Coping Styles and Secondary Traumatic Stress in Direct Care Staff Working in Residential Treatment Centers

Richard Stapleton
*Optimae Life Solutions Behavioral Health*

April Young
*Argosy University*

Tracy Senstock
*Walden University*

Abstract

Relationships were examined between secondary stress symptoms, coping styles, and compassion satisfaction among staff working with child and adolescent residents in treatment. Results indicated male participants and emotional-based coping styles positively correlated with secondary traumatic stress reactions. Implications for future research and suggestions for training programs and clinical practice are offered.

*Keywords: Secondary traumatic stress compassion satisfaction*

Editor's Note: This study focuses on direct care staff in public residential treatment centers (RTCs) that provide residential care for youth referred by the juvenile justice and foster care systems. There are important reasons that this study's findings apply to privately funded RTCs. Both public and private RTCs treat youth in out-of-home care, in a 24/7 treatment milieu, staffed by mental health paraprofessionals and professionals. Trauma is a common problem for youth in both public and private RTCs (e.g., Tucker, Zevlov & Young, 2011). Also, this study focuses on direct care staff or line staff, a role which is comparable in public and residential RTCs. Direct care staff arguably have the most day-to-day contact with youth in both public and private RTCs, and therefore issues related to them are of high priority.

Coping Styles and Secondary Traumatic Stress in Direct Care Staff Working in Residential Treatment Centers

Public residential treatment centers (RTCs) treat youth whose violent and aggressive behaviors make it difficult for them to be successful in less restrictive programs, such as foster care or group homes (U.S. Public Health, 2000). Children who are served in Public RTCs are often referred by the foster care and juvenile justice systems. According to the U.S. Public Health Service Report (2000) and Shin (2004), youth in Public RTCs present with a wide range of treatment issues including abandonment, sexual abuse, physical abuse, neglect, and substance abuse. Because of these treatment issues, many of these youth can exhibit several symptoms of post-traumatic stress disorder (PTSD). PTSD is a disorder listed in the American Psychiatric Association (2000) *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text rev.), in which a person experiences symptoms of arousal, intrusion, and hyper-vigilance as a direct result of a trauma.

There are several levels of staff providing care for youth treated in public RTCs, direct-care staff (DCS) have the most contact with the youth. DCS who work in RTCs are paraprofessionals in the human service and mental health field (Leon, Visscher, Sugimura, & Lakin, 2008). DCS work directly with clients for periods of eight to ten hours per day, four to five days per week. According to Pazaratz (2000), DCS have among the most critical and difficult positions in treatment centers because of their job duties (i.e., nurturing, disciplining, helping with homework, providing meals, managing crises, helping set goals, facilitating psycho-educational groups, supervising recreational activities, and charting). Other duties include ensuring clients safety; transporting clients to appointments; and in
COPING STYLES

some cases when a client becomes a danger to self or others, physically managing the client. DCS may be exposed to behaviors such as spitting, hitting, biting, hair pulling, self-injurious behaviors, and verbal abuse. DCS have the second highest turnover rate in public RTCs - the first-highest turnover rate is the housekeeping staff (Connor et al., 2003). The purpose of this study was to examine the types of coping skills used, and the compassion satisfaction (CS) felt by DCS, as well as the impact of task-oriented and emotion-based coping styles on secondary traumatic stress (STS) and professional quality of life. By understanding these factors, both the staff themselves as well as those who supervise them may be better equipped to manage the impact of STS.

Secondary Traumatic Stress

DCS can suffer from STS as a result of the long working hours and because many of the youth exhibit PTSD symptoms (Bride, 2007; Leon et al., 2008). STS is a phenomenon in which a helping professional personally experiences symptoms of PTSD as a result of working with clients with PTSD (Figley, 1999). Notably, these professionals are not exhibiting PTSD symptoms from personal traumas; rather, their symptoms result from exposure to the traumas of the youth with whom they are working (Bride, 2007; Figley, 1999). Experiencing STS can impact the professional’s conceptual framework of practice, worldview, interpersonal style, functioning on the job, and psychosocial functioning away from the job (Cunningham, 2003).

