УДК 159.98

Mark Newmeyer, Benjamin Keyes, Olya Zaporozhets, Robert Rubinow, Kamala Palmer

CROSS-CULTURAL HELPING INITIATIVES AND COMPASSION FATIGUE PHENOMENA

Фахівці психологічної галузі, що беруть участь у міжнародних ініціативах допомоги на місцях, особливо в середовищах із високим рівнем травми, знаходяться в більшій небезпеці втоми співчуття та інших пов'язаних із ними проблемами. Автори дають огляд існуючих психодіагностичних та скрінінгових інструментів і методів, які допомагають фахівцям компенсувати втому співчуття у крос-культурних контекстах. Автори також надають рекомендації щодо конкретних кроків, які повинні слідувати за діагностикою втоми співчуття в напружених ситуаціях пов'язаних із травмою для забезпечення якості послуг фахівців.

Ключові слова: *втома співчуття, вторинний травматичний стрес, фактори стійкості.*

Специалисты в психологической области, участвующие в международных инициативах помощи на местах, особенно в среде с высоким уровнем травмы, находятся в большей опасности усталости сочувствия и других связанных с ними проблемами. Авторы дают обзор существующих психодиагностических и скрининговых инструментов и методов, которые помогают специалистам компенсировать усталость соболезнования в кросс-культурных контекстах. Авторы также дают рекомендации относительно конкретных шагов, которые должны следовать за диагностикой усталости сочувствия в напряженных ситуациях связанных с травмой для обеспечения качественной помощи специалистов.

Ключевые слова: *усталость сочувствия, вторичный травматический стресс, факторы устойчивости.*

Helping professionals engaging in cross-cultural immersion experiences, especially in high-trauma ecologies, are at greater risk for compassion fatigue and other associated problems. The authors give an overview of existing assessment and screening tools and techniques

© Mark Newmeyer, Benjamin Keyes, Olya Zaporozhets, Robert Rubinow, Kamala Palmer, 2015

that help professionals to offset compassion fatigue in cross-cultural contexts. The authors also present specific action-steps that should follow compassion fatigue assessment in intense trauma-related situations for ensuring quality services.

Key words: *compassion fatigue, secondary traumatic stress, resiliency factors.*

The Problem. Helping professionals engage in cross-cultural immersion experiences, especially in high-trauma ecologies, are at greater risk for compassion fatigue and other associated problems. Compassion fatigue, burnout, and vicarious trauma are all stress-related conditions common among caregivers (e.g. professional counselors, medical personnel, first responders) engaging with highly traumatized human populations. Counselors, social workers, psychologists, and other allied professionals engage in helping roles that commonly intersect with trauma, which often result in the minimization of their own emotional responses. Therefore, it is important to research assessment and coping strategies that help professionals to offset compassion fatigue in cross-cultural contexts for ensuring quality services.

The Analysis of the Current Research and Publications. Over the past few years, researchers have closely examined the effects of working with traumatized populations on mental health professionals [1; 2; 3; 4; 5]. Many of these studies have gleaned significant insight into the components and consequences of *secondary traumatic stress* (STS) and *compassion fatigue* (CF), as well as the specific protective factors for resiliency among those who care for traumatized clients.

At the same time, there is much still to learn, especially in relation to the effects of secondary trauma on new mental health professionals. As universities incorporate short-term cultural immersion experiences into their graduate training programs, new counseling interns, for example, have the opportunity to gain firsthand knowledge in treating populations in cross-cultural contexts [6; 7; 8; 9]. These experiences pose both benefits and potential risks to the novice. Understanding these risks, and what factors may mitigate the effects of such risks, is imperative to the design of programs that protect and promote the overall functioning, well-being, and longevity of counselors-in-training.

