factors with the minimum criteria of 1.0; factor loading scores; and a minimum of three variables loading per factor were examined to determine whether another test was called for with fewer factors extracted. What follows are the results from the process of factor number determination for the STS risk and depression measures. Finally, this section will address the naming and interpretation of the remaining factors.

STS Risk Factor Number Determination

The first test run was based on extracting 5 factors from the 8 STS risk measures, namely "the inmates/clients are hostile and demanding", "the inmates/clients are violent offenders", "you hear about the crimes and stories of abuse, assault, violence, etc. directly from inmates/clients", "you read the reports and file materials about the crimes and victim impact statements", "you have been working in the field for some time and have been exposed to lots of traumatic material", "workplace does not recognize stress effects of secondary trauma", "not able to discuss distress with colleagues and coworkers" and "not able to discuss distress with supervisors or management". Based on the eigenvalues, scree plot and factor loading structure, it was decided to reduce the factor number. Table 6 visually supports the justification for that decision, and further offers an example for the rationale behind subsequent tests in this analysis where the decision was made in the process to reduce the factor number.

Table 6

STS Eigenvalues After Varimax Rotation for 5 Factors

No.	Eigenvalue	Individual Percent	Cumulative Percent	Scree Plot
1	**2.079703**	35.32	35.32	||||||||
2	**1.886415**	32.03	67.35	|||||||
3	**1.643013**	27.90	95.25	||||||
4	0.183930	3.12	98.37	|
5	0.096980	1.65	100.02	|
6	0.005435	0.09	100.11	|
7	0.001491	0.03	100.14	|
8	-0.007972	-0.14	100.00	|

After running a 3-factor test, it was determined to reduce the final number of retainable factors to 2. This decision was based primarily on: the eigenvalues and number of variables per factor on loading. While three eigenvalues maintained a score of 1.0 or higher (2.15, 1.86 and 1.53 respectively), helping to validate the three groupings from the original questionnaire set, two factors were ultimately retained for the STS measures. Table 6.1 and 6.2 follow showing the eigenvalues and factor loadings. Figure 1 also reflects the statistical decision to retain 2 factors.

Table 6.1

STS Eigenvalues After Varimax Rotation for 2 Factor Extractions

No.	Eigenvalue	Individual Percent	Cumulative Percent	Scree Plot
1	3.038289	61.48	61.48	||||||||||||
2	1.885304	38.15	99.63	|||||||
3	0.353503	7.15	106.78	||
4	0.014775	0.30	107.08	|
5	-0.000693	-0.01	107.07	|
6	-0.052701	-1.07	106.00	|
7	-0.103162	-2.09	103.91	|
8	-0.193410	-3.91	100.00	|

Table 6.2

STS Factor Loadings After Varimax Rotation

STS Variables	Factor I	Factor II
1. Clients hostile/demanding	-0.700351	0.112380
2. Clients are violent offenders	-0.718535	0.131818
3. Hear stories of violence	-0.825008	0.193560
4. Read reports of violence	-0.881187	0.175930
5. Long term exposure to STS	-0.694056	0.340462
6. Work doesn't recognize STS	-0.232521	0.736702
7. Can't discuss with colleagues	-0.124768	0.677769
8. Can't discuss with supervisors	-0.151757	0.817843

*Underlined scores denote those greater than 0.40.

Figure 1

STS Bar Chart of Absolute Factor Loadings After Varimax Rotation

STS Variables	Factor I	Factor I
1. Clients hostile/demanding	|||||||||||||||	|||
2. Clients are violent offenders	|||||||||||||||	|||
3. Hear stories of violence	|||||||||||||||	||||
4. Read reports of violence	|||||||||||||||	||||
5. Long term exposure to STS	|||||||||||||	|||||||
6. Work doesn't recognize STS	|||||	|||||||||||||
7. Can't discuss with colleagues	|||	|||||||||||
8. Can't discuss with supervisors	||||	|||||||||||||||

Two distinct factors emerge from the STS risk variables with eigenvalues of 3.04 and 1.89 as illustrated in Table 14. All STS variables in the factor loadings in Table 6.2 show significant negative correlation in relationship to Factor I. Variables 1 – 5 are especially high. Conversely the factor loadings show the STS variables in significant positive correlation with

Factor II. The bar chart in Figure 1 also helps to visually demonstrate these patterns of relationship.

Depression Factor Number Determination

The first step in determining the number of factors to extract from the depression measures was to run an initial test with 7 factors from the list of 14 variables. Based on the correlation matrix, eigenvalues, factor loadings and factor structure results, the researcher decided to remove the variable "thoughts of suicide with a plan forming", and reduce the factor number to 5. This was based on: the extremely low correlations this variable showed in relationship with the other depression variables; similarly "thoughts of suicide with a plan forming" showed low factor loading coefficient scores; and did not load on the factor structure results.

A series of subsequent tests were run with a factor selection number of 5, 3 and 2 respectively. The final decision was to be left with 2 factors due to the significant eigenvalues on the 2-factor extraction test (3.13 and 2.76 – the closest eigenvalue by comparison was 0.36), scree plot, factor pattern coefficient loadings and factor structure summary. These results are illustrated in Tables 7, 7.1 and Figure 2.

Table 7

Depression Eigenvalues After Varimax Rotation for 2 Factors

No.	Eigenvalue	Individual Percent	Cumulative Percent	Scree Plot
1	**3.134862**	52.92	52.92	||||||||||
2	**2.758853**	46.58	99.50	|||||||||
3	0.360533	6.09	105.59	||
4	0.294937	4.98	110.57	|
5	0.177931	3.00	113.57	|
6	0.120299	2.03	115.60	|
7	0.050728	0.86	116.46	|
8	-0.059348	-1.00	115.45	|
9	-0.117935	-1.99	113.46	|
10	-0.152757	-2.58	110.88	|
11	-0.161944	-2.73	108.15	|
12	-0.189015	-3.19	104.96	|
13	-0.293793	-4.96	100.00	|

Table 7.1

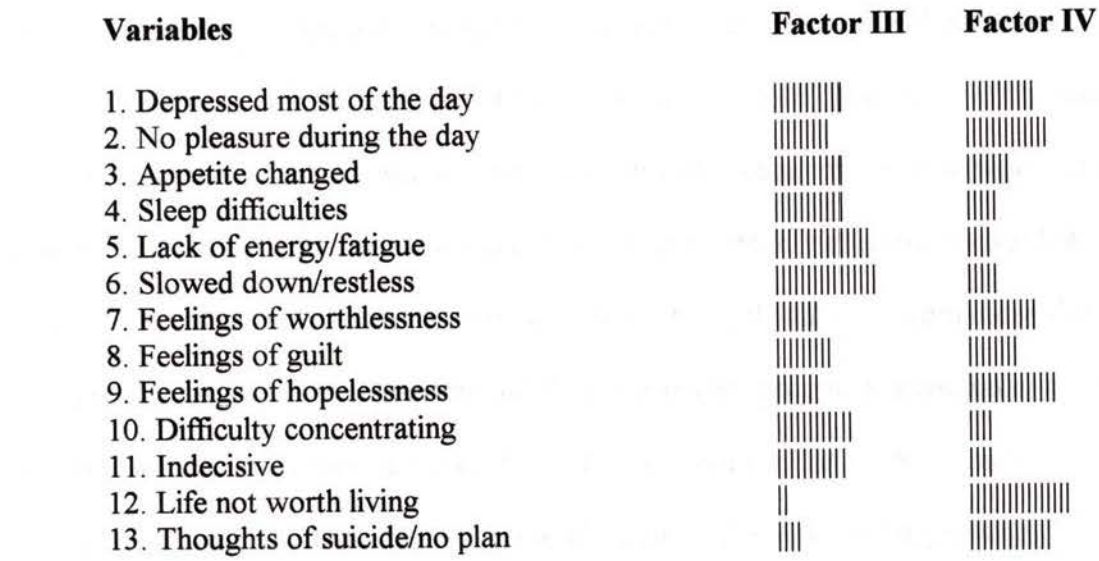
Depression Factor Loadings After Varimax Rotation

Variables	Factor III	Factor IV
1. Depressed most of the day	-0.511301	0.515285
2. No pleasure during the day	-0.431392	0.622003
3. Appetite changed	-0.510275	0.327930
4. Sleep difficulties	-0.508276	0.245799
5. Lack of energy/fatigue	-0.737782	0.178949
6. Slowed down/restless	-0.755264	0.229525
7. Feelings of worthlessness	-0.339424	0.509280
8. Feelings of guilt	-0.425501	0.381835
9. Feelings of hopelessness	-0.330220	0.652018
10. Difficulty concentrating	-0.581699	0.156638
11. Indecisive	-0.530329	0.158692
12. Life not worth living	-0.077566	0.782671
13. Thoughts of suicide/no plan	-0.151393	0.601002

*Underlined scores denote those greater than 0.40.

Figure 2

Depression Bar Chart of Absolute Factor Loadings After Varimax Rotation



A pattern similar to the STS loadings emerged within the depression variables factor extraction tests. Factor III shows significant negative correlation to the depression variables, and Factor IV shows equally positive correlation. More specifically, Factor III correlates highly (-.40 or higher) with nine of the depression variables, namely "slowed down/restless" (-0.76), "lack of energy/fatigue" (-0.74), "difficulty concentrating" (-0.58), "indecisive" (-0.53), "depressed most of the day" (-0.51), "appetite has changed" (-0.51), "sleep difficulties" (-0.51), "feelings of guilt" (-0.43) and "no pleasure during the day" (-0.43). Factor IV is notably correlated (.40 or higher) with "thoughts that life is not worth living" (0.78), "feelings of hopelessness" (0.65), "no pleasure during the day" (0.62), "thoughts of death or suicide without a plan" (0.60), "depressed most of the day" (0.52) and "feelings of worthlessness" (0.51).

Factor Interpretation and Definition

In determining what substantive meaning or definition finally attached to each of the 4 retained factors, the following criterion was thoughtfully examined: the predominant common theme, concept, or content that each of the variables contributed; the high loading variables measures and what those variables conceptually shared in common (or otherwise worded, a construct identified as having the reasonable capacity to identify all variables that loaded high); how variables that loaded high on each factor were distinctly different from those shared and measured by the variables supporting the 2nd factor in each grouping; attention to any patterns of similarity between variables that loaded on a factor; consideration of those loaded variables with correlations *lower* than 0.40; current understanding of STS risks and depression; context of the workshop delivery; and ultimately, the judgment of the researcher at the time this study was undertaken (Kim & Mueller, 1989).

Factor interpretations and naming for each of the STS and depression measure results are dealt with sequentially following this section. A factor structure summary introduces this process. To conclude Chapter IV, an overall summary of the analysis results will be offered prior to the next chapter and discussion section of this study.

Factors I and II

Figure 3 follows showing the factor structure summary for the STS risk variables that loaded 0.40 or higher on the factor loadings, including the conceptual names attached to each. The STS risk variables are listed in order ranking of highest correlation with the respective factor each is associated with.

Figure 3

STS Factor Structure Summary After Varimax Rotation

Factor I	**Factor II**
Managing STS Exposure	**Workplace Isolation**
Read reports of violence	Can't discuss STS with supervisors
Hear stories of violence	Work doesn't recognize STS
Clients are violent offenders	Can't discuss STS with colleagues
Clients are hostile/demanding	
Long- term exposure to STS	

Factor I: the STS variables that loaded high on this factor reflect an extremely robust inverse, or negatively correlated pattern of relationship. These variables are indicative of situational workplace risk factor distress levels specific to the probation officers at the time they participated in the workshop. A strong conceptual theme of exposure to violent material has emerged – whether directly or indirectly through the context of probation work. Notably, though to a lesser degree is the length of exposure or years of service. It also bears mentioning that no variables within this grouping loaded high on both factors (although "long –term exposure to STS" loaded at a noteworthy 0.34 on Factor II).

Given the predominant shared conceptual theme or content that each of the STS risk variables contributed, Factor I was named *Managing STS Exposure*. The concept of managing or coping with STS exposure is assumed to be the key underlying process driving the relationships among the STS risk variables. Case in defence, it is reasonable to assume that distress levels for workplace conditions such as reading reports of violence, and hearing stories of violence rise, are conversely related to managing STS exposure.