Researchers began studying the phenomenon of employee burnout in the field of social services in the early 1970s. At the time, it was suggested that people experiencing burnout should be encouraged to explore other career options (Freudenberger, 1977). More recently, other factors (i.e., managerial support, job satisfaction, employee personality, and psychiatric characteristics such as extraversion and neuroticism) have been explored as to how they might contribute to job burnout and how to manage it (Leon et al., 2008). Employee burnout can lead to a decrease in emotional energy, which is often coupled with the negative self-belief of being inadequate or being unable to complete the required job responsibilities. Such negative beliefs may lead to detachment and avoidance of clients (Leon et al., 2008). Having less emotional energy can lead an employee to experience a sense of powerlessness. An employee may begin to feel as if they are a babysitter rather than a treatment provider (Decker, Bailey, & Westergaard, 2002).

Further research has determined that what often appears as burnout may actually be the deeper psychological issue of STS resulting from working with traumatized clients (Figley, 1999). STS is defined as “the natural, consequent behaviors and emotions resulting from knowledge about a traumatizing event experienced by a significant other. It is the stress resulting from helping or wanting to help a traumatized or suffering person in the mental health field” (Figley, 1999, p. 10). STS can impact an employee’s feelings of vulnerability thereby causing emotional numbing or avoidance of a client’s traumatic material (Bride, Raden, & Figley, 2007). The effects of STS can be especially debilitating for DCS at RTCs because of the long hours they work and their direct exposure to the youth exhibiting symptoms of PTSD (Pearlman & Saakvitne, 1995). These effects may include emotional numbing, sleep difficulties, poor self-care, relational problems, poor work performance, flashbacks, addiction, withdrawal from clients or coworkers, withdrawal from support systems, decreased use of supervision, and poor client care (Bride et al., 2007; Figley, 2002; Pearlman & McIan, 1995; Pearlman & Saakvitne, 1995). In order for staff to provide care for their clients, it is necessary to develop healthy ways of coping and to recognize symptoms of STS (Figley, 1999; Leon et al., 2008).

Compassion Satisfaction

Compassion satisfaction (CS) is used to explain positive emotions associated with working with clients (Figley, 1995a, 1995b). CS explains the sense of pleasure or satisfaction counselors feel when they believe they are having a positive impact (Alkema, Linton, & Davies, 2008; Figley, 2002). This sense of satisfaction can be achieved not only from the belief that one is having a positive impact on clients, but by having positive coping strategies as well. These strategies can include developing social networks, maintaining a balance between personal and professional life, getting adequate rest and sleep, taking part in physical exercise, fostering spirituality or religious beliefs, seeking continuing education, and practicing healthy eating habits (Alkema et al., 2008). A supervisor can assist by encouraging the development of positive coping strategies which increases the counselor’s ability to experience CS, while helping others (Radey & Figley, 2007). Negative coping styles, such as substance abuse or failing to utilize support systems can lead to STS or burnout; whereas, positive coping styles can lead to
Coping Styles
Coping styles can influence a person's psychological and physical reactions to stressful situations and influence the outcomes when he or she faces stressful life events (Shikai et al., 2007; Wang, Lightsey, Pietruszka, Uruk, & Wells, 2007). Endler and Parker (1999) identified three dimensions of coping, which included (a) task-oriented coping; (b) emotion-oriented coping; and (c) avoidant behaviors. Task-oriented coping refers to a positive problem-solving approach to managing stress (Jang, Thordarson, Stein, Cohan, & Taylor, 2007), such as staying organized, utilizing supervision, exercising, and participating in religious or spiritual activities. Emotion-oriented coping is generally related to a more negative coping style because the individual tends to react with an emotional response to stressful situations (Endler & Parker, 1994; Jang et al., 2007; Shikai et al., 2007; Wang et al., 2007). An emotional response to a stressful situation can lead to symptoms such as depression, anxiety and physical illness. The third dimension of coping is referred to as avoidance. Avoidant counselors may call in sick from work to avoid stress or spend long periods of time on the computer instead of talking about stressful situations with others for support (Cohan, Jang, & Stein, 2006).