The trauma-related literature has classified symptoms and reactions to traumatic events with different terms, including: vicarious traumatization, secondary trauma, compassion fatigue, burnout and occupa-

tional stress, to name a few. In order to accurately understand a person's response to a traumatic event, it is necessary to understand the distinguishing characteristics of trauma-related terminology. According to McCann and Pearlman, «Vicarious traumatization can be understood as related both to the graphic and painful material trauma clients often present, and to the therapist's unique cognitive schemas or beliefs, expectations, and assumptions about self and others» [10, p. 131]. Similarly, vicarious traumatization has been equated with *secondary trauma*, defined as «encountering distress while empathizing for another who has been affected by an event» [11, p. 54]. McCann & Pearlman defined STS as «counselors' trauma reactions that are secondary to their exposure to clients' traumatic experiences [10]». Figley defined compassion fatigue as a «state of exhaustion and dysfunction (biologically, psychologically and socially) as a result of prolonged exposure to compassion stress» [12p. 253]. In other words, compassion fatigue decreases professional mental health workers' empathy and desire to care for clients [13]. CF remains a function of a number of variables, including extended exposure to suffering, the treatment provider's own history of trauma, as well as various other disruptions in the provider's personal and professional life [4]. *Burnout* and *occupational stress* appear without vocational bias and are best defined as job-related stress, which include symptoms of exhaustion, cynicism, and ineffectiveness, and can occur in individuals not working with trauma-related settings [14]. Compassion fatigue, burnout, and vicarious trauma are all stress-related conditions common among caregivers (e.g. professional counselors, medical personnel, first responders) engaging with highly traumatized human populations [15, p. 314].

Current research identifies specific risk factors salient to such conditions, including: inexperience, overwork, high caseloads, isolation, lack of support and supervision, lack of training, lack of role clarity, marital status, and personal history of unresolved trauma [15, p. 317-318). Another study identified severity of client problems, time limitations, inadequate resources, and emotional demands of the work as significant risk factors for burnout [16]. Additionally, counselors, social workers, psychologists, and other allied professionals engage in helping roles that commonly intersect with trauma, which often result in the minimization of their own emotional responses [13].

There is added emphasis to stress reaction levels of treatment providers when considering the environment in which they practice. Much

research has also come about exploring the impact of work-related stress in various cultural environments with traumatized populations [16; 17; 18]. For instance,MacRitchie and Leibowitz [19] studied the effects of STS, as well as perceived empathy and social support of treatment providers in South Africa where violence remains prevalent. And in Australia, Hatcher and Noakes examined the experiences of compassion fatigue and burnout among treatment providers of sex offenders [17].

It is evident that client population and environmental differences play a role in the experience of STS among treatment providers regularly working in various cultural settings. However, research is scarce regarding the prevalence of STS and CF among treatment providers who immerse themselves within another culture to treat trauma-affected populations. Protective factors and training preparation of these treatment providers need to be examined.

A study by Hernandez et al. explored protective factors in treatment providers, and found that therapists reported a sense of vicarious resilience (i.e. being positively affected by clients' posttraumatic healing and growth), and described changes in their own attitudes, emotions, and behaviors while witnessing clients overcome adversity [4]. These changes include: 1) reflecting on human beings' capacity to heal; 2) reaffirming the value of therapy; 3) regaining hope; 4) reassessing the dimensions of one's own problems; 5) understanding and valuing spiritual dimensions of healing; 6) discovering the power of community healing; and 7) making the professional and lay public aware of the impact and multiple dimensions of violence by writing and participating in public speaking forums [4, p. 72–73].

Phelps et al. looked at other protective factors such as emotional boundaries, peer support, clear role definition, spiritual faith, cognitive reappraisal and adaptation under adverse conditions, finding meaning in adversity, having a «hardy» personality, and compassion satisfaction [15]. It should be noted that this study provides a caveat to the component of spiritual faith, indicating that some traumatic situations may actually contribute to a crisis of faith, wherein meaning and previous religious assumptions are shaken considerably.

Other protective factors for resiliency may include reciprocity between therapist and client, and a meaningful frame of reference that encompasses one's identity, worldview, and belief system [4]. Trippany, Kress, and Wilcoxon added: the capacity of the self to maintain

a coherent sense of identity, connection, and positive self-esteem; ego resources that allow one to meet one's psychological needs and relate to others interpersonally; sense of personal safety, trust, esteem, intimacy, and control; and adaptive cognitive schemas [20]. Additionally, Gentry emphasized components of adequate self-care (e.g. sharing with colleagues, exercise, meditation, nutrition, rest, sleep, recreation, sense of humor, balance, prayer and spirituality, and strategic coping skills) when working with victims of trauma [21, p. 48–51]. Finally, in cases of vicarious trauma, debriefing that employs techniques, such as Francine Shapiro's Eye Movement, Desensitization and Reprocessing (EMDR) therapy, can be quite effective in maintaining caregiver resiliency [22].