Factor II: 3 STS risk variables loaded high on this factor – all of these variables are associated with the perceptions of STS support and the distress experienced through the lack or existence of that

support within the context of a probation officer's work. In other words, the capacity and/or level of comfort the officers in this study felt in sharing their distress with supervisors or colleagues brings abou a factor of isolation in their work environment. Also, the strong positive direction of the relationship these variables hold with Factor II, points to *Workplace Isolation*.

Factors III and IV

The factor structure summary for the depression variables that loaded 0.40 or higher are reflected in Figure 4, (the conceptual names are also attached). Similar to Figure 3, the depression variables are ordered in ranking of highest correlation with the respective factor each is related to.

Figure 4

Depression Factor Structure Summary After Varimax Rotation

Factor III	**Factor IV**
Physiological Well - Being	**Psychological Distress**
Slowed down/restless	Life not worth living
Lack of energy/fatigue	Feelings of hopelessness
Difficulty concentrating	No pleasure during the day
Indecisive/difficulty making decisions	Thoughts of suicide/no plan
Depressed most of the day	Depressed most of the day
Appetite changed	Feelings of worthlessness
Sleep difficulties	
No pleasure during the day	
Feelings of guilt	

Factor III: the depression variables that loaded high, reflected statistically significant negative inter-correlations with this factor. Seven out of 9 of these variables are conceptually associated with physiological conditions. Logic and good sense dictates that physiological well - being is inversely related to the depression variables that loaded high on this factor. While clearly less directly or literally connected with the construct of physiological well - being presented,

"no pleasure during the day" and "feelings of guilt" are arguably linked. It is not unreasonable to conclude that decreased physical pleasure and feelings of guilt may hold relationship with elements of physical health. Factor III holds meaning connected to physical aspects of health, thus it has been interpreted as *Physiological Well - Being.*

It bears mentioning that Factors III and IV shared the common connection of 2 depression variables, namely "no pleasure during the day" and "depressed most of the day". It is also significant to note that the correlations were opposite, in that for Factor III the relationship was negatively correlated, and positively correlated with Factor IV. Interestingly, the magnitude of the correlation for "depressed most of the day" with both factors was a mirrored value, although opposite in their direction, -0.51 and 0.52 respectively.

A total of 6 of the 9 depression variables loaded statistically high on Factor IV. All of the depression variables that loaded high on this factor share psychological characteristics, including elements of emotion, cognition and qualities associated with purpose or meaning. Given the direction and magnitude of the individual depression variables' relationship with this factor, it is conceptually linked to suffering and strain in the psychological realm, namely *Psychological Distress.*

Summary

The results from this analysis reflect the questionnaire responses of 167 probation officers working with B.C. Community Corrections at the time of the workshop delivery. Demographic examination reflected a grouping relatively gender balanced (slightly more male than female participants) with an average age of 40.5 years.

The probation officers in this study generally reported "moderate" distress levels for all STS variables (overall average = 2.62) with those variables concerned with exposure to traumatic material averaging the highest. For the depression variables, "sleep difficulties", "lack of energy and a sense of fatigue" and "slowed down or restless and agitated" showed the greatest frequencies for how often participants reported experiencing these symptoms over the two week period prior to the workshop. It is clinically, if not statistically significant that some of the participants were in difficulty as indicated by their responses to the suicide and death symptom related statements. Sixteen of those officers who responded to these items reported these symptoms as at least "fairly often". One officer reported "consistently" having thoughts of suicide with a plan forming "fairly often".

As shown in the inter-correlation results, distress associated with an officer's perception of the workplace not acknowledging effects of traumatic stress, to be positively correlated with the depression variables shown in these results. Given the nature of probation work, and what we suspect about the subculture within corrections work, it is valid to expect there to be some relationship between distress levels experienced by an officer's inability to discuss his or her distress with colleagues or supervisors with depression-related symptoms.

As stated earlier in this chapter, the decision was made to eliminate two variables through the process of the exploratory factor analysis, namely "clients are sex offenders" from the STS grouping and "having thoughts of death or suicide with a plan forming" from the depression measures. These variables correlated very low by comparison, and this was the driving consideration in removing each from the factor analysis process. However, it is important to acknowledge in this analysis that officers carrying a sex offender case load (although only 16% of the total participants) were counted in other sections of the analysis, hence it may be difficult to

determine within the limitations of this study how carrying this specialized type of client played into their responses for other parts of this analysis. Comparably, but to a much lesser degree however, the suicide-related depression variable that was eliminated showed very little correlation with any of the other variables. Again, this was most certainly due to the fact that only one officer reported having these thoughts consistently.

The exploration of the STS and depression variables examined in this study using factor analysis as the vehicle, resulted in four factors: Managing STS Exposure, Workplace Isolation, Physiological Well - Being and Psychological Distress. Essentially, these factor interpretations were founded on what the variables had in common after careful examination of what the high loading variables measured, the predominant common theme, concept, or content that each of the variables contributed, context of the workshop and researcher judgment.

CHAPTER V – DISCUSSION

The general purpose of this research has been to make a theoretical contribution to the ongoing investigation of secondary traumatic workplace stress risk factors and symptoms of depression, generally for probation officers, corrections personnel and related fields, but more specifically for the probation officers who voluntarily participated in this study, and the B.C. Community Corrections Branch. This was accomplished through the statistical exploration and analyses of the demographic, STS risk and depression variables extracted and examined from *The Road Back to Wellness: Stress, Burnout and Trauma* workshop that was facilitated through the Justice Institute of B.C., and delivered throughout the province of British Columbia during 2001.

This chapter has been organized to first revisit, and discuss each of the specific research questions asked at the onset of this study. Discussions of the implications, limitations and recommendations for further research will follow to conclusion.

Discussion of the Research Questions

Question 1: What were the general demographics of the probation officers who participated in this study?

The first question asked in this study was around the demographics of the probation officers who participated. Specifically, gender, age, years of service, caseload (including type of client, risk level), financial stress and perceived adequacy of training received were examined. In light of exploring a population sample that arguably reflects both genders, this study may be stated as having offered a reasonable balance of both male and female participants, even though there were 6% more males. This relative equilibrium allowed for the measures to conceivably be

reflective of both genders. The limited scope of this study did not permit separating the results from male and female participants to see how they might compare, or differ in terms of reported distress levels for the STS workplace risk factors and frequency of depressive symptoms. However, it is also worth noting that the research that has examined gender differences in studies on correctional officer stress has met with conflicting and inconsistent findings. Some have found differences in females experiencing more occupational stress, whereas others have found no differences between genders (Morgan et al., 2002). For reasons of study limitations, the question of gender differences was not explored.

Only 24% of the participants were noted as being in a primary relationship. Given that the average age of the probation officers was 40.5 (SD = 9.14), one might expect a higher percentage of officers to be in significant partnerships. While it is not the intention or within the scope of this study to perpetuate any unjustifiable notions about age and being in primary partnerships as the norm, this apparent low percentage of officers for this characteristic seems to beg the question: does the nature of probation work place undue strains on sustaining intimate relationships?

The average probation officer caseload was 71 clients (SD = 19.51) with a range numbering from a minimum of 25 to a maximum of 120. The average risk level for clients was medium to high with 16% or 26 out of the 167 participants recorded as carrying a specialized client load. In all cases "specialized" was noted as referring to sex offenders. All other responses to "client type" were of a "mixed/generic" category. This suggests that many of the probation officers in this study perceive their clientele to pose considerable risk for stress. It is not unreasonable to conclude that the more difficult the client, as logically would be the case with a client who has a criminal history of violence, the higher the potential for increased stresses. While

assumed to be so, it was not determined from the demographic information whether those officers with fewer caseloads were actually carrying the greater number of high risk clients, such as sex offender types. Future exploration and analyses of the data might examine the relationships between responses to the STS workplace risk variables and symptoms of depression in a way to compare those officers with higher risk clients, and those with lower risk.

Sixty-three percent of the probation officers also indicated that they did not feel they were adequately trained for their job. This information is significant for a few reasons. This statistic speaks to the fact that well over half of the probation officers working for B.C. Community Corrections and participating in this study felt they were not sufficiently prepared to meet the demands and stresses of their jobs. This perception in and of itself may create undue stress for the individual officer, and in the workplace. In particular, officers who felt they were not prepared to meet the demands of working with specialized groups, such as sex offenders may be especially vulnerable.

Question 2: What were the measures of central tendency and variability, and what percentage of probation officers reported experiencing higher distress levels for the work-related secondary traumatic risk variables?

To summarize from the results, the probation officers in this study generally reported "moderate" distress levels for all nine of the STS workplace risk variables (overall average = 2.62). Those variables necessarily concerned with an officer's exposure to traumatic material whether through visual or auditory contact showed the highest mean scores ranging from 3.47 to 3.15. This was also a reflection of distress levels reported for long-term exposure or length of time in the field. This statistic is significant because it is an indication of what aspects of the work

may be responsible for creating higher STS distress levels for officers through the course of their duties. Furthermore, it is not surprising to find that officers might often experience high distress levels through the course of their duties around the direct and indirect exposure to traumatic material that is a risk inherent in the nature of probation work.

The probation officers in this study showed comparatively lower distress levels for aspects of their support environment. The lowest average distress level was reflected in being "unable to discuss with colleagues". There may have been a general sense of perceived ability to discuss work stress with colleagues operating, or it might have been influenced by the context of the workshop delivery. The format of the workshop was designed in a way to potentially promote a sense of collegiality, and support through the facilitation process. Hence, it is difficult to firmly conclude whether these results are simply mirrors of that context as an isolated event, or truly indicative of a systemic dynamic that encourages and permits opportunities to debrief with colleagues in the workplace? If assumed to hold validity, it does offer a potential supportive pathway for those officers at risk for developing STS and its' associated symptoms. (This assertion will be discussed further in the implications section of this chapter.)

Officers reported higher levels of distress for their perceived capacity to discuss their secondary traumatic distress with supervisors or management personnel, and for their perceptions of B.C. Community Corrections and their organizational willingness to recognize STS effects. This is not a riveting result if one considers it to echo a system that is suspected for having a subculture traditionally steeped in paramilitary perspectives similar to law enforcement (Violanti, 1996; Carlier et al., 2000; Coman, 1993), where 'talking' about traumatic stress might be perceived as weakness. In light of this, it is not surprising that officers in this study reported higher distress levels for these workplace variables.

The probation officers in this study reported by comparison, higher frequencies of distress for clients who are hostile and demanding or violent offenders. These statistics may be a reflection of the number of officers who carry hostile or violent clients or a combination of officers feeling inadequately trained to deal with aggressive clients who are prone to volatile and violent behaviours. Once more, given that we know probation officers often work in isolation when they meet with clients, having foreknowledge of an individual client's past or even present behaviours may be unnerving, stressful to say the least. Compounding this perception is the question that was cited earlier around how adequately officers feel they are prepared for their duties – again, 63% of the officers who participated in this study did not feel sufficiently trained for their job.

STS distress levels that were reported for sex offenders were comparatively lower than the other STS variable examined in this study. This may be a deceiving statistic because only 16% of the probation officers from this study were noted as carrying sex offenders as part of their caseload. Thus, it is logical to conclude that the general descriptive statistical results for this variable would be more indicative of the other 84% of total officer participants who would most likely not have reported experiencing distress from sex offenders if this specialized group was not part of their caseload. Consequently, it is difficult to ascertain within the limits of this particular analysis to determine how probation officers who carry sex offenders in their caseloads differ or compare in reported distress levels to the other probation officers in this study. This would pose another direction for analysis with the results herein, and taken through further exploration of the larger data set.

Question 3: What were the measures of central tendency and variability, and what percentage of probation officers reported experiencing depressive symptoms "consistently", "fairly often" and "never or rarely"?

Taken from the descriptive statistic results for the depression symptom variables, those symptoms having physiological qualities were reported most frequently and with the most consistency. Difficulties with or disruptions in sleep patterns were reported as "fairly often" by roughly 42% of the officers. Given this, it may necessarily follow that a sense of fatigue and\or depleted energy, restless and agitation may result from problems with sleep, whether that being a question of not enough or too much. What the scope of this study does not offer are clear conclusions as to whether those symptoms are causally related to any or all of the STS workplace risk variables examined through this investigation.

The suicidal-related symptoms were important in determining the level of suicidal thoughts at the time of participation in the workshop for this particular group of probation officers. While the statistical results demonstrate generally low levels of suicidal risk for the group at large, it is noteworthy that some of the participants were clinically at risk as indicated by their responses to, in particular the last three suicide-related symptom items on the depression checklist. It surely raises clinical concern, if not statistically significant to note that even one participant was having "thoughts of death and/or suicide with a plan forming" "fairly often".