Gender and STS
Knight (2010) reported that female social workers experienced STS symptoms more than males. Knight found that women scored lower on CS and showed more signs of vicarious trauma than men. Similarly, women were twice as likely to develop PTSD symptoms as men (Knight, 2010). According to Grubaugh, Cusack, Knapp, and Frueh (2007), this gender difference is possibly due to the frequency of traumatic events and the frequency of reporting traumatic events. Research by Creamer and Liddle (2005), however, did not support these gender differences. They reported that women showed slightly higher STS, but it was not a significant difference. Instead, they reported that years of experience and the number of hours spent with the client, especially children experiencing trauma, were clinically significant in predicting STS. They explained that one possible reason why gender did not appear to be significant was because there were fewer males working in the mental health field, therefore making it more difficult to measure the effects of gender on STS.

Years of Experience and STS
Years of work experience appear to be a significant factor for CS and STS symptoms. More experienced mental health workers may have developed stronger, more positive coping styles through education, supervision, and experience (Bride, Jones, & MacMaster, 2007). Though significant correlations have been found between age and burnout, experience appears to be a greater predictor of CS, when considering emotional and physical well-being, which make up the main components of CS (Alkema et al., 2008). Potentially, younger professionals enter the human service field filled with an enthusiasm for wanting to help people. This assumption may be diminished when clients’ outcomes fail to meet the expectations of the new professional.

Research Questions and Hypothesis
The research questions addressed in this study were a) do any of the following sets of independent variables: (1) gender, (2) years of professional experience, (3) approximate number of work hours per week, (4) level of task-oriented coping, and (5) level of emotion-based coping, predict the dependent variable of STS; and b) do any of the following sets of independent variables: (1) gender, (2) years of professional experience, (3) approximate number of work hours per week, (4) level of task-oriented, and (5) level of emotion-based coping, predict the dependent variable of CS? For each question we predicted the null hypothesis that there will be no combinations of the independent variables that will predict staff’s symptoms of STS or CS.

Method
Procedure
Institutional Review Board approval was obtained from Argosy University before the research began. Requests for participation were sent to various site directors’ facilities selected from a directory of public RTCs put together through an Internet search. Once the facility supervisors agreed to have their site utilized in the study, they distributed the e-mail inviting their DCS to participate. The e-mail sent to the DCS contained a web address, which directed them to the Survey Monkey© site. Participants were presented an informed consent form which explained that participation in the study was voluntary and confidential.
Participants
Participants in this study were DCS working in child and adolescent RTCs. Ninety-two participants completed all three instruments in their entirety. The majority of the participants were female (75.6%). Participants identified as Caucasian (81.1%), 6.7% African American, 2.2% Native American, 2.2% Asian American, 3.3% Hispanic/Latino, and 4.4% selected the category of “other.” In terms of education, 46.7% held a bachelor’s degree and the remainder held a master’s degree (27.8%), an associates’ degree (20%), a high school diploma or GED (3.3%), or a doctorate degree (1.1%). The average number of years working for a residential treatment center was six (6.093; SD = 5.665) and the average numbers of hours worked per week were 32 (32.228; SD = 14.114). A total of 51.1% of the participants reported receiving self-care training.

Instruments
Participants completed a demographic questionnaire created for this study, the Secondary Traumatic Stress Scale (STSS, Bride, Robinson, Yegidis, & Figley, 2004), the Professional Quality of Life Scale (ProQOL, Stamm, 2009), and the Coping Inventory for Stressful Situations (CISS, Endler & Parker, 1994).

According to Bride, Radey, and Figley (2007), the internal consistency of the STSS is .86 to .94 and construct validity was demonstrated through convergent, discriminate, and factorial analyses. The STSS uses a five-point scale (1 = never, 5 = very often). It has three subscales including Intrusion (e.g., “It seemed as if I was reliving the trauma(s) experienced by my client(s)”; Avoidance (e.g., “I had little interest in being around others”); and Arousal (e.g., “I had trouble sleeping”), which correspond to the criteria for PTSD in the DSM-IV-TR (Bride, Radey, & Figley, 2007).