The Purpose of theArticle. The purpose of this article is to give an overview of existing assessment and screening tools and techniques that help professionals to offset compassion fatigue in cross-cultural contexts. The authors also present specific action-steps that should follow compassion fatigue assessment in intense trauma-related situations for ensuring quality services.

Main Material Presentation.

Assessments. There are a variety of brief, but reliable measures that help identify both at-risk and protective features. When used prior to the cross-cultural experiences these instruments can facilitate a before-the-fact orientation and help individuals identify personal strengths and weaknesses. When used again after the cross-cultural experiences, the assessments can identify changes which will inform debriefing strategies, specific insights about the individual, and requisite supports. These instruments are: The Ego Resiliency Scale, Daily Spiritual Experience Scale (DSES), Stress Vulnerability Scale, and the Compassion Satisfaction and Fatigue Subscales (CSFS) of the Professional Quality of Life (ProQOL) Assessment.

Ego Resiliency (ER) refers to one's capacity to «contextually modify one's level of control in response to situational demands and affordances.» [23, p. 396]. Masten and Coatsworth referred to ER as a set of constructive coping mechanisms that are used by an individual during and following a traumatic event [24]. Ego resiliency refers to a system of behaviors, not one's personality; therefore, this concept can be taught and learned [13]. If ER is assessed prior to deployment a counselor's vulnerability can be identified and skills taught that target the unique needs identified. The ER Scale was developed in 1951 by Jack Block to produce a «continuous concept of ego resiliency» [25,

p. 157]. Block and Kremen developed the ER Scale as the most current self-reporting ER scale [26]. The ER scale attains reliability when studied across several ethnic populations [23; 27]. Those with high ER can modify their level of ego control in accordance to the situation [23]. Researchers found high ER to be a protective factor for adolescents who had been maltreated during childhood [28]. Researchers also found high ER leads to greater individual emotional regulation and flexibility [29; 30].

The Daily Spiritual Experience Scale measures «a person's perception of the transcendent (God, the divine) in daily life and his or her perception of his or her interaction with or involvement of the transcendent in life» [31]. Interrater reliability and internal consistency reliability levels were both found to be statistically high. Good internal consistency reliability among all research samples was reported. Some critics have reported a concern over unidimentionality [31]. The DSES achieves validity as used across several ethnicities and religions [32–35].

The Stress Vulnerability Scale (SVS) developed by Miller and Smith is a series of 20 Likert-scale questions assessing habitual, lifestyle, and basic needs [36]. Application of the SVS is widely used in a variety of settings including university and corporate environments. While the SVS used in this study is based off of the first iteration of the assessment, this particular subscale remains the same, but as a part of a larger assessment. More recent reliability levels were found to be statistically high [36].

The Compassion Satisfaction and Fatigue Subscale measures compassion fatigue as related to job burnout [2]. Participants answered 30 Likert-scale questions assessing levels of happiness, connectivity to work, and resiliency (e.g. «My work makes me feel satisfied») [37]. Recent applications of the CSFS include assessing for symptoms of PTSD and professional quality of life with nursing staff at a forensic psychiatry security unit, and measuring compassion fatigue among clergy and other disaster-relief workers following the terrorist attacks of September 11, 2001 [38; 39].

Practical Action-Steps. Perhaps imagine you are taking a team of professional counselors to work for two weeks in a remote region of a third world country that experienced a significant earthquake two months prior to the trip. The loss of life and devastation to buildings and infrastructure has been significant. To help the treatment team members prepare, each member completed the battery of instruments. After

the two-week trip, perhaps while traveling home, team members completed the battery as a post-evaluation process. How might results be used prior to the cross-cultural immersion? What changes might you anticipate seeing across the team afterwards? Considering your team, would you hypothesize the following?

1. Treatment team members will report diminished ego resiliency immediately after the experience.

2. Team members will report diminished professional quality of life satisfaction and increased compassion fatigue immediately after the experience.

3. Team members will report increased vulnerability to stress immediately after the experience.

4. A mediating/moderating factor for team members across instruments will be spiritual vitality as measured by the DSES.

If these hypotheses (or other similar hypotheses) seem reasonable, how might this inform practical action-steps to reduce the risk of CFP? As evidenced in the literature and in this brief summary, the risks of developing compassion fatigue are high for those who move toward traumatized populations. It is not enough, therefore, to send counselors into a system we know is embedded with great risks without adequate preparation. Preparation can be obtained through several key action-steps which may make the difference between a counselor who is compassion -fatigued or compassion-satisfied.