It is important to bear in mind that at the time the questionnaire was completed many immeasurable factors, both individually for participants and systemically could have played into the results discovered through this analysis and exploration of the variables in question. Hypothetically, any number of unreported crises or life events could have unfolded in the lives of individual officers at the time of the workshop delivery that potentially increased an officer's

vulnerability to experiencing depressive symptoms more consistently (Cohen, 1988). Regardless of the necessary consideration of these intangibles in this discussion, many differing opinions exist a propos the nature of depression vulnerability. For instance, factors contributing to vulnerability may be viewed as some form of permanent risk indicators, and conversely others may be viewed as more yielding to change. Consequently, factors may be perceived as an immovable extension of the individual officer (e.g. in the case of neuroticism), or as characteristics of the social context of the work environment (e.g. lack of support). (Moran et al., 2001) These varying conceptualizations of vulnerability, in particular as viewed by the B.C. Community Corrections Branch will have bearing on how preventable depression is thought to be, who such preventative initiatives should be aimed at, and the types of factors targeted. This point will be addressed further in the implications and recommendations portion of this discussion.

Question 4: What are the inter-correlations among the STS workplace risk variables?

The results from this study reflected significantly high positive correlations among the STS workplace risk measures. This is not surprising given the thematic content of each STS variable, however the resulting inter-correlations were instrumental in helping determine two important components of this part of the investigation: construct validity, and determination of variables to be justifiably retained through exploratory factor analysis.

To revisit, the most prominent correlated pairing was between "hearing about crimes and stories of violence, assault, etc." and "reading reports and file materials, victim impact statements" etc. The perception of distress for years in the field and long-term exposure to traumatic material correlated positively with all of the STS workplace risk variables. This tells us

that experiencing higher levels of distress at being exposed to secondary traumatic workplace risks over a longer period of time will also result in higher distress levels for other STS workplace risk factors. Essentially, the magnitude and direction of relationships connecting all of the STS variables investigated in this study indicates they are measuring STS workplace risk factors that share a commonality of having the similar tendency to show distress levels that move together, otherwise stated as one is higher, so shall the others be, at least for this particular group of probation officers at the time of the workshop and questionnaire completion.

Question 5: What are the inter-correlations among the symptoms of depression variables?

The symptoms of depression variables did not correlate with the same strength as the inter-correlations among the STS grouping. However varying the resulting degrees of relationships discovered through the results, all fourteen variables were nonetheless, positively correlated. There were groupings of variables that emerged as more strongly correlated: generally those variables associated with psychological conditions, and those associated with physiological conditions. As with the STS inter-correlations, the intention was to successfully measure construct validity, look for patterns of relationship, as well as determine variables appropriate for the exploratory factor analysis step.

Question 6: What are the inter-correlations among the STS and depression variables, and what are the patterns of relationship that emerges?

The examination of correlations between the STS workplace risk and symptoms of depression variables revealed relational directions that were both positive and negative. This would be expected given the content of individual variables. Distress levels for hostile clients

were notably correlated with physiological symptoms. Theoretically, this may indicate that having higher distress levels from dealing with hostile or aggressive clients can also result in increased fatigue, sleep difficulties and feeling slowed down or restless. Similarly, if dealing with violent offenders increases distress levels, changes in appetite may also follow along with feelings of being slowed down or restless.

Perhaps curiously, "clients are sex offenders" was negatively correlated with "depressed most of the day" and "feelings of guilt". Arguably, this might be a reflection of the presence of distress for dealing with clients who have committed sexual offenses (pedophiles in particular, although this study does not focus specifically on the nature of the sexual offenses) working in opposite direction to experiencing depressed feeling throughout the day and guilt. Given the nature of sexual offenses, it is plausible that officers might experience decreased feelings of guilt, in particular a decrease in the difficulties they might experience as a result of dual role conflict – that of custodian and advocate in promoting a crime-free lifestyle.

Another grouping of significantly correlated variables from the results was among the STS workplace risk variables that were concerned with exposure to traumatic material and symptoms associated with "lack energy/fatigue", "slowed down or restless", "appetite has changed" and "thoughts of death or suicide without a plan". While never absolutely conclusive, it is reasonable to assert (and as reflected in the patterns of correlations), that higher levels of distress experienced by probation officers through continuous exposure to traumatic material (directly from the client, through court process and written materials, such as reports, files and impact statements) are linked with symptoms of decreased energy, fatigue, changes in eating patterns and thoughts about death.

The STS workplace risk variables that were concerned with support in the environment also correlated positively with a number of the depression variables. It is valid to expect distress associated with an officer's perception of the workplace not acknowledging effects of traumatic stress, to mirror the risks for increased consistency of symptoms of depression. Similarly, the question of the inability to debrief with colleagues or supervisors, and what must surely create a sense of isolation reflects the same relationship with depressive symptoms – not surprisingly given what is suspected about the subculture within corrections work.

Question 7: Which, and to what degree are the variables related to any underlying, influential factors or constructs inferred from the exploration of this data? (More specifically, how many different factors are needed to explain the pattern of relationships among these variables? What is the nature of those factors? How well do the hypothesized factors explain the observed data?)

Four distinct factors emerged from the exploratory factor analysis of the STS risk and depression variables investigated in this study: Managing STS Exposure, Workplace Isolation, Physiological Well - Being and Psychological Distress. Managing STS Exposure and Workplace Isolation were determined from the STS workplace risk variables. Physiological Well - Being and Psychological Distress were determined from the symptoms of depression variables.

All STS variables in the factor loadings showed significant negative correlation in relationship to Managing STS Exposure. The thematic structures of these variables were all necessarily concerned with STS effect risks from exposure to traumatic material, length of exposure and the nature of the client population. A critical characteristic of this factor is the direction of its' relationship with the STS variables that loaded high on it. Essentially, it tells us

that underlying these risk variables that are all thematically related, is a predictor of distress levels for these aspects of probation work. Otherwise stated, Managing STS Exposure represents a preventive concept for alleviating the risks of higher distress levels for the specific aforementioned risks inherent in the job.

Workplace Isolation was revealed as a positive linear combination of three of the STS workplace risk variables concerned with support in the probation officer's environment. The responses for officers inability to discuss distress with supervisors, colleagues and perceptions of B.C. Community Corrections not recognizing STS effects suggests a factor of isolation in their work environment. Simply stated, isolation in the workplace is theoretically a predicting factor for distress levels experienced through an environment that is not felt to be supportive. These are critical points of consideration for any strategies aimed at decreasing risks for STS effects.

Nine depressive symptom variables reflected statistically significant negative inter-correlations with the Physiological Well - Being factor, and six depressive symptom variables loaded high in a positive direction with Psychological Distress. In light of what may be taken from the results, Physiological Well - Being and Psychological Distress are theorized to be predictors of the specific depressive symptom variables with which they each hold significant statistical relationships. Physiological Well - Being is a predictor of lower consistency of reported depressive symptoms that are related to physical health; conversely, compromised physiological well - being is a predictor of increased consistency of the same depressive symptoms.

In the psychological realm, Psychological Distress is a hypothetical predictor of depressive symptoms associated with emotion, cognition and those qualities of life we associate with purpose or meaning. In other words, as psychological distress increases the consistency of

the six specific symptoms of depression will also increase. Of course in theory, the opposite holds true.

The discovery of these four underlying influences is particularly useful because they represent constructs that are linear combinations, and theoretically predictors of the variables. The factors offer insight into what theoretically predicts increased or decreased STS effects and vulnerability to depressive symptoms. As argued within the larger context of this study, they are strong hypothetical representatives of the observed data. Although it might have seemed logical to forecast these predictors, the final results are designed to be a part of the justification for the preventive and intervention strategies that are recommended, both for individual officers and at the organizational level. These will be taken as a culmination of the results of this study, current research, and knowledge of current practices within the B.C. Community Corrections Branch.

Implications

There are numerous implications to infer through the findings in this analysis. The high contribution rates from the participating officers in this study point to a keen commitment on their part to unravelling the issues related to stress inherent in the context of their duties and workplace. Therefore, a certain level of confidence in the validity of the findings from this investigation is justified.

Simply stated and revisited, this study was aimed at taking part in the scientific journey of exploring, identifying and explaining theoretical factors or predictors of secondary traumatic stress and depression, most directly for the probation officers who participated, and more

generally in theory for those who work in related high-risk professions. It was designed more specifically to assist the B.C. Community Corrections Branch in the interpretation of this portion of the workshop results, as well as a vehicle for validating, revising or making recommendations around their current attitudes and practices in dealing with secondary traumatic stress and depression in their probation officers and workplace. In the end, it was also intended to assist in paving the way for continued exploration of the larger existing data set, and future research directions in the field of corrections.

The intention of the statistical exploration was dual: to aid in data interpretation, as in what is informative from the descriptive statistics; and the discovery of a smaller number of underlying independent factors, namely, Managing STS Exposure, Workplace Isolation, Physiological Well - Being and Psychological Distress. In theory, these factors serve as predictors for the STS effects and symptoms of depression that have been investigated. Per se, the study has been an instrument to assist with promoting the identification of the underlying risk factors or buffers behind the STS and depression variables, and what this discovery means to the officers who participated and the B.C. Community Corrections Branch. Ultimately, this work has intended to make a humble contribution to research within the field of secondary traumatic workplace stress and associated symptoms.

Clinical and Organizational Responses

It is evident that probation work is stressful. The job exposes probation officers to specialized challenges that are unique to their workplace contexts. We have recognized that verbal abuse and physical threat from those in their care, custody and control is an established reality of the job (Fisher, 2000a; Corneluis, 1994). Clients range from low to high-risk, sexual

and violent offenders, mentally disordered offenders, and those who are susceptible to volatile behaviours. These duty-related factors place individual officers at risk for potentially developing symptoms associated with STS and depression. (Province of British Columbia Ministry of Attorney General Job Description)

Probation officers are also expected to respond to the rehabilitative needs of their clients through an array of intercessions such as: enforcement of probation conditions, program delivery, interviewing, counselling, and liaison with and referral to those agencies involved with the case of individual clients. Compounding these unique stresses, we suspect a systemic subculture that places certain values, expectations and demands on individual officers (Violanti, 1996). Moreover, the knowledge base and accumulated experience derived from working with offenders is specialized in ways that separates it from the general public's understanding of the complexities entrenched in the work (Fisher, 2000a; 2002a). This may have the impact of compounding an officer's sense of social isolation, especially if that support is lacking within the subculture or organizational structure of the work environment.

The nature of the support system within the workplace plays a crucial role in increasing or diminishing STS effects. This study has offered varying degrees of results into the support environment question for this particular group of probation officers. Clearly, there was a significant amount of distress reported concerning support-related issues for this group of probation officers to warrant attention. The resulting predictive factor of Work Isolation has begged the question: has the organizational structure of the B.C. Community Corrections Branch addressed the determined needs to be informed about the risks of STS, and implemented branch-wide strategies to promote and encourage a supportive work environment that is safe, and non-stigmatizing for those officers who have been impacted?

As previously mentioned at the outset of this study, the nature of probation work may also cause the individual belief systems an officer holds about self and the world, to be put into question (Fisher, 2000a). We are all protected, yet limited by our beliefs. Some belief systems are more pliable, with the suppleness to accommodate unexpected experiences. Notwithstanding, even when a certain amount of flexibility is characteristic of our beliefs, we all are limited by those events that have either forced us into denial and rationalization, or the belief system has stretched, perhaps shattered (Janoff-Bulman, 1992; 1989). Consequently, individual resilience, the ability to concentrate, and hopefulness about life may be challenged on a broader scale through the nature of probation work (Fisher, 2000).

Strategies aimed at diminishing STS effects and symptoms of depression need to take into account social support, but also collective interventions that are designed not only to deal with the immediate impacts of exposure, but the organizational contexts that may be suspect for increasing strain and depleting an individual officer's sense of control. Which factors, workloads, role conflicts, or aspects of the organizational culture contribute to increased risk for secondary traumatic effects and associated symptoms? This study has helped address at least part of this question in theoretically identifying four factors that may play roles in reducing, or exacerbating the impact of STS and depression in this particular group of probation officers.