The Professional Quality of Life Scale (ProQOL) was used in this study to measure CS as well as compassion fatigue. Bride, Radey and Figley (2007) estimated that the internal consistency reliability was .87 for the Compassion Satisfaction scale, .72 for the Burnout scale, and .80 for the Compassion Fatigue/STS scale. The multi-trait, multi-method approach to convergent and discriminate validity supported the discriminate validity of the test, and the researchers did not publish convergent validity. Respondents answer questions based on a five-item scale (0 = never, 5 = very often).

Endler and Parker (1994) reported the validity of the CISS, focusing on the multidimensionality of the CISS scales and the construct validity of the CISS scales. According to Endler and Parker, the three factor solutions, (1) task-oriented coping, (2) emotion-oriented coping, and (3) avoidance-oriented coping, were compared statistically, using congruence coefficients. The assessment contained 48 items in three sections with 16 items each that assessed task-oriented coping (e.g., “Outline my priorities”), emotion-oriented coping (e.g., “Do what I think is best”), and avoidance-oriented coping (e.g., “Think about the good times I’ve had”; Endler & Parker, 1994). Endler and Parker defined task-oriented coping as being purposeful efforts to problem-solve the situation; whereas, emotion-oriented coping aims to reduce stress, which often results in self-blame, anger, becoming tense, self-preoccupation, or fantasizing.

Results
Data Analysis
For this study, the alpha level was set at .05, the beta level was set at .80, and the regression analysis used the five independent variables. Cohen and Cohen’s (1983) benchmarks were utilized to describe the absolute value of effect sizes. Accordingly, the estimated population effect size used for this study was for a moderate effect, or \( R^2 = .13 \). Thus, a sample of 92 was needed to detect a population \( R^2 \) of .13 using 5 predictors, with a 20% risk of a Type II error, and a 5% risk of a Type I error.

Three hierarchical multiple regression analyses were conducted to test both hypotheses. A four-model analysis was conducted as follows: (a) gender; (b) years of professional experience working in RTCs; (c) average number of work hours per week; (d) positive or task-oriented coping styles; and (e) negative or emotion-based coping styles. The \( R^2 \) change statistics were examined to compare models so that the independent and successive contributions of all the variables could be assigned. In the case of a significant \( R^2 \) value, the beta weights were examined to determine the relative contributions of the individual variables.
Results of Hypotheses
As seen in Table 1, the $R^2 = .026$ ($p = .516$) for the first model (i.e., approximate number of work hours per week, gender, and years of professional experience) did not reach statistical significance level of less than .05. The second model, which added emotion and task-oriented coping, $R^2 = .414$ was significant ($p = .000$), suggesting that more than 40% of the variance in the STS scores was explained by the combination of the demographics and the coping scores. Moreover, the amount of explained variance was increased by almost 39% when the emotion-based coping and task-oriented coping scores were added. The demographics of gender, years of professional experience, and approximate number of work hours per week did not significantly predict STS in staff, however, adding coping style did produce a significant regression equation.

Table 1
Multiple Regression Results for the Total Score on the Secondary Traumatic Stress Scale

<table>
<thead>
<tr>
<th>Model</th>
<th>$R^2$</th>
<th>Adjusted $R^2$</th>
<th>$R^2$ Δ</th>
<th>$pF$ Δ</th>
<th>ANOVA $pF$</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>.026</td>
<td>-.008</td>
<td>.026</td>
<td>.516</td>
<td>.516</td>
</tr>
<tr>
<td>2</td>
<td>.414</td>
<td>.380</td>
<td>.038</td>
<td>.000</td>
<td>.000</td>
</tr>
</tbody>
</table>

The coefficients generated for a multiple regression equation are meant to actually be used in a prediction equation and may be examined more closely in case of a significant finding to weigh the relative contributions of individual predictors (Cohen & Cohen, 1983). Whereas the finding of a significant $R^2$ involves the set of predictors, the coefficients examine the predictors on an individual basis, it was therefore unnecessary to examine the actual coefficients for the first model since the equation failed to reach the required alpha level of .05. The coefficients for the second model are presented in Table 2 which indicate the beta weight for emotion-based coping was significant (Beta = .556, $p = .000$), no other coefficients were statistically significant.