One key tactic used by organizations mobilizing counselors is the debriefing process known as Critical Incident Stress Management (CISM) [40 – 42]. Key elements of CISM are: pre-incident preparation and training, demobilization, crisis management briefing, defusing, critical incident stress debriefing, family crisis intervention, individual crisis intervention, pastoral crisis intervention, organizational consultation and development, and follow-up and referral [42]. The aim of these stages is stabilization and progression in intervention strategies. The CISM model also supports the helper during times of crisis by providing tools to process their cognitive and affective reactions in a way that activates coping methods and resilience [13].

Another action step is to bolster the self-care strategies of the counselors through identification of their personal and professional strengths, life-giving habits, and basic wellness (diet, exercise, rest, healthful relationships) patterns. A crucial skill for counselors is the ability to empathize with their clients, but over-empathizing may lead to taking

responsibility for others problems rather than empowering them to take responsibility. Therefore, it is necessary for counselors to understand components of healthy boundaries, recognize their own internal triggers, and how to ask for help in the little choices. In a study,Harrison and Westwood attempted to identify protective practices that reduce risks of vicarious traumatization among mental health therapists [43]. When clinicians practice «exquisite empathy» (being highly present, having good boundaries, and being sensitive), they describe themselves as *invigorated* rather than *depleted* by their involvement with the traumatized client.

A third action-step consists of identifying the motivating forces that compel helpers to help. This includes examining a person's expectations, goals, philosophical framework for suffering and healing, and sense of mission. Of note, Hirschidiscovered that people reported more stress and reduced job satisfaction when they did not feel like they were fulfilling their purpose [44]. Conversely, fulfilling one's career calling may serve as a moderator against stress [13]. In fact, research demonstrates a connection between spirituality and calling. Dik, Sargent, and Steger found a positive correlation between Spiritual Strivings scores, religious commitment, career calling, and meaning in life [45]. Therefore, highlighting the mission of the group and the sense of call that the individuals within it identify may uncover a framework for the purpose, progress, and limitations of helping encountered in reality.

Interestingly,McClelland introduced an effect he termed the Mother Teresa Effect, reproducing results across three studies [46]. Participants in all three studies viewed a documentary film of Mother Teresa's work amongst suffering individuals in Calcutta, India. Some participants were inspired by the film despite the suffering displayed. Therefore, a final (but not exhaustive) action step to prepare counselors for their work includes creating a bond or ethos within the team that communicates the values, creates cohesion, and inspires the counselors to do the task set before them.

Conclusion. The implementation of ongoing assessment and screening tools for helping professionals engaging in high-trauma ecologies, can significantly reduce the overall risk for compassion fatigue and other associated problems on the field that emerge as a result of such fatigue. By identifying both risk- and protective-attributes in treatment and sustaining quality interventions that lead to increased self-care among professional helpers, the effects of compassion fatigue in cross-

cultural contexts can be diminished, while ensuring qualitative delivery of services among traumatized populations.

References:

1. Bride, B. E. (2004). The impact of providing psychosocial services to traumatized populations. Stress, Trauma, and Crisis, 7, 29–46.

2. Bride, B. E., Radey, M., &Figley, C. R. (2007). Measuring compassion fatigue. Clinical Social Work Journal, 35, 155–163.

3. Collins, S. & Long, A. (2003). Too tired to care? The psychological effects of working with trauma. Journal of Psychiatric and Mental Health Nursing. 10, 17–27.

4. Hernandez, P., Engstrom, D., &Gangsei, D. (2010). Exploring the impact of trauma on therapists: Vicarious resilience and related concepts in training. Journal of Systemic Therapies, 29, 67–83.

5. Jenkins, S. R., & Baird, S. (2002). Secondary traumatic stress and vicarious trauma: A validational study. Journal of Traumatic Stress, 15 (5), 423–432.

6. Alexander, C. M., Kruczek, T., &Ponterotto, J. G. (2005). Building multicultural competencies in school counselor trainees: An international immersion experience. Counselor Education and Supervision, 44 (4), 255–266.

7. Baggerly, J. (2006). Service learning with children affected by poverty: Facilitating multicultural competence in counseling education students. Journal of Multicultural Counseling and Development, 34 (4), 244–255.