Paralleling others who work in the fields of justice administration and law enforcement, emergency services and mental health, probation officers are exposed to stressors that increase the possibility of risk for STS effects and depressive symptoms – as referred to earlier in this study, incidents of secondary trauma (e.g. traumatic material that may be graphically violent and disturbing) and abuse are accepted as a routine part of probation work (Fisher, 2000a; Ministry

of the Attorney General Job Description, 2002). It bears repeating that anyone who is capable of feeling is vulnerable to these effects. As inferred from the analysis results herein, the probation officers who participated in this study showed concerning levels of distress for their exposure to traumatic material through the course of their duties. This has obvious implications for the individual officers and B.C. Community Corrections at the organizational level.

Actual exposure to trauma, directly or indirectly may actually be less stressful than job organization and administration (Burke, 1990). We already know the evidence is out on administrative and organizational stress, conflict with management, and promotional policies and procedures as important determinants of stress levels in related fields such as law enforcement (Hart et al., 1995; Cedric, 1999). Conventional clinical approaches to STS and depression have focused on individual interventions intended to provide symptomatic relief from stress and the related psychological and physiological symptoms. We know from the research that individual oriented prevention and interventions on its' own, as in symptom treatments are unlikely to have any lasting effect in the health or work of a probation officer. This is not to suggest that individual strategies are not called for, quite the contrary, however for long-term lasting benefits to both the individual and organization, both levels need to participate as partners in addressing the risks associated within the individual, the work itself and the sociocultural context (Fisher, 2000b; 2001b; 2002b; Dick, 2000).

What may be the consequences of organizations that accept prior theories of workplace stressors and negative effects as residing solely within the individual? If officers judge themselves to be individually responsible for controlling and coping with organizational stressors, they may become disillusioned when their solo strategies prove to be ineffective over time.

Consequently, an officer may begin to question his or her self-efficacy, and experience an increased sense of isolation, perhaps to the point of withdrawal. If individuals do not normally experience control of their routine work environment, this is likely to generalize their sense of isolation and inadequacy in managing secondary trauma and depressive symptoms. Essentially, they may be less prepared or capable of responding in ways that have the potential to minimize STS effects. (Fisher, 2000a; 2002a) Without question, the work setting has a profound effect on officer vulnerability to STS and symptoms of depression.

At this point in the discussion, it is appropriate to revisit the fact that sixty-three percent of the probation officers were revealed in this study as feeling they were inadequately trained to meet the demands of their job. Role ambiguity can occur in circumstances where people do not feel sufficiently prepared to perform their job tasks (Fisher, 2002a). As brought forward earlier in this study (compliments of the B.C. Ministry of Attorney General Job Description), the duties and responsibilities of an adult B.C. Probation Officer are multileveled, and arguably, sometimes also conflicting in nature. The demands of probation work require an individual with an array of honed skills, knowledge and capacities – some of which they will most certainly bring to the job, others will require specialized training and preparation. Ensuring their officers are sufficiently prepared to meet the demands of their duties is largely the responsibility of the organization. It would seem prudent of any organization that is privy to knowing their staff feel inadequately trained, to take notice.

There is much diversity of conceptual opinion concerning the nature of depression susceptibility. The greatest risk of onset appears to be derived from the blend of a hostile and unsupportive environment, and the sensitivity of the individual to the effects of a crisis or severe

life event (Moran et al., 2001). Certainly, as was with the case of the probation officer group who participated in this study, the STS workplace risk variable descriptive results indicated sufficient degree of concern to raise eyebrows around the distress levels from the hostility of the clientele, exposure to violent material, compounded by a perception that support was lacking in the environment of the workplace. In turn, this may have placed some officers at greater risk for depressive symptoms.

Depression vulnerability is aptly viewed as the interface between intrapersonal and interpersonal conditions - assessment of both is required to maximize prediction of onset, and to assist in identifying officers at greatest risk in ways that encompass not only interventions to aid officers who may be impaired, but also as preventive measures (Moran et al, 2001). Herein, the presence of two distinct underlying factors or predictors of depression were uncovered through the exploratory factor analysis of the depression measures in this study – Physiological Well - Being and Psychological Distress. As predictors, they point to the need for individual strategies, such as self-assessment, as well as those at the organizational level that would be designed to enhance overall officer and organizational health. Initially, this is to be viewed from a preventive stance, offering meaning to the individual officer (e.g. self-care) and for the organization (e.g. stress management programs). While it is not within the scope of this investigation to explore the efficacy of strategies for maintaining physical and psychological health, generally the recommendation is to have the strategies adopted be the responsibility that stretches from the individual officer to the highest management levels. Otherwise stated, the individual officer's responsibility for self-care from a holistic perspective is a vital contributing piece to these questions, however there has to also be a sincere commitment of partnership with all levels within the organization to implementing workplace wellness initiatives.

There appear to be several critical dimensions to any efforts aimed at addressing the concerns around STS effects and depression raised from this study: education; training and preparation; debriefing and group support; office-level support for probation casework and load; and organization-wide commitment to human resources (Ursano et al., 1996; Annscheutz, 1999). First, education about traumatic stress, its sources and signs is the recommendation for all front line officers and management staff. This effort would be collectively aimed at bringing staff together with opportunities to share the personal impact of their work, and acquire new language and understandings around how secondary trauma affects them as human beings (Fisher, 2000b; 2001b; 2002b).

It is important not to lose sight of the fact that probation officers are given the burden of responsibility for supervising adult offenders in the community, managing level of risk (as in protecting the community) and assessment, preserving the interests of victims and the public while steering their clients toward a non-criminal lifestyle (Province of B.C. Ministry of Attorney General Job Description, 2002). Indeed, the scope of their responsibilities requires an officer to be highly skilled and knowledgeable about many facets of the criminal justice system – encountering challenges, such as assuming the responsibility for a client who is a sex offender without adequate understanding and skills to deal with this specialized group, has the potential to compound existing STS effects and symptoms of depression. Role ambiguity of this kind is known to be a significant stressor in the workplace (Neunan & Hubbard, 1998).

The educational implementation of the workshop and wellness program has inevitably involved an ocean of change in the culture of B.C. Community Corrections. As organizations grow to understand more within this comparatively infant field of STS, it will be necessary to

embrace continued openness to changes in strategies and directions aimed at alleviating STS effects, depression and promoting a healthy workplace. Officers, managers and the highest order of administrative personnel need to understand clearly the mechanisms, symptoms, self-care needs, and treatment considerations with STS and its' associated symptoms (Fisher, 2000b). It seems that this is best managed by providing education and training regarding strategies for self-care, stress management, and effective responses to STS effects, both for individual personnel and at the organizational level. Fisher's (2000a; 2000b) *The Road Back to Wellness: Stress, Burnout and Trauma in Corrections* program and rollout was, and continues to be at the forefront of contributing a vehicle for developing comprehensive, integrated, strategic individual and organizational responses to workplace stress, burnout and trauma.

From an occupational health perspective, this study has intended to help identify the presence of underlying factors or predictors (Managing STS Effects, Workplace Isolation, Physiological Well – Being and Psychological Distress) from the workplace, as well as those from individual officers that either alleviates or exacerbates STS effects and symptoms of depression. It has already been determined that social support within the workplace, from both peers and management helps to buffer the effects of job-related stress – in this respect, Workplace Isolation has been argued to be a contributing predictor. The research has also offered validation in acknowledging that lack of social support in the workplace has been shown to be an important exponent to emotional health (Cooper & Davidson, 1989), and it arguably follows to be suspect in partly determining the capacity for managing the effects of STS and depression.

The accessibility of expert consultation and supervision are fundamentally important to managing the risks for STS effects. Both experienced and novice officers will inevitably have moments when they lack confidence in their judgment. Opportunities to consult can provide vital support and grounding. Consulting with both experts and peers diminishes the feelings of isolation and alienation associated with STS. Managers can also help facilitate this through the endorsement of informal collaborative talks with frontline officers, arranging regular supervision meetings, and establishing mentor programs - these can prove meaningful for both novice and seasoned officers (Fisher, 2000b; 2002b).

Secondary trauma "is a normal human consequence of exposure to traumatic material second-hand"(Fisher, 2002 p. 28). Unless managers and organizations deliberately aim at normalizing through publicly acknowledging the issues of STS, it is unlikely that much benefit will accrue from strategic programs or interventions. In this sense, managers serve as social and cultural agents for change. As role models, their attitudes and actions will shape those of their staff. Therefore, the leadership provided by management is irrefutably critical. (Fisher, 2002b)

Restated, and to summarize the more general implications to be taken from this study, the individual and collective variables that were investigated, showed descriptive statistical results that offered insight into the STS distress levels and consistency of depressive symptoms experienced for the probation officers who participated at the time of their involvement in the workshop delivery. Four key thematic constructs also emerged from the exploratory factor analysis to offer theoretical explanations for the statistical findings, and to help isolate underlying predictors for the STS workplace risks and symptoms of depression investigated through this study. While hypothetical by derivation, Managing STS, Workplace Isolation, Physiological

Well - Being and Psychological Distress are important for confirming what the literature and prior research has had to say to date, and potentially assist with the identification of associated risk and protective factors. Simply stated, how organizations manage STS, work to decrease workplace isolation, promote physiological and psychological health in their officers will have bearing on either diminishing or exacerbating the negative impacts of secondary traumatic stress and symptoms of depression.

Limitations of the Study

It is extremely difficult, if not impossible, to complete a study in this field that would be above reproach. Given that secondary traumatic stress remains largely theoretical and exploratory in nature at this infant stage of its' development, understanding of the phenomenon has been largely perpetuated through clinical practice, insight and judgments founded in experience. While research is on the rise in what appears to be a necessary, and expanding interest in the subject matter, (in particular since the tragedy of September 11th, 2001 and the attack on the World Trade Centre in New York), it is limited. Thus, conclusions drawn can only be ethically and validly asserted as hypothetical. Moreover, this comparative infancy of theory placed restrictions on the capacity of this particular study to be evaluated by comparison to others due to the lack of empirical research at the time it was conducted.

The breadth of this investigation is consequently and necessarily, limited. The data had already been collected, and results are bound specifically to this probation officer sample. While results may hold meaning for this particular group, caution must be exercised in generalizing the results beyond the study sample and drawing firm conclusions about the applicability to probation officers as a larger population or to related fields. Also, the context of how the data

was collected naturally raised questions around the degree to which the peer dynamic influenced the results – theoretically this could have had the impact of swaying the questionnaire results in either direction.

The effectiveness of standardized questionnaires must also be considered with a certain degree of skepticism. In particular, this group is suspected to exist within the social context of a subculture that is prone to stigmatization; consequently, the context of the measurement instrument may have masked repressed feelings or placed undue conformity pressure on the participating officers. The study is further limited by the likelihood that reactions and responses are prone to vary, thus it would be important to ascertain the causes of stability and change over time. Arguably, the results for any one of the particular workshop settings through the province-wide delivery of the program might have conceivably been different on a different day. There are countless life events and conditions within the everyday context of human lives that could have impacted the in-the-moment responses to the questionnaire items.

It is reasonable to expect that some of the STS workplace risk and depression variables were more sensitive to possible errors - in particular, those variables that may have been received by the participants as indicative of weakness. There is no guarantee that human beings will respond honestly under peer pressure, assuming it may have operated in this dynamic. Perhaps non - response was another factor that skewed the results. Also, given that the effects of STS are believed to place individuals at higher risk for impairing one's judgment (Figley, 1995), officer responses may have been distorted by this possibility. Thus, it is important to consider that reporting biases of these kinds are unavoidable in any study that utilizes human subjects with the method that was undertaken here.

Although it was a relatively small percentage, there were some non-respondents in this study. Therefore, it is difficult to determine exactly how the absence of their responses for some of the items might have played into outcomes. It was previously stated in the results that despite omissions for some of items under investigation by some of the officers, those participants were still included in other sections of this analysis. Exactly how any discrepancies or why the officers in question neglected to respond to the respective items remains unanswered through this study.

Finally, *The Road Back to Wellness: Stress, Burnout and Trauma in Corrections* (Fisher, 2000) program and rollout was, and continues to be making ground-breaking contributions to the development and implementation of a comprehensive vehicle for increasing awareness, and offering strategies for individual and organizational responses to workplace stress and trauma. Longitudinal studies will be needed to verify the long-term impact for benefits or necessary revisions as circumstances change, in this particular case for the B.C. Community Corrections Branch.

Recommendations for Further Research

The overall recommendations for further research are: continued exploration of the results from this study as well as with the larger existing data set from the 2001 two-day workshop delivery; and with the one-day wellness follow-up workshop that is understood to have been delivered within the B.C. Community Corrections Branch eighteen months following the initial rollout; and to ultimately suggest that further research is needed concerning issues related to STS in high risk workplaces, and the promotion of healthy organizations.