Table 2
Coefficient Results for the Secondary Traumatic Stress Scale

<table>
<thead>
<tr>
<th>Model</th>
<th>Unstandardized</th>
<th>Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$B$</td>
<td>$SE$</td>
</tr>
<tr>
<td>2 (Constant)</td>
<td>27.066</td>
<td>8.968</td>
</tr>
<tr>
<td>Gender</td>
<td>2.377</td>
<td>2.171</td>
</tr>
<tr>
<td>Years of experience</td>
<td>-.031</td>
<td>.170</td>
</tr>
<tr>
<td>Hours per week</td>
<td>.060</td>
<td>.066</td>
</tr>
<tr>
<td>Emotion-coping subscale</td>
<td>.593</td>
<td>.098</td>
</tr>
<tr>
<td>Task-coping subscale</td>
<td>-.176</td>
<td>.110</td>
</tr>
</tbody>
</table>

It can be seen in Table 3 that the first model (i.e., approximate number of work hours per week, gender, and years of professional experience) had no statistical significance on participants’ total compassion fatigue score; however, the $R^2 = .086$, $p = .051$ is noteworthy as anything less than .05 is statistically significant. As seen in the table, the second model (i.e., emotion-based coping and task-oriented coping) provided the largest value for the $R^2$ (.371). This represented a significant accretion in explained variance when the emotion-based coping and task-oriented coping scores were added ($R^2$ change = .285, $p$ change < .000).
Table 3
Multiple Regression Results for the ProQOL on the Compassion Fatigue Subscale

<table>
<thead>
<tr>
<th>Model</th>
<th>$R^2$</th>
<th>Adjusted $R^2$</th>
<th>$R^2$ $\Delta$</th>
<th>pF $\Delta$</th>
<th>pF $\Delta$ ANOVA</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>.086</td>
<td>.054</td>
<td>.086</td>
<td>2.702</td>
<td>.051</td>
</tr>
<tr>
<td>2</td>
<td>.371</td>
<td>.334</td>
<td>.285</td>
<td>19.029</td>
<td>.000</td>
</tr>
</tbody>
</table>

Model 1 was not found to be significant, thus the individual coefficients for this model were not reviewed. It was concluded that the demographics of gender, years of professional experience, and approximate number of work hours per week did not significantly predict staff's level of CS. Model 2, which consisted of gender, years of professional experience, approximate number of work hours per week, emotion-based coping, and task-oriented coping, explained approximately 20.6% of the variance in the CS scores of the participants. The standardized coefficient for the emotion-based and task-based coping scores were statistically significant, $p = .000$ and $p = .002$ respectively, as seen in Table 4. An examination of the Beta weights shows that emotion-based coping was a larger contributor to the explained variance ($\beta = .353$) than task oriented coping ($\beta = .398$).

Table 4
Coefficient Results for the ProQOL Compassion Satisfaction Subscale

<table>
<thead>
<tr>
<th>Model</th>
<th>Unstandardized</th>
<th>Standard</th>
<th>$\beta$</th>
<th>t</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 (Constant)</td>
<td>13.672</td>
<td>9.523</td>
<td>1.445</td>
<td>.152</td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td>-1.688</td>
<td>2.305</td>
<td>-.073</td>
<td>- .732</td>
<td>.466</td>
</tr>
<tr>
<td>Years of experience</td>
<td>.184</td>
<td>.181</td>
<td>.104</td>
<td>1.016</td>
<td>.313</td>
</tr>
<tr>
<td>Hours per week</td>
<td>-.015</td>
<td>.070</td>
<td>-.020</td>
<td>-.207</td>
<td>8.36</td>
</tr>
<tr>
<td>Emotion coping subscale</td>
<td>.386</td>
<td>.104</td>
<td>.398</td>
<td>3.713</td>
<td>.000</td>
</tr>
<tr>
<td>Task coping subscale</td>
<td>.380</td>
<td>.117</td>
<td>.353</td>
<td>3.250</td>
<td>.002</td>
</tr>
</tbody>
</table>