8. Burnett, J. A., Hamel, D., & Long, L. L. (2004). Service learning in graduate counselor education: Developing multicultural counseling competency. Journal of Multicultural Counseling and Development, 32 (3), 180–191.

9. Lindsey, E. W. (2005). Study abroad and values development in social work students. Journal of Social Work Education, 41 (2), 229–249.

10. McCann, I. L., & Pearlman, L. A. (1990). Vicarious traumatization: A framework for understanding the psychological effects of working with victims. Journal of Traumatic Stress,3, 131–149.

11. Figley, C. R. (1999). Traumatology of Grieving. Philadelphia: Taylor and Francis.

12. Figley, C. R. (1995). Compassion fatigue as secondary traumatic stress disorder: An overview. In C. R. Figley (Ed.), Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized (pp. 1-20). New York: Brunner/Mazel.F

13. Newmeyer, M., Keyes, B., Gregory, S., Palmer, K., Buford, P., Mondt, P., &Okai, B. (2014). The mother teresa effect: The modulation of spirituality using the CISM model with mental health service providers. International Journal of Mental Health and Human Resilience, 16, 13–19.

14.Maslach, C. & Leiter M. (1997). The truth about burnout. San Francisco : Jossey-Bass.

15. Phelps A., Lloyd D., Creamer M., & Forbes D. (2009). Caring for careers in the aftermath of trauma. Journal of Aggression, Maltreatment, & Trauma,18, 313–330.

16. Fourie, L., Rothmann, S., & van de Vijver, F. J. R. (2007). A model of work wellness for non-professional counselors in South Africa. Stress and Health, 24, 35–47.

17. Hatcher, R., &Noakes, S. (2010). Working with sex offenders: the impact on Australian treatment providers. Psychology, Crime & Law, 16, 145–167.

18. Zhao, Y., Meyers, L., & Meyers, B. (2009). Cross-cultural immersion in China: Preparing pre-service elementary teachers to work with diverse student populations in the United States. Asia-Pacific Journal of Teacher Education, 37 (3), 295–317.

19. MacRitchie, V., & Leibowitz, S. (2010). Secondary traumatic stress, level of exposure, empathy and social support in trauma workers. South African Journal of Psychology, 40 (2), 149–158.

20. Trippany, R. L., White Kress, V. E., & Wilcoxon, S. A. (2004). Preventing vicarious trauma: What counselors should know when working with trauma survivors. Journal of Counseling & Development,82, 31–37.

21. Gentry, J. E. (2002). Compassion fatigue: A crucible of transformation. Journal of Trauma Practice, 37–61.

22. Shapiro, F. (1995). EMDR: Eye movement, desensitization, & reprocessing. NY : Basic Books.

23. Letzring, T. D., Block, J., & Funder, D. C. (2004). Ego-control and ego resiliency: Generalization of self-report scales based on personality descriptions from acquaintances, clinicians, and the self. Journal of Research in Personality, 39, 395-422. doi:10.1016/j.jrp.2004.06.003

24. Masten, A. S. &. Coatsworth, J. D. (1998). The development of competence in favorable and unfavorable environments: Lessons from successful children. American Psychologist, 53, 205–220.

25. Waaktaar, T., &Torgersen, S. (2010). How resilient are the resilience scales? The big five scales outperform resilience scales in predicting adjustment in adolescents. Scandinavian Journal for Psychology 51, 157–163. doi: 10. 10.1111/j.1467-9450.2009.00757.x

26. Block, J., &Kremen, A. M. (1996). IQ Personality and motivation structure and ego- resilience : Conceptual and empirical connections and separateness. Journal of Personality and Social Psychology, 70, 349–361.

27. Mak, W. W. S., Ng, I. S. W., & Wong, C. C. Y. (2011). Resilience: Enhancing well-being through the positive cognitive triad. Journal of Counseling Psychology, 58, 610–617. doi:10.1037/a002519

28. Cicchetti, D., &Rogosch, F. A. (1997). The role of self- organization in the promotion of resilience in maltreated children. Development and Psychopathology, 9 (4), 799 – 817. Retrieved from http://dionysus.psych.wisc.edu/lit/Articles/CicchettiD1997a.pdf