While it was not the intention, or within the limits of this study to explore the demographic distinctions in the results, save the descriptive percentages reported, this would be a

logical direction to pursue given that we know certain individual risk factors contribute to STS effects and symptoms of depression. This direction could be taken with either the results from this isolated study, or within the scope of the larger data set from the workshop delivery. There is clearly a vast amount of potential areas to explore within these contexts, as taken from this study itself, the workshop and for new directions within the larger research community. For example, it would be a worthwhile undertaking to explore how demographic differences such as gender, age, years of service, personal trauma history and others might account for, or explain any fluctuations in the STS and depression variable responses in this study, and potentially assist in the continued development of interventions and strategies for coping with the effects of STS.

Future exploration and analyses of the results taken from this study ought to also examine the relationships between responses to the STS workplace risk variables and symptoms of depression in ways to compare other work-related demographic differences, such as those officers with higher risk clients versus lower risk. Another direction for extended analysis of these results would be to investigate how probation officers who carry sex offenders in their caseloads differ or compare in reported distress levels or consistency of depression symptoms to the other probation officers in this study.

It might prove revealing to try utilizing more advanced statistical procedures to further investigate the hypothetical factors extracted from this study. For example, future examinations could test whether there is evidence of any significant relationships between Managing STS and Workplace Isolation with Physiological Well - Being and Psychological Distress. Although it may be somewhat presumptuous, the intuitive sense of the researcher in this study ponders the existence of a linear relationship between these predictors.

Future studies should also target how probation officers cope with job-related stressors. An investigation of this kind could help shed light on individual resiliency factors (Kobasa, 1979) against the effects of exposure to secondary trauma and symptoms of depression. It is a given that officers cannot avoid the hazards built into the nature of the job, but what makes one officer more resilient than another to the effects of STS or symptoms of depression? Extending this idea, studies aimed at exploring the efficacy of any existing stress reduction strategies and techniques could follow.

This study has exposed a subculture that is highly suspect of existing within the paramilitary style organizations such as law enforcement agencies and corrections organizations. Supported by the research, it has been argued that officers have traditionally been denied the psychological and emotional impact of their work. Those affected have been stigmatized. (Violanti, 1996; Evans & Coman, 1993) To accurately examine those attitudes and behaviours that measure social change, longitudinal research would be required to allow for a diachronic analysis of the incidence of conditions and events that underlie this phenomenon in workplaces that are suspect.

Longitudinal research would also be recommended in terms of investigating the long-term impact of the wellness initiatives that appear to continue to be a part of the B.C. Community Corrections mandate. In the interests of the organization, probation officers and other corrections personnel, it would be crucial to know whether the core programming, infrastructure development and ultimate aim for a self-sustaining, self-directed system (Fisher, 2003) are working to the ends intended by the implementation. This is where the collection and analysis of data over time would be necessary to measure the impact. For example, this could take the form

of data collected in time sequences that clarifies the direction as well as the magnitude of change among variables.

The evidence has been clear that work in corrections and related fields is highly stressful. While research interest in the field of STS has markedly increased, in particular since the September 11th, 2001 tragedy, the empirical evidence is yet lacking. The research community needs to continue to direct studies toward the optimistic premise that there is something that can be done to diminish the risks of STS, to increase resilience to the inevitable exposure to secondary trauma, and assist with healing as necessary. Research must therefore, continue to target the awareness, assessment, and understanding of the impact of STS and depression in the corrections field, and beyond.

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APPENDICES

Informed Consent to Participate in Research & Program Evaluation

As participants in the workplace wellness program – The Road back to Wellness: Stress, Burnout & Trauma in Corrections – you are also being asked to participate in a program evaluation and research study.

APPLICATION OF THE RESEARCH & EVALUATION DATA

The program evaluation is intended to determine both program acceptance as well as program effectiveness in promoting and fostering employee wellness. The research is concerned with identifying the mechanisms and themes associated with employee stress. This will result in a report for the Provincial Director, Community Corrections, and the Ministry's Personnel Services Division. The report will assist in identifying sources of stress and will allow Community Corrections managers to focus on specific stress reduction strategies. The research results will also be used in the preparation of academic research reports.

VOLUNTARY PARTICIPATION

Participation in this research and evaluation is strictly voluntary, and there will be no penalties or negatives consequences should you choose to not participate.

CONFIDENTIALITY

The data being collected will in no way be identifiable as belonging to any given individual. You will note that the forms you will be asked to complete do not ask for your name or any other information that could be used to uniquely identify you. The forms all have a number identifying your unique data set, and these numbers are assigned at random.

DATA COLLECTION

There are 6 sets of information included in your envelope:

1. This Informed Consent document
2. Pre-Assessment Questionnaire
3. Background Information
4. Job Stress & Burnout Risk Assessments
5. Self Care Assessments
6. Workplace Stress Effects

The last 3 sets of self-assessment forms (the risk assessments, self-care assessments and effects checklists) are provided with carbonless second copies. These are duplicates of the self-assessment forms in the program workbook. After you have completed all the forms, you will be asked to remove the first sheet of the self-assessment forms, to keep for your own use, and place the second sheets in the envelope along with the Pre-Assessment Questionnaire and the Background Information form. Please then seal the envelope, and the program facilitator will collect it. The program facilitator will collect this signed document separately, as it identifies you. The envelopes containing the anonymous information will be sent immediately to Dr. Patricia Fisher, the Registered Psychologist responsible for the research program and program evaluation.

DATA CODING, STORAGE & USES

The data will be coded and stored under Dr. Fisher's direction, at the Justice Institute of B.C., a Registered Post-Secondary Institution authorized and entitled to participate in research. The data will be safeguarded, such that only Dr. Fisher or other qualified researchers, approved by her, shall have access to it. Analyses of the data, research reports, and all other uses of the data must conform to the Ethical Standards and Principles for Research in Psychology as defined by the Canadian Psychological Association and the American Psychological Association.

Having read and understood the foregoing description of this research and evaluation program, I agree to participate.

Name: _____ **Signature:** _____

Date: _____ **Location:** _____ **Witness:** _____

RISK FOR JOB STRESS & BURNOUT

INSTRUCTIONS: Please rate each of the items, on the 1-5 scale, in terms of how stressful you find them in your workplace. After completing the measure, please enter the scores for each of the 13 subsections in the appropriate box.

QUESTIONAIRE: JOB STRESS & BURNOUT RISK	Levels of Distress: Low		Moderate			High
WORKPLACE RISK FACTORS	**0**	**1**	**2**	**3**	**4**	**5**
1. WORKLOAD						
Feel overwhelmed by too many demands on the time available						
Not enough work, too much inactivity or down time						
Too much paperwork, difficulty meeting deadlines						
Workload Total Score						
2. LEVELS OF CONTROL						
High levels of responsibility, and little control						
Difficulty directing daily schedule and sequence of tasks						
Lack of participation in policy-making and operational decisions						
Levels of Control Total Score						
3. ROLE AMBIGUITY						
Unclear definitions of job description and expectations						
Inconsistent job expectations and assignment of new & unfamiliar duties						
Conflict with supervisor						
Role Ambiguity Total Score						
4. ROLE CONFLICT						
Conflicting job expectations from different sources (e.g., administrators, supervisors, coworkers, those being supervised, etc.)						
Job description inconsistent with perceived needs of the community						
Being asked to do things you feel are inappropriate or wrong						
Role Conflict Total Score						
5. VIOLATIONS OF FAIRNESS & VALUES CONFLICT						
Tasks not fairly distributed – have to cover for those not doing their share						
Resources and supplies not fairly distributed						
Personal values in conflict with organizational values						
Fairness & Values Conflict Total Score						
6. JOB DEMANDS AND RESOURCES CONFLICTS						
Equipment not adequate or of poor quality						
Not enough staff to cover the workload						
Coworkers poorly motivated and not doing their job						
Demands & Resources Total Score						

JOB STRESS & BURNOUT RISK (Cont.)	Levels of Distress: Low		Moderate			High
WORKPLACE RISK FACTORS (cont.)	0	1	2	3	4	5
7. SOCIAL SUPPORT						
Inadequate support by supervisors						
Lack of support from colleagues & coworkers						
Lack of recognition for good work						
Social Support Total Score						
8. RESPITE & TIME OFF						
Inadequate personal time (i.e., coffee breaks, lunch)						
Working overtime						
Inadequate holiday time, poor shift scheduless						
Respite & Time Off Total Score						
9. CONDITIONS OF WORK						
Shift work						
Inadequate resources to meet personal needs (e.g., storage, washrooms, etc.)						
Exposure to disease						
Conditions of Work Total Score						
10. COMPENSATION AND CAREER ADVANCEMENT						
Salary and benefits levels						
Competition for advancement						
Opportunities for advancement or desired job changes						
Compensation & Career Advancement Total Score						
INDIVIDUAL RISK FACTORS						
11. PHYSICAL HEALTH STATUS						
Poor level of physical fitness						
Chronic medical condition (e.g., asthma, arthritis, heart disease, etc.)						
Frequent infectious illnesses or stress effects such as headaches, stomach problems, etc.						
Physical Health Total Score						
12. BELIEF THAT THE WORK IS VALUABLE						
Do not see the work as worthwhile yourself						
Do not feel that your work is valued in the workplace (i.e., supervisor, coworkers, community members, the courts, etc.)						
Do not feel that family or friends respect or value the work						
Work Value Total Score						
13. WORK FAMILY CONFLICT						
Work is getting in the way of your family and personal life						
Demands from family conflict with work demands and expectations						
Feel like you have no down time given the multiple demands of work, family, home, etc.						
Work-Family Conflict Total Score						

SUMMARY : RISK FOR JOB STRESS & BURNOUT

Instructions: Please enter your sub score totals from the questionnaire in the appropriate columns.

	Mild						Moderate									Serious
	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
WORKPLACE RISK FACTORS																
1. Workload																
2. Levels of control																
3. Role ambiguity																
4. Role conflict																
5. Violations of fairness & values																
6. Demands & resources conflict																
7. Social support																
8. Respite time off																
9. Conditions of work																
10. Compensation & advancement																
INDIVIDUAL RISK FACTORS																
11. Physical health status																
12. Belief that the work is valuable																
13. Work family conflict																

RISK FOR DISCRIMINATION & SEXUAL HARASSMENT

INSTRUCTIONS: Please rate each of the items, on the 1-5 scale, in terms of how frequently they occur in your workplace. After completing the measure, please enter the scores for each of the 5 subsections in the appropriate box.

DISCRIMINATION & HARASSMENT RISK	Occurence Never					Frequently
DISCRIMINATION RISK FACTORS	0	1	2	3	4	5
1. INSTITUTIONAL ATTITUDES						
Discrimination against women or minority groups						
Racist, homophobic, or sexist comments or behaviors are tolerated						
Managers are seen to hold racist, sexist, homophobic, or other discriminatory attitudes						
			Institutional Attitudes Total Score			
2. DOMINANT GROUP						
There is one clearly dominant ethnic group in the workplace						
There is a greater proportion of males/females in the workplace						
Work task assignments follow traditional gender/race/class stereotyping						
			Dominant Group Total Score			
SEXUAL HARASSMENT RISK FACTORS						
3. UNWANTED SEXUAL ATTENTION						
Unwanted sexual comments directed at you personally (e.g., on appearance, etc.)						
Unwanted sexualized behaviors directed at you (e.g., touching, invasion of personal space, etc.)						
Other unwanted sexualized attentions (e.g., questions about sexual preferences, behaviors, etc.)						
			Unwanted Sexual Attention Total Score			
4. SEXUAL COERCION						
Unwanted sexual advances made by supervisor or senior employee						
Unwanted sexual advances made with *implicit* understanding that rejection of them will result in job loss or loss of privileges						
Unwanted sexual advances made with *explicit* understanding that rejection of them will result in job loss or loss of privileges						
			Sexual Coercion Total Score			
5. GENDER HARASSMENT						
Negative remarks about women's competence in performing their jobs						
Discussions or remarks about women that are degrading or lewd						
Presence of pornographic or sexual images or materials in the workplace						
			Gender Harassment Total Score			

Instructions: Please enter your sub score totals from the questionnaire in the appropriate columns.