Findings indicate that two of the five independent variables tested significantly correlated with the DCS symptoms of STS. The two significant predictors of STS were gender and emotion-based coping. Specifically, the male participants had higher scores on the emotion-based coping styles as well as higher levels of STS. The findings also indicated that only two of the five independent variables tested significantly correlated with the staff's CS. Demographic variables failed to predict CS, but the coping styles were significant predictors.

Inspection of the standardized coefficients indicated statistical significance in Model 1 for hours worked, with Beta = .215, $p = .042$, suggesting that the more hours counselors work, the higher the level of CF they will experience. It is noteworthy to remember, however, that these results need further confirmation before it is possible to extrapolate to other counselors similar to the participants in this study. In Model 2, gender had statistical significance with Beta = -.241, $p = .008$, which suggests that males reported more symptoms of STS than females. Task-oriented coping was not statistically significant, $p = .346$, suggesting no relationship between task-oriented coping and STS. The standardized coefficient for the emotion-based coping score was statistically significant; Beta = .497, $p = .000$, as seen in Table 5. The coefficient score for emotion-based coping indicates that as emotion-based coping scores increase, symptoms of STS also increase. An examination of Beta weights shows that emotion-based coping was a larger contributor to explained variance ($\beta = .497$) than gender ($\beta =
Table 5  
Coefficient Results for the ProQOL Compassion Fatigue Subscale

<table>
<thead>
<tr>
<th>Model</th>
<th>Unstandardized</th>
<th>Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>B</td>
<td>SE</td>
</tr>
<tr>
<td>1 (Constant)</td>
<td>49.222</td>
<td>3.616</td>
</tr>
<tr>
<td>Gender</td>
<td>-4.501</td>
<td>2.435</td>
</tr>
<tr>
<td>Years of experience</td>
<td>-.122</td>
<td>.188</td>
</tr>
<tr>
<td>Hours per week</td>
<td>.153</td>
<td>.074</td>
</tr>
<tr>
<td>2 (Constant)</td>
<td>39.687</td>
<td>8.476</td>
</tr>
<tr>
<td>Gender</td>
<td>-5.585</td>
<td>2.052</td>
</tr>
<tr>
<td>Years of experience</td>
<td>-.130</td>
<td>.161</td>
</tr>
<tr>
<td>Hours per week</td>
<td>.107</td>
<td>.062</td>
</tr>
<tr>
<td>Emotion coping subscale</td>
<td>.483</td>
<td>.093</td>
</tr>
<tr>
<td>Task-oriented subscale</td>
<td>-.099</td>
<td>.104</td>
</tr>
</tbody>
</table>

Discussion

Emotion-Based Coping

For this study, two testing instruments were used to measure STS. In the first regression, the Secondary Traumatic Stress Scale was used to measure STS and the Coping Inventory for Stressful Situations was used to measure coping styles utilizing the subtests for emotion-based and task-oriented coping (Endler & Parker, 1994). In the first regression, emotion-based coping styles were correlated with STS symptoms. This may suggest that DCS who utilize coping styles such as finding ways to distract from the stress—venting to others, building up to expect the worst, or dwelling on how things could have been handled differently—are more likely to experience STS symptoms if they are working with clients with PTSD.

A second testing instrument was used to measure STS, which resulted in the second regression. The subtest from the Professional Quality of Life Scale (ProQOL) for compassion fatigue, another term for STS, was used (Stamm, 2009). The regression had similar results as the STSS in that emotion-based coping was correlated with STS.