29. Sahdra, B. K., MacLean, K. A., Ferrer, E., Shaver, P. R., Rosenberg, E. L., Jacobs, T. L.,Zanesco, A. P., King, B. G., Aichele, S. R., Bridwell, D. A., Mangun, G. R., Lavy, S., Wallace, B. A., &Saron, C. D. (2011). Enhanced response inhibition during intensive mediation training predicts improvements in self-reported adaptive socioemotional functioning. Emotion, 11, 299–312. doi: 10.1037/a002276

30. Waugh, C. E., Thompson, R. J., &Gotlib, I., H. (2011). Flexible emotional responsiveness in trait resilience. Emotion, 11, 1059-1067. doi: 10.1037/a002178

31. Underwood, L, & Jeanne, T. (2002). The daily spiritual experience scale: development, theoretical description, reliability, exploratory factor analysis, and preliminary construct validity using health-related data. Annals of Behavioral Medicine, 24, 22-33. doi: 10.1207/S15324796ABM2401_04

32. Fincham, F. D., Ayjai, C., & Beach, S. R. H. (2011). Spirituality and marital satisfaction in African American couples. Psychology of Religion and Spirituality. Advance online publication. doi: 10.1037/a002390

33. Ng, S., Fong, T. C. T., Tsui, E. Y. L., Au-Yeung, F. S. W., & Law, S. K. W. (2009). Validation of the Chinese version of Underwood's daily spiritual experience scale: Transcending cultural boundaries? International Journal of Behavioral Medicine, 16, 91-97. doi:10.1007/s12529-009-9045-5

34. Sallquist, J., Eisenburg, N., French, D. C., Purwono, U., &Suryanti, T., A. (2010). Indonesian adolescents' spiritual and religious experiences and their longitudinal relations with socioemotional functioning. Developmental Psychology, 46, 699-716. doi:10.1037/a001887

35. Solomon, K., & Tower, R. B. (2009). The daily spiritual experiences scale and well-being: Demographic comparisons and scale validation with older Jewish adults and a diverse Internet sample. Journal of Religion and Health, 48, 402-417. doi:10.1007/s10943-008-9203-0

36. Miller, L., & Smith, A. D. (2004). Reviewer's guide to the personal stress navigator. Retrieved from http://www.stressdirections.com/images/pdf/reviewerguide_12-02.pdf

37. Stamm, B. H. (2005). The ProQOL manual: Compassion satisfaction, burnout & compassion fatigue/secondary trauma scales. Brooklandville, MD: Sidram Press.

38. Lauvrud, C., Nonstad, K., &Palmstierna, T. (2009). Occurrence of post traumatic stress symptoms and their relationship to professional quality of life (ProQOL) in nursing staff at a forensic psychiatric security unit: A cross-sectional study. Health and Quality of Life Outcomes, 7 (31), 1–6.

39. Roberts, S. B., Flannelly, K. J., Weaver, A. J., &Figley, C. R. (2003). Compassion fatigue among chaplains, clergy, and other respondents after September 11th. The Journal of Nervous and Mental Disease, 191 (11), 756–758.

40. Boscarino, J., Adams, R. &Figley, C. (2005). A prospective cohort study of the effectiveness of employer-sponsored crisis interventions after a major disaster. International Journal of Emergency Mental Health, 7(1), 9–22.

41. Vogt, J., Leonhardt, J., Köper, B., &Pennig, S. (2004). Economic evaluation of CISM–a pilot study. International Journal of Emergency Mental Health, 6(4), 185–196.

42. Everly, G. S. Jr., Langlieb, A. (2003). The evolving nature of disaster mental health services, [special article]. International Journal of Emergency Mental Health, 5(2) 109–115.

43. Harrison, R. L., & Westwood, M. J. (2009). Preventing vicarious traumatization of mental health therapists: Identifying protective practices. Psychotherapy: Theory, Research, Practice, Training, 46(2), 203–219. doi:10.1037/a0016081

44. Hirschi, A. (2012). Callings and work engagement: Moderated mediation model of workmeaningfulness, occupational identity, and occupational self-efficacy. Journal ofCounseling Psychology, 59(3), 479–485. doi:10.1037/a0028949

45. Dik, B. J., Sargent, A. M., & Steger, M. F. (2008). Career development strivings: Assessinggoals and motivation in career decision-making and planning. Journal of CareerDevelopment, 35, 23–41. doi:10.1177/0894845308317934

46. McClelland, D. (1989). Motivational factors in health and disease. American Psychologist, 44(4), 675-683.