	Mild						Moderate							Serious		
DISCRIMINATION RISK FACTORS	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
1. Institutional attitudes																
2. Dominant group																
SEXUAL HARASSMENT RISK FACTORS																
3. Unwanted sexual attention																
4. Sexual coercion																
5. Gender harassment																

Note: Sexual harassment is more likely to occur in environments that tolerate discrimination. Thus, higher scores on the discrimination risk factors (1 and 2) will increase the risks for sexual harassment. Although heterosexual women who are being harassed by heterosexual men most often experience sexual harassment, sexual harassment can also be experienced by gay and lesbian people, and by heterosexual men.

RISK FOR PRIMARY TRAUMATIC STRESS

INSTRUCTIONS: Please rate each of the items, on the 1-5 scale, in terms of how personally stressful you find them in your workplace. After completing the measure, please enter the scores for each of the 7 subsections in the appropriate box.

PRIMARY TRAUMATIC STRESS RISK	Levels of Distress: Low		Moderate			High
WORKPLACE RISK FACTORS	**0**	**1**	**2**	**3**	**4**	**5**
1. TRAUMATIC EXPERIENCE FACTORS						
Levels of risk for dangerous incidents and potential injury						
Frequent experience of potentially dangerous or threatening incidents						
Risk that workplace incident could lead to serious injury or death						
Traumatic Experience Total Score						
2. TRAINING & PREPARATION						
Do not feel able to predict dangerousness of situations or individuals						
Do not feel prepared to cope with potential dangerous incidents						
Do not feel adequately trained about critical or dangerous incidents						
Training & Preparation Total Score						
3. RESOURCES						
Workplace does not recognize stress effects of traumatic experiences						
Not able to discuss distress with colleagues and coworkers						
Not able to discuss distress with supervisors or management						
Resources Total Score						
INDIVIDUAL RISK FACTORS						
4. TRAUMA RESPONSES						
Feel frozen at the time of a critical incident						
Feel overwhelmed and ineffective at the time of a critical incident						
Feel out of control at the time of a critical incident						
Trauma Responses Total Score						
5. SUPPORT						
Do not have emotionally supportive relationship with spouse/partner						
Do not have emotionally supportive relationship with family members						
Do not have emotionally supportive relationship with friends						
Support Total Score						
6. TRAUMA HISTORY						
History of childhood physical or sexual abuse						
History of sexual or physical assault as an adult						
History of traumatic experience as adult (e.g., accident, natural disaster, workplace assault, etc.)						
Trauma History Total Score						

PRIMARY TRAUMATIC STRESS RISK (Cont.)	Levels of Distress: Low		Moderate			High
INDIVIDUAL RISK FACTORS (Cont.)	0	1	2	3	4	5
7. FAMILY HISTORY						
Family history of negative parenting and/or psychiatric illness						
Early history of separation from parents or multiple care givers						
Early history of neglect, substance abuse, or family violence						
				Family History Total Score		

SUMMARY : RISK FOR PRIMARY TRAUMATIC STRESS

Instructions: Please enter your sub score totals from the questionnaire in the appropriate columns.

	Mild						Moderate							Serious		
	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
WORKPLACE RISK FACTORS																
1. Traumatic experience factors																
2. Training and preparation																
3. Resources																
INDIVIUAL RISK FACTORS																
4. Trauma responses																
5. Support																
6. Trauma history																
7. Family history																

RISK FOR SECONDARY (VICARIOUS) TRAUMATIC STRESS

INSTRUCTIONS: Please rate each of the items, on the 1-5 scale, in terms of how stressful you find them personally and in your workplace. After completing the measure, please enter the scores for each of the 11 subsections in the appropriate box.

SECONDARY TRAUMATIC STRESS RISK	Levels of Distress					
	Low		Moderate			High
WORKPLACE RISK FACTORS	**0**	**1**	**2**	**3**	**4**	**5**
1. WORKLOAD						
The workload is heavy and demanding						
The pace of work provides little relief from pressure						
There is too much paperwork, difficulty making deadlines						
Workload Total Score						
2. NATURE OF THE WORK						
High levels of responsibilities						
Making critical, immediate, decisions						
Making decisions that are critical to the safety of others						
Nature of the Work Total Score						
3. NATURE OF THE POPULATION						
Contact with hostile, demanding and verbally abusive community members						
Amount of time spent in court						
Specializaton requires excessive contact with emotionally demanding individuals or groups (e.g., vice, drugs, sex crimes, undercover, etc.)						
Nature of the Population Total Score						
4. EXPOSURE TO TRAUMATIC MATERIAL						
First responder at serious accidents and violent crime scenes						
Investigations of child physical and sexual abuse; adult sexual assault; domestic violence						
Investigations of violent assault and death						
Exposure to Traumatic Material Total Score						
5. SUPERVISION & RESOURCES						
Lack of available safe, trustworthy, and accessible supervision						
Lack of available skilled, expert consultation resources						
Lack of material resources						
Supervision and Resources Total Score						
6. SUPPORT ENVIRONMENT						
Workplace does not recognize stress effects of secondary trauma						
Not able to discuss distress with colleagues and coworkers						
Not able to discuss distress with supervisors or management						
Support Environment Total Score						

SECONDARY TRAUMATIC STRESS RISK (Cont.)	Levels of Distress: Low		Moderate			High
WORKPLACE RISK FACTORS (Cont.)	0	1	2	3	4	5
7. TRAINING & PROFESSIONAL HISTORY						
Do not feel adequately trained for the work						
Do not feel adequately trained regarding the stress effects of the work						
Do not receive appropriate ongoing training and in-service						
Training & Professional History Total Score						
8. SOCIAL & CULTURAL CONTEXT						
Your work is devalued in the workplace						
Your work is devalued by your family and/or friends						
Your work is devalued by society						
Social and Cultural Context Total Score						
INDIVIDUAL RISK FACTORS						
9. TRAUMA HISTORY						
History of childhood physical or sexual abuse						
History of sexual or physical assault as an adult						
History of traumatic experience as adult (e.g., accident, natural disaster, workplace assault, etc.)						
Trauma History Total Score						
10. PERSONAL SUPPORT						
Do not have emotionally supportive relationship with spouse/partner						
Do not have emotionally supportive relationship with family members						
Do not have emotionally supportive relationship with friends						
Personal Support Total Score						
11. CURRENT LIFE CONTEXT						
Personal life unstable or stressed relationships						
Health problems (self or family members)						
Financial pressures						
Current Life Context Total Score						

SUMMARY : RISK FOR SECONDARY (VICARIOUS) TRAUMATIC STRESS

Instructions: Please enter your sub score totals from the questionnaire in the appropriate columns.

	Mild						Moderate							Serious		
	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
WORKPLACE RISK FACTORS																
1. Workload																
2. Nature of the work																
3. Nature of the population																
4. Exposure to traumatic material																
5. Supervision & resources																
6. Support environment																
7. Training & professional history																
8. Social & cultural context																
INDIVIDUAL RISK FACTORS																
9. Trauma history																
10. Personal support																
11. Current life context																

THINGS TO LOOK FOR

After completing this section, it is often helpful to review the summary graphs and look for the areas of comparative strengths and vulnerabilities.

- What are the relative proportions of risk factors in the mild, moderate and serious levels?
- Is there a pattern to the mild, moderate and serious *workplace* risk factors across the different stress types?
- Is there a pattern to the mild, moderate and serious *individual* risk factors across the different stress types?
- What are the particular vulnerabilities you have noticed?
- What are the strengths you have noticed?

SELF-CARE IN THE WORKPLACE

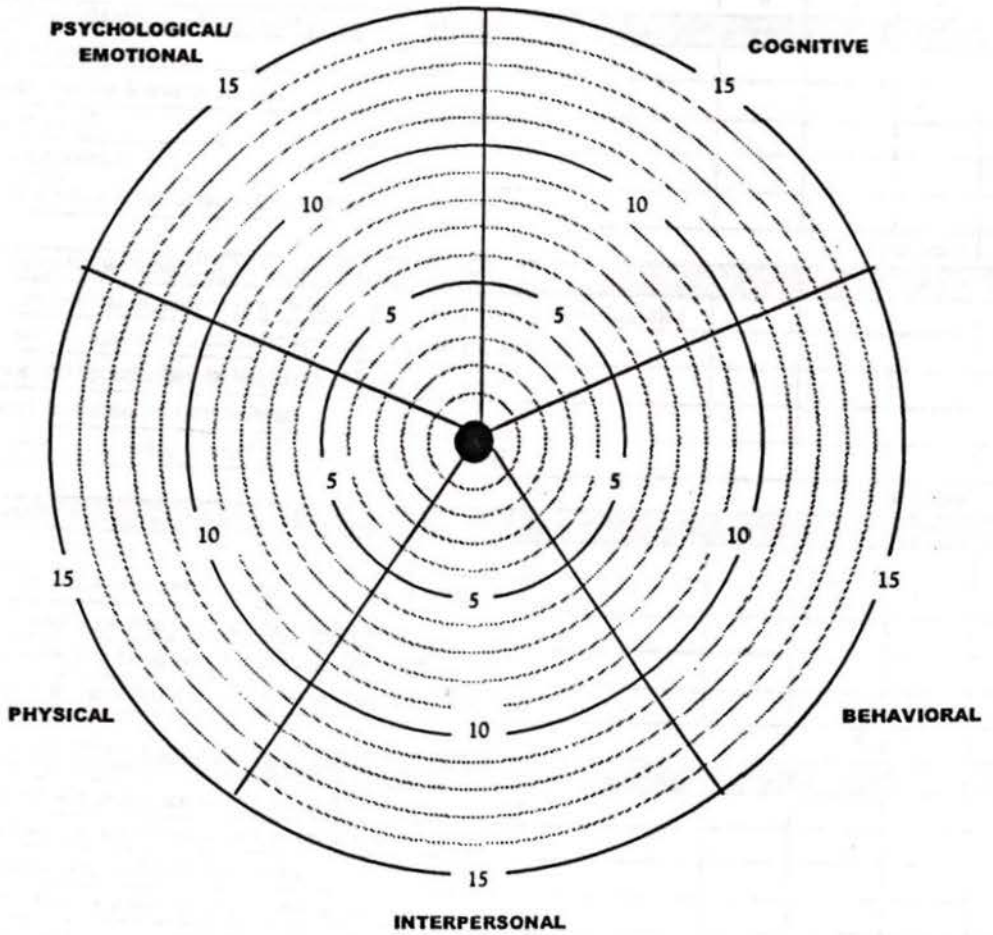
INSTRUCTIONS: Please rate each of the items (on the 0-3 scale) in terms of how often you use them in your workplace. Try to be honest with yourself and look at what you **actually** do, rather than what you think you **should** do. Then, enter the scores for each of the 5 subsections in the appropriate box.

WORKPLACE SELF-CARE	How Often: Never	Rarely	Fairly Often	Usually
	0	1	2	3
1. PHYSICAL SELF-CARE				
Take regular lunch and coffee breaks				
Eat a healthy lunch and snacks				
Drink 4-8 cups of water during the workday				
Limit caffeinated beverages to 3 cups/day				
Make opportunities to stretch and be active during the workday				
			Total Score	
2. PSYCHOLOGICAL/EMOTIONAL				
Check in with your emotional state through the day and identify distressing feelings (e.g., anxiety, fear, sadness, etc). Recognize what is causing the distressing feelings.				
Stop to recognize & appreciate when you have done something you could feel good about				
Recall the positive reasons why you are doing this work				
Identify projects or tasks that you find interesting and rewarding				
Recognize the emotional states of those you are interacting with				
			Total Score	
3. COGNITIVE				
Give yourself a mental map about what you are going to do that day – set goals, tick them off				
Allow yourself to feel interested in what you are doing				
Engage in activities which increase your professional knowledge base & sense of competency				
Share your knowledge with others				
Initiate new projects or procedures, consider ways you could improve the job				
			Total Score	
4. BEHAVIORAL				
Create quiet time to complete tasks				
Set limits with witnesses, suspects, and victims				
Set limits with co-workers, supervisors and court personnel				
Balance your daily tasks so that you are not overwhelmed				
Keep your workspace comfortable				
			Total Score	

WORKPLACE SELF-CARE (Cont.)	How Often: Never	Rarely	Fairly Often	Usually
	0	1	2	3
5. INTERPERSONAL				
Take daily time to chat and be social with co-workers				
Make use of a peer support group to debrief				
Keep communications open with supervisor				
Get specialized consultation when you need it				
Participate in workplace social occasions (e.g., gatherings, luncheons, sports, etc.)				
			Total Score	

WORKPLACE SELF-CARE GRAPH

INSTRUCTIONS: As in the example, please enter the sub-scores from your questionnaire in the appropriate segments of the wheel graph and then fill them in..