Gender and Emotion-Based Coping

Findings from the analyses indicated that gender was also correlated with STS, with males having more STS symptoms than females. This may suggest that males tend to utilize emotion-based coping styles, or internalize their feelings more frequently. Gender, years of experience, hours worked per week, and level of task-oriented coping had no correlation with STS in the first regression; yet, gender was found to be statistically significant in the second regression. It is important to note, however, that while in the second regression hours worked per week may not have been statistically significant, hours worked per week did have a large impact on the results. DCS at RTCs should be monitored on the number of hours working each week as this may help reduce the possibility of STS symptoms.

There is very little literature on the impact of emotion-based coping and STS symptoms. The literature does support the finding that counselors who utilize emotion-based coping styles can have a tendency toward reacting negatively toward clients by expressing anger and later blaming themselves for how they handled the situation (Endler & Parker, 1999; Shikai et al., 2007; Wang et al., 2007). There are some arguments amongst researchers on the importance of gender and STS. Knight (2010) reported that female social workers experienced STS symptoms more than males and that it was most likely due to females having more incidents of traumatic events in their past. This was not supported in this study as evidenced by males reporting greater incidents of STS than females on the CF subtest of the ProQOL. Creamer and Liddle (2005) did not support gender differences as being clinically
significant in identifying STS; instead, they reported that a possible explanation for women having higher incidents of STS was due to more women working in the mental health field. Although only 24.4% of the respondents of this study were males, there was still a statistical significance in male DCS experiencing STS symptoms in RTCs. Furthermore, Creamer and Liddle went on to suggest that hours spent working with the clients, especially children experiencing trauma, was significant; however, the findings in this study did not have significance on either the STSS or CF subtest on the ProQOL. Based on the results of this study, male DCS may be more at risk for STS. More research is needed to determine the relationship between gender and STS.

Compassion Satisfaction
The CS subscale on the ProQOL was used in this regression to measure staff’s CS. The two independent variables of emotion-based coping and task-oriented coping showed statistical significance. This may suggest that the staff may not have been exposed to PTSD. It may also suggest that whichever coping style the DCS is using, is working to help maintain CS. If staff is utilizing emotion-based coping styles, it is important to note that with the last two regressions only emotion-based coping was statistically significant as a predictor for secondary trauma.

These findings are consistent with research by Endler and Parker (1999) and Cohan et al. (2006) in that emotion-based coping can lead to STS. It is also important to note from the literature that when a coping style fails, it is essential for the counselor to utilize support systems, counseling opportunities, supervision, and training opportunities in order to prevent an increase in STS symptoms (Endler & Parker, 1999; Shikai et al., 2007; Wang et al., 2007). The signs of a coping style failing can be symptoms of depression or burnout (Jang et al., 2007; Wang et al., 2007). The literature also suggests that utilizing task-oriented coping styles can help staff by increasing a sense of resilience and success (Radey & Figley, 2007).

Implications for Mental Health Practitioners
Based on the evidence presented, STS can have a negative impact on the job performance, careers, and the health and well-being of DCS working in child and adolescent RTCs (Cunningham, 2003; Pearlman & Saakvitne, 1995). These symptoms can impact the performance in their helping roles both on the job and away from the job (Cunningham, 2003; Pearlman & Saakvitne, 1995). The results of this study can be used to assist in the development of training programs for DCS as well as other professionals working closely with youth in RTCs. Although staff who experience CS utilized both task-oriented and emotion-based coping, for this study, emotion-based coping, such as internalizing thoughts and emotions, indicated a more significant relationship with STS. Supervisors can utilize this information in encouraging employees to develop task-oriented coping styles. According to Cohan and colleagues (2006), this includes activities such as staying organized, utilizing supervision, exercising, and participating in religious or spiritual activities. A counselor who effectively uses task-oriented coping may have a stronger ability to problem solve, re-conceptualize a problem, or minimize the effects of the problem (Shikai et al., 2007; Wang et al., 2007). Strengthening positive coping strategies can help employee retention and help reduce or manage STS symptoms. By helping the professionals, ultimately the clients they serve are helped.
References


COPING STYLES