SELF-CARE IN YOUR PERSONAL LIFE

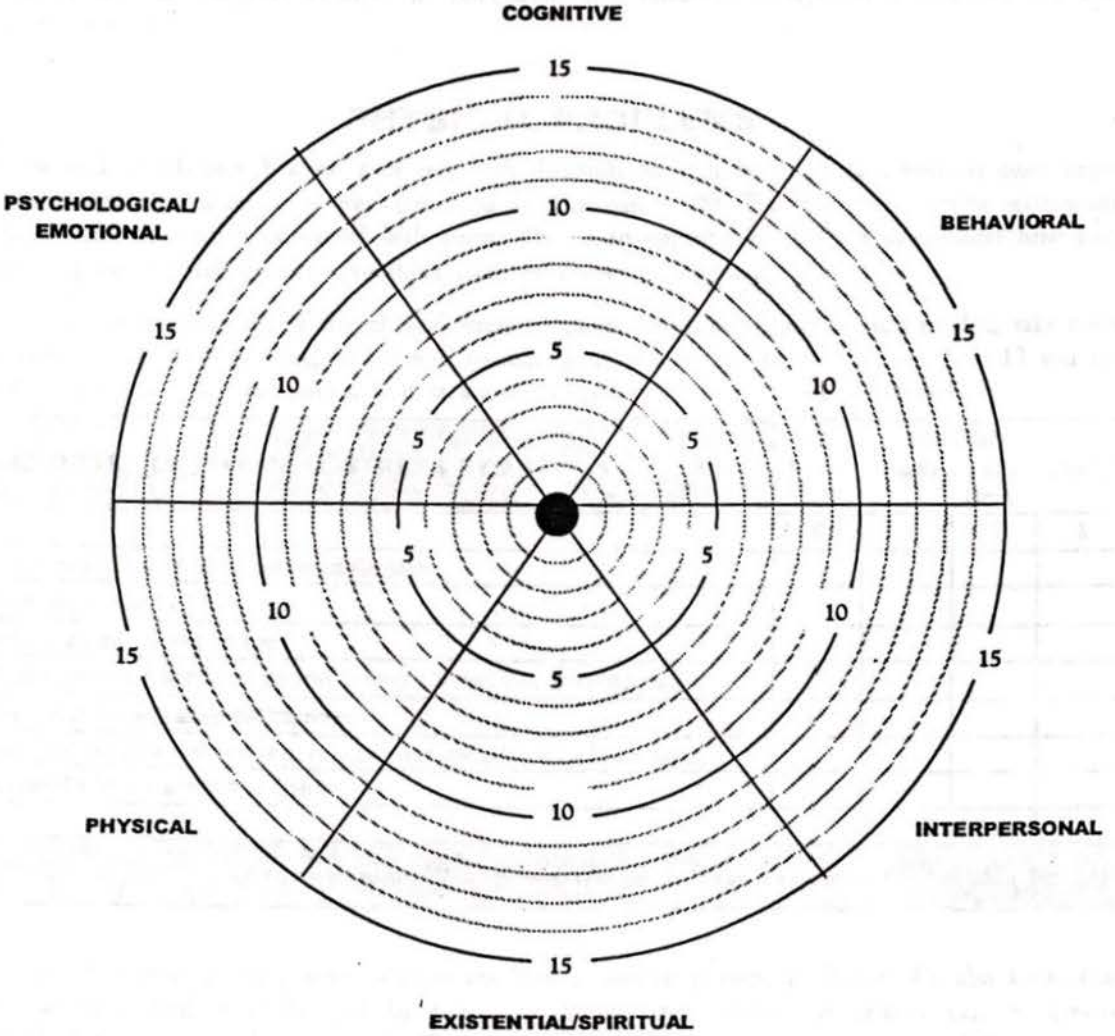
INSTRUCTIONS: Please rate each of the items (on the 0-3 scale) in terms of how often you use them in your workplace. Try to be honest with yourself and look at what you **actually** do, rather than what you think you **should** do. Then, enter the scores for each of the 6 subsections in the appropriate box.

PERSONAL LIFE SELF-CARE	How Often: Never	Rarely	Fairly Often	Usually
	0	1	2	3
1. PHYSICAL SELF-CARE				
Eat regularly and healthily				
Get regular exercise & maintain fitness				
Get enough sleep				
Take time for yourself				
Get regular medical & dental preventative care				
			Total Score	
2. PSYCHOLOGICAL/EMOTIONAL				
Listen to your internal experience (e.g., feelings, thoughts, beliefs, judgements, etc.)				
Allow yourself to experience distressing emotions (e.g., let yourself cry)				
Make space and opportunities for laughter and fun				
Actively work to reduce your stress levels				
Make opportunities to safely connect with others and be yourself				
			Total Score	
3. COGNITIVE				
Take time for self-reflection				
Recognize and value your strengths, capabilities and accomplishments				
Discuss and exchange thoughts and ideas with others				
Encourage yourself to be actively curious and interested				
Read books or material that does not have anything to do with work				
			Total Score	
4. BEHAVIORAL				
Ask for support and assistance when you need it				
Do things where you are not an expert or not in charge				
Say no to added responsibilities & stresses				
Engage in hobbies, or interests, that are not work-related				
Give yourself day-trips, mini-vacations or breaks from the routine				
			Total Score	

PERSONAL LIFE SELF-CARE (Cont.)	How Often: Never	Rarely	Fairly Often	Usually
	0	1	2	3
5. INTERPERSONAL				
Make time for your intimate relationship				
Spend quality time with children & family members				
Spend time with friends who are important to you				
Take risks in letting people know different aspects of you				
Set limits to taking on responsibilities and burdens that are not yours				
			Total Score	
6. EXISTENTIAL/SPIRITUAL				
Be aware of what is meaningful to you and notice its place in your life				
Pray, meditate, or engage in other practices which give you grounding and a sense of peace				
Hold awareness of the nonmaterial aspects of your life				
Find a spiritual connection or community that shares your beliefs & values				
Take part, in some way, in causes you believe in				
			Total Score	

PERSONAL LIFE SELF-CARE GRAPH

INSTRUCTIONS: As in the example, please enter the sub-scores from your questionnaire in the apptopriate segments of the wheel graph and then fill them in..



THINGS TO LOOK FOR

Take some time to look at your wheel graphs and see if you can see patterns or themes:

- Does your work wheel look similar to, or different from, your personal wheel?
- How balanced or unbalanced do the wheels look?
- In which areas of your life do you take best care?
- In which areas are you most neglectful of yourself?
- Has it always been like this for you, or has this changed over the past few years?
- How aware were you of the areas of strength and those of vulnerability?

Core Stress Effects

This is the set of secondary clinical disorders that often results from exposure to severe and/or chronic stress or trauma. Negative changes in self-esteem and increased interpersonal problems are also common effects.

PHYSICAL PROBLEMS

As reviewed in Chapter 3, stress puts very high demands on your body. In fact, virtually every organ system is negatively affected by stress (Hubbard & Worknan, 1998). The following checklist reviews the physical symptoms often associated with stress. This is an opportunity for you to consider how your body may be responding to the multiple types of stress you experience.

If you are experiencing any of the physical stress symptoms often, or frequently, you need to take them seriously - your body is trying to tell you something. If your total score is between 7 to 12 you are experiencing significant symptoms. If it is above 12, you really need to pay attention!

CHECKLIST OF PHYSICAL STRESS SYMPTOMS	How Often: Never	Rarely	Fairly Often	Usually
	0	1	2	3
I get colds and flus and other infectious illnesses				
I have headaches				
I experience muscle and joint pain				
I have experienced significant changes in weight (weight loss or weight gain)				
I have problems with sleep disturbance				
I have gastrointestinal problems (e.g., nausea, upset stomach, irritable bowel, colitis, etc.)				
I experience fatigue and lack of energy				
			Total Score	
KEY: 4-6 = mild symptoms; 7-12 = moderate symptoms; 13-21 = serious symptoms				

We know that prolonged exposure to stress can lead to serious physical problems. We also know that when an individual is challenged by illness or injury, their ability to recover can be greatly diminished by background stress levels. The next checklist covers common stress related illnesses and disease states. If you answer yes to any of these, it is very important that you attend to the role of stress in your life

CHECKLIST OF STRESS-RELATED ILLNESS & DISEASE	No	Yes
	0	1
Peptic ulcers		
Diagnosed with arthritis		
Diagnosed with auto-immune illness		
History of cancer		
Sought medical attention for cardiovascular symptoms (e.g., shortness of breath, chest pains, irregular heartbeat, faintness, etc.)		
Diagnosed with cardiovascular illness (e.g., high blood pressure, high cholesterol levels, hardening of the arteries, etc.)		
Taking medications for a cardiovascular condition		
History of heart attack or stroke		
KEY: Any yes is significant. Use your judgement to decide whether this rates as moderate or serious.		

DEPRESSION

This checklist asks you to think about the last 2 weeks as you answer the questions. If your total score is 10 or above, you may qualify for a diagnosis of clinical depression and you would be wise to seeyour physician or a mental health practitioner. If you answer yes to any of the last three questions, you should also take this very seriously and see your physician or a mental health practitioner.

CHECKLIST FOR DEPRESSION	How Often: Never or Rarely	Fairly Often	Consistently
	0	1	2
I feel depressed most of the day or others see me as depressed			
I don't seem to feel much pleasure in anything through the day			
My appetite has changed (e.g., losing interest in food, or eating more than normal)			
I am having problems with sleep (e.g., either difficulty falling asleep, staying asleep, or early waking or oversleeping)			
I feel a lack of energy and a general sense of fatigue			
I feel either slowed down or restless and agitated			
I feel a sense of worthlessness or inadequacy			
I have feelings of guilt			
I have feelings of hopelessness			
I am having difficulty concentrating and holding attention			
I feel indecisive and have difficulty making decisions			
I am having thoughts that life is not worth living			
I am having thoughts of death or suicide without a plan			
I am having suicidal thoughts and a plan is forming			
		Total Score	
KEY: 1-4 = mild symptoms; 5-9 = moderate symptoms; 10-28 = serious symptoms (If yes to any of the last three questions then serious)			

ANXIETY DISORDERS

As you will see in chapter 8, there are various diagnostic types of anxiety disorders. However, the two most common types of anxiety disorder associated with workplace stress are "generalized anxiety" and "panic disorder", and the following two checklists review the symptoms associated with them.

CHECKLIST FOR GENERALIZED ANXIETY	How Often		
	Never or Rarely	Fairly Often	Consistently
	0	1	2
I feel restless, keyed up or on edge			
I become easily fatigued			
I have difficulty concentrating or find my mind going blank			
I feel irritable			
I experience muscle tension			
My sleep is disturbed			
		Total Score	
KEY: 1-3 = mild symptoms; 4-6 = moderate symptoms; 7-12 = serious symptoms			

If you score over 3 on the Generalized Anxiety checklist you are showing significant levels of symptoms. If you score below this, but find the symptoms troubling or find that they are impairing your quality of life, you also need to address them

This second checklist lists the criteria for panic attack and is concerned with whether or not these symptoms develop abruptly and reach a peak within 10 minutes.

CHECKLIST FOR PANIC ATTACK	No	Yes
	0	1
I experience heart palpitations, pounding heart or rapid heartbeat		
I start sweating		
I start trembling or shaking		
I experience shortness of breath or a feeling of smothering		
I have a choking feeling		
I have chest pain or discomfort		
I feel nauseous or have abdominal distress		
I feel dizzy, unsteady, lightheaded or faint		
I feel a sense of unreality or of being detached from myself		
I experience a fear of losing control or of going crazy		
I feel like I'm going to die		
I experience numbness or tingling sensations		
I have chills or hot flushes		
	Total Score	
KEY: 1-3 = mild symptoms; 4-5 = moderate symptoms; 6-13 = serious symptoms		

SUBSTANCE ABUSE

It is quite common for people who are experiencing high levels of stress to attempt to relieve their distress by means of substance use. Most commonly this begins as a type of "self-medication". Unfortunately, however, substance use can escalate to either dependency or addiction with all the attendant health and social problems. As you will note in the following checklist, there are a wide range of substances which can become problematic.

CHECKLIST FOR SUBSTANCE ABUSE PROBLEMS	How Often		
	Never	Occasionally	Often
	0	1	2
I smoke tobacco			
I smoke marijuana and/or hashish			
I have more than 2 drinks of alcohol per day			
I use non-prescription pain relief medication			
I use prescription drugs for pain			
I use prescription drugs for anxiety			
I use stimulants (prescription, non-prescription and non-legal)			
I use opiates (prescription, non-prescription and non-legal)			
My substance use causes financial strain			
My substance use interferes with my functioning			
My substance use interferes with my work and/or relationships			
		Total Score	

KEY: 1-3 = mild symptoms; 4-6 = moderate symptoms; 7-22 = serious symptoms
(If any question is scored with 2, then the problem is serious)

SELF ESTEEM

Self-esteem basically deals with the underlying beliefs we hold about ourselves. When our self-esteem is good, we believe ourselves to be worthy and entitled to respect and love. When our self-esteem is challenged oreroded, we no longer have a positive view of ourselves. It is very difficult to function on a day-to-day basis when you have little faith or trust in yourself, or when you do not believe that you are worthy.

CHECKLIST FOR SELF-ESTEEM PROBLEMS	How Often: Rarely	Fairly Often	Consistently
	0	1	2
I feel inadequate			
I feel insecure			
I feel uncertain about my decisions and judgements			
I feel that people will reject me or think less of me if they really know me			
I have a sense of the "imposter syndrome" (people see me as competent, but I don't feel it is really true)			
I don't feel deserving of love and respect			
I don't feel like a "good" parent, partner, spouse or friend			
		Total Score	
KEY: 1-3 = mild symptoms; 4-6 = moderate symptoms; 7-14 = serious symptoms			

INTERPERSONAL PROBLEMS

When we feel badly about ourselves, are stressed, depressed and/or anxious, it becomes increasingly difficult to connect with other people. People's beliefs in their need for, and entitlement to, community begin to erode and they can become increasingly alienated, isolated, lonely, sad and angry.

CHECKLIST FOR INTERPERSONAL PROBLEMS	How Often: Rarely	Fairly Often	Consistently
	0	1	2
I feel annoyed or angry with citizen contacts			
I seem to have difficulty communicating with supervisors and/or coworkers			
I feel cut off and alienated from my coworkers			
I feel "on the outside looking in" in social groups at work			
I have trouble talking about my personal life with others (work and/or home)			
I am irritable and impatient with others (work and/or home)			
I feel emotionally distant from my spouse or partner			
I have lost interest in intimacy and sex in my relationship			
I do not enjoy social occasions with friends or family			
I avoid social occasions and/or time with friends			
		Total Score	
KEY: 1-3 = mild symptoms; 4-6 = moderate symptoms; 7-20 = serious symptoms			

Specific Stress Effects

The following section takes you through the checklists for the specific systemic and traumatic workplace stress symptoms and effects. You will see that there is some symptom overlap between the 5 types of systemic and traumatic stresses. Please just bear with it though - the results will give you a more complete profile.

JOB STRESS SYMPTOMS & EFFECTS

CHECKLIST FOR JOB STRESS SYMPTOMS & EFFECTS	How Often		
	Rarely or Never	Fairly Often	Frequently
	0	1	2
I get colds, flus and other infectious illnesses			
I feel tired and fatigued throughout the day			
I have trouble sleeping			
I feel depressed and moody			
I feel anxious and worried			
I am irritable			
I feel bored and dissatisfied at work			
I have trouble concentrating and keeping my attention focussed			
I work overtime			
I have accidents and mishaps at work			
I smoke more than I should			
I use alcohol or other substances more than I should			
I have trouble communicating with coworkers and/or supervisors			
I feel that others are critical and judgmental of me			
Other than what is strictly necessary as part of the job, I don't have much to do with my colleagues			
I think about leaving the job and finding other employment			
The job has negative effects on my personal and family life			
I miss work due to illness or health-related problems			
		Total Score	

KEY: 1-4 = mild symptoms; 5-9 = moderate symptoms; 10-36 = serious symptoms

BURNOUT SYMPTOMS & EFFECTS

CHECKLIST FOR JOB STRESS SYMPTOMS & EFFECTS	How Often: Rarely or Never	Fairly Often	Frequently
	0	1	2
I get colds, flu's and other infectious illnesses			
I have physical problems such as headaches, gastrointestinal problems, joint and muscle pain, etc.			
I feel fatigued and exhausted			
I have problems with sleep			
I worry about my health			
I feel like a failure			
I feel helpless and confused			
I feel like I don't have any control			
I feel guilty			
I don't feel motivated			
I am irritable			
I feel anxious			
I feel depressed			
I feel isolated and alienated from others			
I feel angry			
I feel pessimistic and negative			
I have trouble concentrating and attending to tasks			
I abuse substances			
I don't use my time efficiently			
I feel detached and hostile toward others			
I treat other people in ways that are aggressive and/or demeaning			
I have trouble communicating with supervisors and/or colleagues			
I miss work due to illness or health-related problems			
I think about leaving the job			
		Total Score	

KEY: 3-5 = mild symptoms; 6-11 = moderate symptoms; 12-48 = serious symptoms

DISCRIMINATION & SEXUAL HARASSMENT SYMPTOMS & EFFECTS

CHECKLIST FOR DISCRIMINATION & SEXUAL HARASSMENT SYMPTOMS & EFFECTS	How Often: Rarely or Never	Fairly Often	Frequently
	0	1	2
I get colds, flu's and other infectious illnesses			
I have physical problems such as headaches, nausea, stomach upset, ulcers, irritable bowel syndrome, etc.			
I feel shamed and humiliated			
I feel helpless at work			
I feel trapped at work			
I am afraid at work			
I feel anxious			
I feel depressed and hopeless			
I feel inadequate, unworthy, or like I'm not good enough			
I do not feel confident in my judgement			
I have problems with concentration and attention			
I feel isolated from my coworkers and colleagues			
I don't feel safe to talk about my problems with workplace discrimination or harassment with supervisors or co-workers			
		Total Score	

KEY: 1-2 = mild symptoms; 3-6 = moderate symptoms; 7-26 = serious symptoms

PRIMARY STRESS SYMPTOMS & EFFECTS

The following checklist deals with the symptoms associated with posttraumatic stress disorder - the most serious response to primary traumatic stress.

CHECKLIST FOR POSTTRAUMATIC STRESS SYMPTOMS & EFFECTS	No	Yes
	0	1
A. REEXPERIENCING OF THE EVENT		
I have recurring and distressing thoughts about the event(s)		
I have recurring and distressing images or perceptions about the event(s)		
I have distressing dreams about the event(s)		
At times I act as if the event(s) are recurring		
At times I experience flashbacks to aspects of the trauma that feel as if I am reliving it		
At times I experience illusions or hallucinations that seem as if the traumatic event is happening again - this can occur when I'm waking up, or when I'm intoxicated		
I can become very emotionally upset and distressed when I'm exposed to situations or things which remind me of the traumatic event(s)		
I experience a physical anxiety response when I'm exposed to situations or things which remind me of the traumatic event(s)		
Subtotal Score		
B. AVOIDANCE & NUMBING		
I try to avoid thoughts, feelings or conversations associated with the trauma		
I try to avoid people, places or activities that remind me of the trauma		
I have difficulty remembering an important aspect of the traumatic event		
I have less interest, or am less involved in activities which used to be important to me		
I feel detached or estranged from other people		
I am pretty flat emotionally		
I have trouble looking ahead to the future and feeling positive about it		
Subtotal Score		
C. INCREASED AROUSAL		
I have difficulty falling asleep and/or staying asleep		
I am irritable or I can have angry outbursts		
I have trouble concentrating		
I find myself remaining hypervigilant and overly alert to possible threat or danger.		
I am startled by loud noises, or other unexpected events that are not immediately dangerous to me		
Subtotal Score		
Total Score		

KEY: Subtotal Scores:
Section A: 1-2 = mild symptoms; 3-4 = moderate symptoms; 5- 8= serious symptoms
Section B: 1 = mild symptoms; 2 = moderate symptoms; 3 - 7= serious symptoms
Section C: 1-2 = moderate symptoms; 3 - 5= serious symptoms

KEY: Total Score
3 – 5 = mild symptoms; 6 – 7 = moderate symptoms; 8 – 20 = serious symptoms

SECONDARY (VICARIOUS) TRAUMATIC STRESS SYMPTOMS & EFFECTS

As discussed by in chapters 2 and 3, the symptoms and effects associated with secondary/vicarious trauma have been most widely researched by Figley (1996) and Pearlman and her colleagues (McCann & Pearlman,1990; Pearlman & MacIan, 1995; Pearlman & Saakvitne 1995; Saakvitne & Pearlman, 1996). An important feature of Pearlman's model is her differentiation between the stress component of the trauma and the despair component. The latter refers to the destructive alterations in the person's system of meaning that tends to occur with vicarious trauma. The following checklists are largely derived from the work of Pearlman, as well as from my own research and practice with criminal justice professionals.

CHECKLIST FOR SECONDARY TRAUMATIC STRESS SYMPTOMS & EFFECTS	How Often: Rarely or Never	Fairly Often	Frequently
	0	1	2
STRESS COMPONENT			
I get colds, flu's and other infectious illnesses			
I have physical problems such as headaches, nausea, gastrointestinal problems, joint & muscle pain, etc.			
I experience fear responses such as rapid heartbeat, dizziness, breathing difficulties, or sweating when I am reminded about secondary traumatic material			
I feel helpless and powerless			
I feel alone and isolated			
I feel overwhelmed and exhausted			
I feel emotionally shutdown and/or numb			
I feel sadness and/or grief			
I feel guilty			
I feel afraid			
I feel angry or rageful			
I feel depressed			
I feel anxious			
I have problems with concentration and attention			
I feel confused and/or indecisive			
I am moody and unpredictable			
I am irritable and impatient with others			
I abuse substances			
I am preoccupied with the traumatic material I hear about at work			
I have nightmares about work-related themes			
		Subtotal Score	
DESPAIR COMPONENT			
I feel disoriented			
I doubt my judgement or competency			

CHECKLIST FOR SECONDARY TRAUMATIC STRESS SYMPTOMS & EFFECTS (Cont.)	How Often: Rarely or Never	Fairly Often	Frequently
	0	1	2
DESPAIR COMPONENT (Cont.)			
My work seems meaningless			
I am intolerant and judgemental			
I am mistrustful of others			
I withdraw from family and friends			
I've withdrawn from intimacy with my spouse/partner			
I feel a lack of purpose			
I question the meaning of my life			
I feel hopeless			
I question my religious or spiritual beliefs			
		Subtotal Score	
		Total Score	

KEY: Subtotal Scores:
The Stress Component: 1-6 = mild symptoms; 7-14 = moderate symptoms; 15-40 = serious symptoms
The Despair Component: 1-2 = mild symptoms; 3-5 = moderate symptoms; 6-22 = serious symptoms

KEY: Total Score
2 – 8 = mild symptoms; 9 – 20 = moderate symptoms; 21 – 62 = serious symptoms

SUMMARY: STRESS SYMPTOMS & EFFECTS

The following chart collates and summarizes the results of the assessment checklists in this chapter. Please take the results seriously as you move forward to the next section which helps you develop strategies to move toward wellness.

SUMMARY: SYMPTOMS & EFFECTS	Minimal Symptoms	Mild Symptoms	Moderate Symptoms	Serious Symptoms
CORE STRESS SYMPTOMS & EFFECTS				
Physical Stress Symptoms				
Stress-related Illness & Disease				
Depression				
Generalized Anxiety				
Panic Attack				
Substance Abuse				
Self-esteem Problems				
Interpersonal Problems				
SPECIFIC SYMPTOMS & EFFECTS				
Job Stress Symptoms & Effects				
Burnout Symptoms & Effects				
Discrimination Symptoms & Effects				
Harassment Symptoms & Effects				
Primary Traumatic Stress Symptoms				
Secondary/Vicarious Trauma Symptoms				

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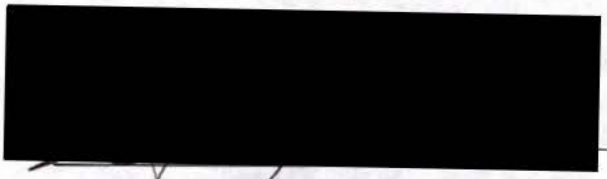
Author 

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